
An open door review of outcome studies in psychoanalysis

Second revised edition

Prepared by the Research Committee of the
International Psychoanalytical Association.

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Association**

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with gratitude to

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It is good news that this second edition of the Open Door Review has been published.

Firstly, it means that the initial edition had a wide circulation.

Secondly, we can continue this circulation process and let people know about the book, and all research work covered therein, not only in the psychoanalytical field, but also in that of research organisations, universities and mental health bodies.

In fact now, more than ever, we must make people aware of empirical research derived from the practice of psychoanalysis and the knowledge acquired through this practice.

While clinical research remains an extremely productive tool, we must widen and complement this knowledge by other methods that are close to epidemiological studies, therapeutic trials and experimental methodology.

The Open Door Review allows us to evaluate the extent and the quality of research work accomplished during past decades. We can thus review methodological progress and collect new data to assist us in our practices and give way to new research.

I hope that psychoanalysts will welcome this second edition and make students and the scientific world around them aware of it.

Daniel Widlöcher

*President-Elect of the International
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July 2001

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The first edition of the open door review has been a considerable success. The IPA has sold at cost of reproduction all the copies that were printed. Nevertheless requests have continued to come in, so we had the choice of updating or reprinting. If you look at the expanded sections of the second edition, I hope you will agree with us that a new edition was the only way to go. Considerable progress has been made over the last 3 years, and we felt this should be reflected in the review. We are pleased that the review now exists in 3 languages: Portuguese and Spanish in addition to the English. The interest of Latin-American psychoanalysts in research is also reflected by the many new sections in the current edition reporting work from that region.

The new edition follows the structure of the first with both minor and major modifications. In this edition Roger Perron has the last word in the epistemological debate. We hope that by the 3rd edition the Anglo-Saxon voice will be able to generate a reply.

An entirely new section on measures has been added under the editorship of John Clarkin, with significant contributions from Andrew Gerber. Measurement methodology continues to be an urgent need for many experienced as well as novice researchers. Providing accounts of some of the most frequently used psychoanalytic instruments seems helpful and appropriate. Note that a number of measures, particularly those related to the monitoring of psychoanalytic process, are listed in the Appendix. This has enabled us to link them to studies where they have been applied at the same time as gathering them in one place for easy identification.

Two new naturalistic studies as well as two significant updates have been added to the section of the review on naturalistic, pre-post, quasi-experimental studies. Of particular interest may be Imre Szecsödy's description of the European multicenter collaboration, which represents a paradigm for effective collaboration amongst senior psychoanalysts. Amongst the 3 significant additions to the follow-up studies, the German Psychoanalytic Association's study is of particular significance for its comprehensive approach to sampling and its imaginative combination of qualitative and quantitative research methodology.

It is particularly heartening that psychoanalysts have risen to the challenge of randomization with experimental studies from Munich and Buenos Aires, and an extended follow-up of the London Partial Hospital Study.

Perhaps most additional information for the second edition is to be found in the process studies section, which features twelve new studies and five updated contributions. Amongst the changing trends are the increasing size of the studies and the increasing use of computer-assisted coding. The most interesting set of additions are to be found in the process-outcome section, with fascinating findings reported from the US and Europe. Sometimes these results have yielded uncomfortable information, but sometimes they have confirmed and strengthened our belief in the appropriateness of our techniques.

Excluding studies of psychotherapy with implications for psychoanalysis, the new edition of the ODR describes 66 investigations, many of which are ongoing research programs that continue to yield exciting new information, and this in a subject where there is supposed to be no research!

It seems to us that the psychoanalytic research project is now well and truly underway. The challenges for the coming years are publications in prestigious peer-reviewed psychiatric and psychological journals, and increasing attempts to harness advances in measurement and statistical technology in other fields. There is no doubt that psychoanalytic research is a late starter relative to other schools. It is nevertheless impossible to ignore the fact that whenever the effectiveness of the method is fairly and appropriately assessed, it yields effect sizes comparable with other therapeutic approaches. No doubt we will have to meet the challenge of costs and

increasingly undertake cost-benefit and cost effectiveness analyses. However, as the recent meta-analysis by Drew Westen and Kate Morrison (Westen & Morrison, in press) has demonstrated, for serious psychological disorders such as depression and generalized anxiety, brief treatments have fleeting effects. As information about the cost of mental illness becomes more comprehensive and as the cost of psychological distress is increasingly recognized, it is clear that the psychoanalytic approach will emerge as a valid and viable alternative for the treatment of mental disorder, notwithstanding the allure of more appealingly packaged alternatives.

The research committee of the IPA has worked hard to update the Open Door Review. We are proud of what we have been able to produce and we are grateful for the support and encouragement we have received from the Kernberg-Tyson administration. As a mark of our gratitude we are pleased to dedicate this volume to two psychoanalysts who have supported research consistently and courageously and against significant political opposition. We hope that we have justified at least some of the confidence that was placed in us.

Peter Fonagy

Editor and Chair of the Research Committee of the IPA
July 2001

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This document was produced by a collaborative effort of the Research Committee of the International Psychoanalytic Association. It covers many of the studies of the outcome of psychoanalytic treatment carried out in Europe and North America over the past decades. The document is intended as a resource to those who wish to further their knowledge of the area. It does not pretend to be much more than a collection of abstracts of work carried out by psychoanalytic researchers. It does not, for example, claim to provide a coherent integrated narrative of outcome research nor does it intend to offer conclusions concerning the efficacy of psychoanalysis as a form of treatment for mental disorder. Such reviews are available elsewhere and they tend to come to dramatically different conclusions (Bachrach, Galatzer-Levy, Skolnikoff, & Waldron, 1991; Crits-Christoph, 1992; Fisher & Greenberg, 1996; Lazar, 1997; Roth & Fonagy, 1996; Trijsburg et al., 2001).

We have decided to begin the review (Part 1) with a counter-point to the epistemological framework within which many of the studies on which we report were carried out. Roger Perron provided a brilliant summary of the reservations which psychoanalysts might appropriately have about empirical investigations of their work. In this context it serves as a kind of “health warning” concerning the rest of the report. This is followed by an epistemological statement from the empiricist position by Peter Fonagy. Following this section, some of the methodological issues of psychotherapy research of particular relevance to psychoanalysis are briefly reviewed by Fonagy.

Part 2 offers descriptions of the studies, organised according to study design, based on the work of the contributors, taken in some cases from drafts submitted by the researchers. They are followed by a summary and conclusion. These are somewhat more optimistic than some of the other similar reviews undertaken in the past, reflecting both recently reported results and ongoing promising studies.

What this report makes clear is the need for the effort to demonstrate the value of psychoanalysis to be an international one. The work has been going on internationally and many current studies are being conducted across national borders. Even more important, psychoanalysts are coming to realise that their individual and national interests are best served by pooling resources and working together towards compelling demonstrations of the value of their approach. Even where such explicit collaboration is not possible, much may be gained by building on past experience and “not reinventing the wheel”. Rather, replication studies should be planned systematically to examine methodological and conceptual problems of past work, extending knowledge where gaps still exist, and working towards an integration of the psychoanalytic research effort on outcome. We hope that this volume is a contribution to this effort.

This is an “open door” document. No claim is made about comprehensiveness, or even up-to-dateness of the review. Our intention is that the document will be made available in electronic form on the WWW and all those working in the field should send the editor material either missed in the initial review or new findings as these become available for summary and inclusion. The research committee of the IPA undertakes the regular update of this document and also will attempt to ensure its general availability to members of the organisation or to others with an interest in the field. We hope that this compilation will be of value to members of the organisation around the world. Comments on the document should be addressed to the current editor, Peter Fonagy (email p.fonagy@ucl.ac.uk).

Epistemological and methodological background

SECTION A

Reflections on psychoanalytic research problems –
a French-speaking view**Foreword**

This text has been prepared on the basis of an extensive inquiry by Roger Perron among French-speaking psychoanalysts who are IPA members (Société Psychanalytique de Paris, Association Psychanalytique de France, Belgian, Swiss and Canadian Societies); the views here expressed are widely shared by the responding analysts. Agreement seems to have been reached on two points:

- Agreement is generally expressed with Otto Kernberg's wish for the IPA and the component societies to work on research programs aiming to attain more credibility, as a discipline and as a practice, among the general public, the learned public, and the scientists (including those devoted to "hard sciences", i.e. physics, etc).
- However, many questions are raised about the delimitation of the possible objects of such research actions, and about the methods to be used. Many research activities that seem desirable and possible to some of our colleagues (mainly, but by no means exclusively, in the US) are strongly objected to by French-speaking analysts, particularly those which bear on the outcome and the process of the psychoanalytic treatment. It is therefore necessary to introduce distinctions among the research projects according to their objects and their methods.

The present text, which represents the views of its author, raised two questions:

- a preliminary question: what is to be understood by the term "research" in psychoanalysis?
- and on this basis, how can we delimit the subjects or domains of research, and, for each of these subjects (or type of subjects), what may the appropriate methods be?

What is to be understood by "research" in psychoanalysis?

Two types of research actions may be distinguished in this field: those where a clinical attitude prevails, and those which make use of formal and systematised procedures.

Clinical research

Clinical research follows the traditional model of case studies in medicine; it was used by Freud to create and develop psychoanalysis, and many think it remains essential.

Definition

This research approach is centred on the individual case. It focuses on understanding the specificity of the global functioning in a person. The approach is then steered by an effort to understand a functional structure, taken as a structure. We may recall that according to Freud, and to most psychoanalysts who followed him, we may understand the functioning of a structure by conceptualising the successive steps of its construction. A case is understood through simultaneous study of structure and history. The structural approach and the developmental approach cannot be separated.

Of course one cannot limit study to only one individual case: it is necessary to compare several similar cases to find out similarities and differences.¹ A "family" of cases is established, within which we distinguish variants. From this, we may then abstract a functional model that is structural as well as developmental. It was following this approach that Freud, on the basis of extensive clinical experience and reflection, illustrated and defined more precisely his model of

¹ The comparative clinical study of similarities and differences of cases as part of clinical research, as discussed here, constitutes a fundamental research paradigm, which also includes the techniques of the so-called "exact" sciences.

obsessional neurosis with the Rat man (Freud, 1909b), his model of paranoia with Schreber (Freud, 1911), etc. Psychoanalysis subsequently has proceeded in the same way when proposing new models, and we have no reason to discard this approach.

The aims of clinical research

The aims of clinical research are threefold. These are:

to define syndromes, psychopathologies, etc. Many instances may be cited, as in the description of infantile autism as proposed by Kanner (1943), and the development of this definition by M. Mahler (1952), D. Meltzer (1974), etc. Here, we must distinguish the work of leading to the delimiting of a syndrome and its description in terms of symptoms (which fall into the domain of psychiatry, or psychopathology), from the attempt to identify a functional model of this syndrome, using the theoretical and practical framework of psychoanalysis. For example, in the case of autism we must distinguish the descriptive picture of infantile autism from the dismantlement model as suggested by Meltzer in his understanding of these states. Of course, this raises the question whether a psychoanalytic nosology is possible to achieve without violating the core of psychoanalytic metapsychology?

to formulate theoretical constructions. It is the clinical research approach that has produced all the great theoretical models proposed after Freud. It was on the basis of clinical research methods that the controversies raised about rival models have developed (for instance the British controversies between the followers of M. Klein and those of A. Freud) (King & Steiner, 1991).

to provide research foundations to the therapeutic approach. Clinical research also provides the basis for psychoanalytic therapeutic approaches with their considerable divergences – such as those between the techniques of the followers of Klein (Klein, Heimann, Issacs, & Riviere, 1946), Lacan (1964), Kohut (1977), ego-psychologists (Greenson, 1967), etc.

Advantages and disadvantages of the clinical approach to psychoanalytic research

Freud proved its value! But what is its current power to convince? There is a general agreement that the value of a model derived on the basis of clinical research is measured by its utility, as acknowledged by a wide community of psychoanalysts and other experts.

But how wide must the acceptance of a model go, for it to be judged as valuable? It is evident that no precise criterion can be defined. If we consider Freud's own theories, the rate of agreement would be seen as varying considerably depending on specific propositions. For example, not all accept the second instinct theory, nor does everyone find the concept of instinct useful. After Freud, the major models, be they Kleinian, Ego-psychological, Lacanian, Bionian, Kohutian, etc, are all only selectively accepted by psychoanalysts. How can we then specify the limit beyond which a model might be thought of as unacceptable by the community of psychoanalysts, eventually excluding its author from this community? Adler and Jung were rejected, Melanie Klein (1933) was nearly excluded, Bowlby (1960) was thought to be on the margin, etc. History is generally shaped at a political level, rather than on "scientific" criteria. Therefore, the ambiguities entailed in the evaluation of the results of clinical research raise the problem of the unity of psychoanalysis as a discipline, and its converse deep "schisms" or divisions in our discipline.

The problem is probably even more troublesome when we aim to convince non-psychoanalysts. We generally meet the objection that a clinical approach cannot but produce theories based on ad hoc facts according to an already preconceived idea. Experience shows that it is almost

impossible to convince the sceptic if we appeal to experience, general theory, Freud's authority, etc. If we comfort ourselves by pointing out how our opponent's attitude may be a sign of "resistance" against unconscious ideas, the most likely consequence will be the addition of irony to scepticism. Psychoanalysis comes to be regarded as a faith and the analyst is likened to a religious believer (or a spectator). It must thus seem appealing to turn to methods which could provide a clearer epistemic base for psychoanalysis.

The use of objectivization and systematisation methods

We now turn to procedures for proof whose utility is accepted in other disciplines. We could here also think of the approaches used by the historian, the pre-historian, the sociologist,² etc, but these fields are seldom evoked.

The scientific models

Two disciplines are generally called upon. The first is biology. The framework of biology tends not to be used in the context of its modern approaches (using organic chemistry, molecular biology, genetics etc.), but more following the approaches pioneered by Claude Bernard: functional analysis. This was the central model for Freud, and it remains at the core of clinical research. Within this framework, some authors have tried to bring nearer the theoretical and research models of immunology and that of psychoanalysis, through their common use of the concept of "defence". In this vein we may be able to go no further than the analogy, which can prove nothing, or the evocative metaphor, which is at best illustrative, and has no probative value.

The second is the area of the "hard" sciences (essentially physics and physical chemistry). It is clear that this model appeals to many psychoanalysts – not surprising since it has many theoretical accomplishments, it uses high technology and has high prestige among the public and politicians (not least because of the great financial investments involved). Fascination with hard science at times might lead psychoanalysts to declare that "psychoanalysis is a science" by the canons of the physical sciences. This appears to me to be somewhat of a reaction formation against the doubts raised by the uncertainties of psychoanalytic knowledge discussed above. Moreover, the model adopted from physical sciences often is the one that prevailed prior to the introduction of quantum physics, which ignores the considerable modern transformations of thought in this field, as regards causality, status of time and space, definition of reality, etc.

Perhaps psychoanalysis is a science, but the question remains: what kind of science? The problem can be seen at three levels: (a) epistemology, (b) theory construction, and (c) techniques used to collect and process the data within the framework of these theories.

Criteria of scientificity

With regard to the "hard sciences" model, several criteria tend to be invoked:

- *Procedures for the construction of facts*: Observations must be unequivocally confirmable by qualified observers (this of course begs the question of the qualification of the observer).
- *Quantification*: data must be quantifiable to provide material for subsequent logico-mathematical treatment.
- *The replicability of observation*: it should be possible to repeat any observation given identical conditions and identify the same phenomenon.

² But see D. Tuckett (1994) (*Ed*).

- *Possibility of prediction*: A good scientific theory must allow us to predict the occurrence of the events within its domains.
- *“Falsifiability”*: A criterion made popular by the work of Popper (1959) requires that a theory, if it claims to be scientific, must be amenable to procedures that can realistically disconfirm its predictions.
- *Unambiguous terminology*: In building theories, terms used should have sincere and unequivocal referents and their connection to each other should be equally unambiguous.

We could list further such criteria. In the “hard sciences”, these criteria are open for discussion. Thus, many disciplines are accepted as sciences even if quantification is not instrumental, and the experiments are not possible to repeat, as in palaeontology; Newton’s theory is not “falsifiable”, etc. Moreover, it is evident that, beyond a certain point of generality, a theory is not possible to “prove”, it can only be accepted or not as organising a wide array of facts. This holds for post-Darwinian theories of evolution.

In the field of psychoanalytic research, the pertinence of these criteria varies widely according to the aims of the specific category of research (as outlined below). It should be stressed here that French-speaking psychoanalysts seem generally to agree that the criteria of “hard sciences” cannot be applied to the data and process of “classical” psychoanalytic treatments (armchair-couch). All procedures trying to use them will destroy the very object of study. This view will be justified on epistemological grounds.

Remarks on the epistemology of psychoanalysis

Every scientific approach produces and organises facts, at the boundary of theories and techniques. That this is a necessary but not an easy task is clearly indicated in the problems of contemporary physics, in specifying the relationship between mathematics and experimentation. What about the field of psychoanalysis?

Psychoanalytic fact versus historical event

Psychoanalysis, by definition, involves psychological facts, and more precisely on what we could call psychoanalytical facts, that is to say on objects of observation and thought built at the boundary of psychoanalytical theories and techniques.

We must be careful to distinguish the psychoanalytical fact from an historical event. For instance, if the analyst raises the hypothesis of a psychic trauma in a patient, this psychic trauma is evidently something other than the childhood event reported by the patient, even if the latter is accepted as “real” by the analyst, and is assumed to be the root of the traumatic psychic organisation.

As pointed out above, psychoanalytic ‘facts’ are organised, on the level of the individual, across the two dimensions of their structure and their history. But it is generally agreed that this history is not the history of “real events” that occurred in the patient’s life (as could have been observed by a neutral observer, if we can conceive of such an observer). This history is re-moulded by deferred actions, and moreover “rebuilt” in the course of the treatment by the psychoanalytic process itself. In this respect, the ideas of Serge Viderman (1971) had a great impact on French-speaking psychoanalysis.

The coincidence of the method and subject of observation

The psychoanalytic approach has a unique epistemological feature: the subject and the method of study are identical, the psychic apparatus is discovered by means of the psychic apparatus.

Of course, this can be an “objective” approach, as far as the distinction between the patient’s psychic apparatus and the analyst’s one is maintained. We know, however, that this distinction must not be too sharp; otherwise we could turn a blind eye to the dialogue of transference and counter-transference. In fact, it is to avoid such a blindness that the analyst’s personal analysis is a pre-condition for analytical practice.

We may, without doubt, hope that psychoanalytical thinking (as any other framework) should use terms free of multiple meanings and relate them to each other without ambiguity. It is well known that this is hard to attain. Ambiguities may derive from the very object of its study, as this concerns phenomena and processes characterised by sense multiplicity. If we deprive psychoanalysis of such multiple meanings, the language of psychoanalysis would deny its subject matter.

It follows from these considerations that, more than in any other discipline, theory comes first in the construction process of psychoanalytic facts: this is why these constructions are so open to the criticisms of the non-psychoanalyst sceptic.

Proof versus usefulness

We may finally observe that the body of metapsychology is a general theory of psychic functioning and as a general theory, encompassing a wide array of phenomena, cannot be subjected to a process of testing. It is useful or not in linking a wide range of known phenomena, as well as integrating new facts (but as these new facts are generally produced by the theory itself, this is evidently a circular procedure). Thus, the post-Darwinian theories of evolution which cannot be proven, but are deemed indispensable by most biologists.

Metapsychology has similar qualities, not just as a general theory, but in terms of some of its specific aspects. Thus as regards psychic development: we may say, either that we describe its steps as “real”, as they would be seen by “direct observation” of the baby, of the mother-child relationships, etc, or that we speak of a “virtual” child, of a useful model to account for the final structure, remembering that it is not essential that we speak of a “real child”. In this second way, we may satisfy ourselves by saying that we have a useful model, one which is helpful in organising observations (this issue was developed, in particularly powerful terms, by André Green opposing, among other views, those of D. Stern (Green, 2000).

Identifying research aims and definition of research methods

With regard to the problems discussed in the preceding paragraphs, the choice of aims and methods of the research should be established for several specific categories.

Psychoanalytic and psychotherapeutic treatment

The first category is that of psychoanalytic treatment, in its “classical” form (here defined most simply, by its setting: the armchair-couch). French-speaking psychoanalysts seem generally to agree that in this case the clinical approach is the only one that may be used, and that any attempt to submit the data of the sessions to the “hard sciences” criteria, and treat them by derived techniques, is likely to destroy the very object of the research, and moreover could not be accepted as proof by the sceptics. Recordings (audio- or video-) are then banned, not only for ethical reasons (due to confidentiality), but also because such a situation, even with the explicit agreement of the patient, disturbs gravely the transference-counter-transference relationship. We may of course consider using notes taken during the session by the analyst himself, and apply to these data any coding scheme leading to quantitative treatment). But many objections may be raised in relation to these attempts at quantification. Most importantly it inevitably leads to the

fragmentation of the material, no subsequent statistical calculation, however sophisticated, being able to restore this lost unity. We may question the use of “judges” whose objectivity may be only apparent, and many other aspects.

The same objections may be raised against psychoanalytical psychotherapies (in the armchair-armchair setting). However, in this case, the objections are less powerful, considering that the appropriateness of the use of recording and other approaches may be a function of the types of patients and types of treatments.

Psychoanalysts' practice in other settings

Psychoanalysts frequently practise in other types of therapeutic situations. We may distinguish the following approaches:

- Approaches where the psychoanalytic point of view prevails: such as analytic psychodrama and group dynamics, body therapies (with or without relaxation), joint mother-infant therapies, and family therapies.
- Activities in professional settings where the psychoanalytic point of view is not dominant, but where the practitioner uses his or her psychoanalytical training. These include: institutional treatment, the clinical work of the psychiatrist (diagnosis and psychiatric care, including drug therapy), or of the psychologist (psychological diagnostic, projective techniques, interviews, etc). Such professional positions are held by a number of practitioners who underwent a good analysis, but did not wish to train as psychoanalysts, and people in all the “applied psychoanalytic” approaches (such as psychoanalysis applied to literature, art, history, etc).

Research in institutions

We need to consider separately research activities taking place in and bearing on the functioning of institutions. In the case of institutions such as therapeutic, and educative ones, there are a number of different kinds of studies which involve:

- analysis of the characteristics of the treated population (geographical and socio-economical context, family structure, etc).
- analysis of the reasons for consultation, of the initial diagnosis and of the reasons to engage in treatment.
- comparative studies of the means used to attain a diagnosis (for instance: comparison of the scheme proposed by DSM-IV and the “French Classification of Child and Adolescent Mental Disorders” elaborated by S. Lebovici, R. Misès and N. Quemada, which takes into account a psychoanalytic approach to these disorders).
- comparative studies of therapy and education techniques actually used, taking into account the reasons why each was chosen.
- studies of the process of these treatments, and of their outcome: this is the “efficacy” question, the research activity appropriately proposed by Otto Kernberg. It should be noted that to be adequate such studies need to be co-ordinated with the preceding types of investigation.

The specific problems of efficacy studies

The difficulties of efficacy studies are primarily procedural or methodological. The problems are linked to:

- the criteria to be used in the measurement of change. Measurement of symptom reduction will not be enough. We know that symptoms are erratic, that if one disappears it may give way to another, that some symptoms are useful because they are part of defences and their careless destruction might be dangerous, etc.
- the technical translation (operationalisation) of these criteria, as used in the efficacy study: there are problems in using standard schemata like DSM-IV, but also in building schemata for particular research, or in the use of clinical evaluations.
- the choice of “independent judge(s)” who should use these tools: the analyst himself, another analyst, a non-analyst, the patient? None of these possibilities should be discarded a priori. However, it is also clear that in all these cases the question is raised as to the objectivity of such attained judgements. This question cannot really be well answered by combining several judges’ decisions and computing a degree of agreement, since a good agreement may reflect a common bias.
- some important aspects of change are hard to evaluate by quantification (reduction of life stress, shift from “psychic misery” to “commonplace unhappiness”, etc).
- last, we have to take into account the rather frequent cases where the cure gets to its end without any noticeable improvement, but where we are justified to think that the situation would have been far worse without that cure (case of the patients who thus may have avoided inpatient psychiatric care).

Research involving the psychoanalytic institution

Historical research studies. These studies concern the history of psychoanalysis and of its agents, of the development of concepts and theories, etc. The analysis of the origins and development of the conflicts marking this history is particularly important. To what extent are these conflicts specific, due to the training of analysts, ways of transmission, analytic practice itself?

Studies on the functioning of our institutions. Such studies concern the development of psychoanalytic communities from the creation of new workgroups to becoming component societies as well as the evolution of the IPA itself. An objective analysis of the group dynamics involved in these historical developments would be particularly useful. One can imagine interdisciplinary studies with sociologists or ethnologists and so on.

Conclusions

The identification of research aims and the choice of methods should be done on the basis of the considerations presented in the last sections, but in very different ways according to the topics distinguished above.

It ought to be a major purpose for the IPA Research Committee to work towards this dual delimitation; it seems highly desirable for the Committee to urge, at the level of Regions and Societies, the creation of Research Committees to collect the necessary material.

SECTION B

Reflections on psychoanalytic research problems –
an Anglo-Saxon view**Foreword**

By contrast to the French-speaking contribution, this alternative perspective, drafted by Peter Fonagy, is not presented on the basis of a significant sampling of views of psychoanalytic colleagues in English-speaking countries. This is not because of lack of opportunity and certainly does not reflect an absence of concern. Rather, the reason why the views presented here are solely those of the author is because currently the radical message to psychoanalysis proposed is clearly only held by a small minority of psychoanalysts, or so the current writer believes (Schachter & Luborsky, 1998). It is not impossible that change is in the air. The new generations of psychoanalysts who received their professional education since the revolution in the biological and cognitive sciences in the 1970s and 1980s are probably more reluctant to shed the general principles and specific understandings which these rapidly advancing disciplines have equipped them with. Sadly, as for Freud, for many of the psychoanalysts originally trained in the 50s and 60s, there was no true compelling framework of knowledge genuinely addressing problems of mental functioning – other than psychoanalysis.

The situation within which psychoanalysis has to exist today has radically changed from the conditions which prevailed 30 or 40 years ago. There are two major aspects to this change: (a) there have been major advances in the basic sciences underpinning clinical work in the mental health field; (b) there has been a rapid development of relatively “effective” approaches to the treatment of many of the mental disorders which had previously been the unique purview of psychoanalytic clinicians. Under the first category, one could single out the biological revolution, particularly our increased understanding of brain function and under the second the cognitive revolution in psychology.

This summary is divided into three parts. The first will review the current epistemic problems of psychoanalysis including some worrying indications of a fragmentation within the discipline. The second will consider an alternative epistemological approach, which, if adopted, might ultimately radically change the status of psychoanalysis as a discipline. The third section will consider some of the philosophical problems and difficulties which efficacy studies of psychoanalysis entail. We shall conclude that efficacy studies are necessary – but they are the right answer to the wrong question and as such are unlikely to yield entirely satisfactory results.

The current epistemic problems of psychoanalysis**Crisis! What crisis?**

We have become quite accustomed to worrying about the future of psychoanalysis. Mostly, when concerned about the future of our discipline, we tend to focus on the lack of psychoanalytic patients, lack of appropriate candidates, persistent and increasingly well-received critiques of psychoanalytic theory and practice, the strengthening of alternative therapeutic approaches (particularly biological psychiatry and cognitive-behaviour therapy). Perhaps even more worrying is the spawning of more or less psychoanalytically oriented psychotherapeutic approaches, often masquerading as psychoanalysis, which insidiously invade our practice. What I would like to focus on is far worse than any of these, and may even be responsible for some of our other problems - the knowledge base of psychoanalysis.

The fragmentation of the psychoanalytic knowledge base

The Citation Index study

My colleagues and I have reviewed the *Social Science Citation Index* (Fonagy, 1996). We were curious to explore how often the average article in the *International Journal of Psychoanalysis* and *The Journal of the American Psychoanalytic Association* is referred to in other major journals (medical and non-medical). Overall, the numbers are on the decline, even when adjusted for the tendency for more recent papers to be somewhat less frequently cited across the entire Citation Index. This means that the scientific impact of psychoanalysis upon other disciplines may be on the wane. This trend is even clearer when we look at the expected number of citations of all the articles selected from the first issue of the *International Journal* over the past decade. What is this apparent loss of interest due to? Is it that non-analysts (those publishing in psychiatric or literary studies journals) are less interested in what we write? When we looked at these journals, the trend indicating a decreasing interest disappeared. Admittedly the base rates are not very high but they have been the same for quite some while. The surprising results emerged when we looked at the number of times that an article in the *International Journal* was likely to be referred to in psychoanalytic journals. It seems that this is where the declining interest in psychoanalysis originates. With other psychoanalysts!

What does this imply? If these observations are to be believed, the clear implication is that we no longer take sufficient notice of each others' publications to want to refer to them in our papers. We are no longer accumulating knowledge – but rather (to exaggerate the point somewhat) we are all developing the discipline in our own individual directions, no doubt building on the classics, but by and large and increasingly, ignoring contemporary contributions.

These are statistical trends and I am sure that they could be interpreted in a number of ways. It is likely that psychoanalysis is not the only discipline manifesting this trend and while we adjusted the figures for the overall trend for recent articles to be less frequently cited, there may be certain disciplines including psychoanalysis which are characterised by this same trend.³ It is possible that the decline is specific to the *IJPA* and *JAPA* and is in fact an artefact of the emergence and increasing prominence of new journals over the historical period which the study covered. In this case the declining trend would merely index the declining market share of the 'classical journals'. However, the absolute reduction in citations remains an important observation, even if the suggestion is that one cause of the fragmentation may be the great multiplication of channels of publication. By contrast it may be that this phenomenon is specific to English language journals and a similar effect could not be demonstrated in the Spanish, French or German literature. More worryingly, it could be that more recent articles are genuinely of poorer quality; it could be that people simply do not read the journals. Surveys conducted by the American Psychological Association have shown that most psychologists in clinical practice read less than one new article per year. I fear that the most likely explanation is that this phenomenon signals a major epistemological problem of conceptual fragmentation and the loss of an organising paradigm.

Implications and possible causes

It seems fairly evident that fewer and fewer English publications achieve sufficient acclaim to merit citation. The consequence is obvious. We might have experienced difficulties in professional communications up till now (e.g. Wallerstein, 1992), but such difficulties are

³ Dr Stephen Ellman (personal communication) mentioned a similar study undertaken by him and his colleagues in the field of neuroscience where very similar declining trends were observed.

negligible compared to the problems we shall be facing in a few years time. It could be argued that the so-called major psychoanalytic schools which have emerged to organise our discipline over the last half of the 20th century are breaking down. Ego psychologists are no longer ego-psychologists, Winnicottians are no longer just Winnicottian, self-psychologists have fragmented, Kleinian-Bionians have less and less in common beyond these two giants of the field, Anna Freudians were probably an improbable grouping even during her lifetime, and inter-personalists never had a coherent theme beyond the citation of Harry Stack-Sullivan. From this point of view Victoria Hamilton's book *The Analyst's Pre-conscious*, exploring in depth the conceptual frameworks of over 80 eminent psychoanalytic practitioners, makes sobering reading (Hamilton, 1996).

This fragmentation and confusing absence of shared assumptions is what spells, to me, the inevitable demise of psychoanalysis – more than any of the external challenges that we face. In the absence of a common language, we are forced to occupy increasingly smaller intellectual territory. Increasing fragmentation of the psychoanalytic knowledge base has, after all, been a feature of psychoanalysis from its very inception. Ultimately, we shall all be on our own, fiercely protecting our personal psychoanalytic patch. So, what is responsible for the tendency towards theoretical entropy in psychoanalysis? Roger Perron (this volume), in his incisive and erudite analysis of epistemology, draws attention to this in his discussion of the advantages and disadvantages of the clinical approach to psychoanalytic research. He identifies the lack of power of the functionalist criteria (whether a model is sufficiently useful to a significant number of clinicians) as a significant disadvantage of the clinical research approach. I concur with Perron's analysis and would suggest that a somewhat more in-depth examination of this problem may be in order.

The logical status of theory in practice

Inductive versus deductive arguments in clinical theory building

The problem of clinical theory as it relates to the clinical practice of psychoanalysis is at core a philosophical one, usually considered in philosophy of science under the heading of *methodology*. The subject matter of methodology is defined in opposition to that of *logic* (Papineau, 1995). Whilst logic is the formal description of deductively valid reasoning, methodology covers all the reasoning that we undertake that tends to fall short of deductive reasoning. In making clinical judgements and decisions we use arguments that may give us good reasons for believing in certain conclusions but they do not *compel* acceptance in the manner that deductive arguments might.

All psychoanalytic clinicians work with inductive inferences and therefore, by definition, so does clinical research. In psychoanalytic work we are confronted with a finite set of observations, based on formal or informal assessments, as well as the evolving treatment process. From such a sample, the psychoanalyst then moves to conclusions about how the patient generally behaves and formulations about why he or she does so. In practice, induction is made not simply on the accumulation of past observations about a particular individual, but formalisations of past cases by other psychoanalysts in so-called 'clinical theories' (Klein, 1976). We consider theories to lend support to inductive observations because we assume that theories imply that the number of observations on which an inductive inference is based is very considerable and this somehow lends weight to the conclusions. In so doing, however, we are merely generating inductive arguments for induction. We simply maintain that inductive arguments are acceptable clinically because they *work*. Even if our premises do not logically guarantee our conclusions, they normally turn out to be true anyway. Arguing that inductions are generally acceptable because our experience has shown them to work so far, is, of course, itself an inductive argument. Even if observed patterns have tended to hold good so far, what guarantees that they will continue to do so?

As Bertrand Russell (Russell, 1967) argued, it can hardly help to observe that *past* futures have conformed to past pasts. What we want to know is if *future* futures will conform to *future* pasts. The argument of past co-occurrence has little probative value (it is merely rhetorical, it does not prove anything).

Thus, psychoanalysts have implicitly raised the status of 'clinical theories' to laws and have claimed to explain the client's behaviour using Carl Hempel's (1965) *Covering-Role Model*: given that certain initial conditions are satisfied and covered by a specific law that also specifies consequent events, a specific event that is accompanied by the initial conditions is considered as explained by the law. Because they involve deduction via a law, such explanations are termed deductive-nomological explanations. This process has all the appearance of a piece of deductive reasoning. But such explanations do not rescue us from the problems of induction, since the 'laws' were actually established by induction from past observations of results. In fact, most clinical laws are, in any case, only probabilistic (Ruben, 1993), therefore they could allow only inductive *statistical* explanations rather than deductive-nomological ones. While we know that child maltreatment can give rise to behavioural disturbance, this is by no means inevitably the case (e.g. Anthony & Cohler, 1987). The *Covering-Role Model* thus has crucial philosophical limitations and the impact of these is well illustrated by the history of theory in psychoanalytic clinical practice.

The central point here is that the key function of theory for practitioners is to explain clinical phenomena – in other words it is a mere heuristic device rather than a tool for genuine deduction. This approach, however critical from the standpoint of every day clinical practice, is of limited value in terms of theory construction and elaboration. The value of theory based on clinical research is in supporting clinical work. Its weakness is its extensive reliance on induction and therefore its dramatic failure to aid the construction of a coherent, integrated and sound knowledge base which can systematically evolve and define the psychoanalytic approach.

There are three conditions that should be met for clinical research to be an adequate sole methodology of psychoanalytic theory building. These are: (a) a close logical tie between theory and practice, (b) appropriate deductive reasoning in relation to clinical material and (c) the unambiguous use of terms. The first of these is an essential precondition for us to be able to assume that theory is not generated by technique. In order to be confident that there is no irreparable confound between technique and theory, we must be able to show that technique is entailed in theory; that is, that technique has a known and specifiable relationship with theory and thus the contamination of observations by technique, even if not possible to discount, can be specified. The second criterion, the one of deductive reasoning, must be satisfied if we are to show that observations serve both to prove and to disprove theoretical premises. The third criterion pertains to the possibility of the reliable labelling of observations. In the following sections I intend to show that none of these three criteria are met by current clinical research strategies.

Practice is not entailed in theory

One of the major causes of the failure of the clinical research method is that, while we might wish this to be otherwise, in reality psychoanalytic clinical practice is not logically deducible from psychoanalytic clinical theory. While this is quite a radical premise, and one which even I only believe to be partially true, it is neither new (e.g. Berger, 1985; Fonagy, 1999), nor without considerable corroboration from the psychoanalytic literature. There are powerful arguments that support the general suggestion that psychoanalytic practice bears no logical relationship to theory. We shall only touch briefly on six of these:

- Psychoanalytic technique has arisen largely on the basis of trial and error, rather than as driven by theory. Freud (1912) willingly acknowledged this when he wrote: “the technical rules which I am putting forward have been arrived at from my own experience in the course of many years, after unfortunate results had led me to abandon other methods” (p.111).
- It is impossible to achieve any kind of one-to-one mapping between psychoanalytic therapeutic technique and any major theoretical framework. It is as easy to illustrate how the same theory can generate different techniques as how the same technique may be justified by different theories. For example, Gedo (1979) states that: “principles of psychoanalytic practice...[are]...based on rational deductions from our most current conception of psychic functioning” (p.16). His book makes the claim that the unfavourable outcomes of developmental problems can be reversed “only by dealing with those results of all antecedent developmental vicissitudes that later gave rise to maladaptation” (p.21). However, what sounds like a deduction, on closer examination turns out to be a hypothesis. It is one thing to presume and quite another to demonstrate that in therapy developmental vicissitudes require to be sequentially addressed. Many have powerfully challenged the overuse of the developmental metaphor (Mayes & Spence, 1994) and, even from within the self-psychology orientation to which Gedo belongs, the support for his strong assertion is limited (Kohut, 1984, pp. 42-46). By contrast, it is equally striking how clinicians using very different theoretical frameworks can arrive at quite similar treatment approaches (Wallerstein, 1989).
- The fact that we are not in agreement about how psychoanalysis works also suggests that practice is not logically entailed in theory. The nature of the therapeutic action of psychoanalysis is an inveterate theme for psychoanalytic conferences – started perhaps at the IPA conference at Marienbad (Panel, 1937). Since that time, at roughly 10 year intervals there has been a major symposium on the topic at either the meeting of the American or at the International Psychoanalytic Association and probably at least one in each of the intervening years in one of the major component organisations. If practice was logically entailed in theory, we would undoubtedly have a clear theoretical explanation for therapeutic action.
- Theory and practice have been progressing at very different rates, with practice changing only in minor ways, relative to the major strides made by theories. It is quite realistic to contemplate a single volume account that would encompass most major technical advances (e.g. Clarkin, Kernberg, & Yeomans, 1999; Greenson, 1967; Kernberg, Selzer, Koenigsberg, Carr, & Appelbaum, 1989; Luborsky, 1984). Yet, no single person could hope to provide a scholarly and integrated account that would be faithful to all the enormous theoretical developments that have taken place over the past 100 years. The discrepancy in rates of progress between theory and practice is staggering and would be hard to understand were it not for the relative independence of these two activities.
- Psychoanalytic theory is largely not about clinical practice. Scarcely a single volume of Freud’s 23 volume corpus is devoted to papers on technique. So what is psychoanalytic theory about, if it is not about practice? It was intended as and remains an elaboration of a psychological model and the way that this may be applied to the understanding of mental disorder, and to a lesser extent, to other aspects of human behaviour – literature, the arts, history etc.
- The role of theory in practice underscores the inductive nature of clinical research. The value of theory to the psychoanalyst is in elaborating the meaning of behaviour in mental state terms. Thus there can be no question that theory is valuable – it is, however, intrinsically contaminated by practice. It is driven by what is practically helpful rather than the other way around, that is, practice being dictated by what is true about the mind. Thus the major criterion for assessing validity of clinical research findings is contaminated by a set of

considerations unrelated to their accuracy. Certainly, in principle, a theory may be true but of little practical value (e.g., a mathematical theorem) or untrue but great practical relevance (e.g., religion, politics etc.). The loose relationship between technique and theory is a significant burden which clinical research carries. Theory serves to justify practice largely through analogy and metaphor and we must at all times be aware that what we are practising is based on cumulative clinical experience and what we are theorising may be a useful adjunct to clinical practice – but it cannot be its epistemic justification.

The problems of inductive reasoning explain the overabundance of theorisation

Clinical work and clinical observations provide the chief source of theory building in psychoanalysis. There is no question but that the psychoanalytic treatments provide a unique window on human behaviour and thus psychoanalytic theories are rich and imaginative in developmental, clinical and applied accounts. The limitation imposed on it is in part logical and in part psychological.

The epistemic strategy of practising clinicians is, as we have seen, by necessity inductive. They are predisposed to find patterns in the therapeutic interaction which they can explain using existing theoretical constructs. In observing clinical material psychoanalysts opt for inductive reasoning in favour of pointing to instances where the antecedent is *not* followed by a consequent. The predominant psychodynamic epistemic strategy, encapsulated in the clinical case report, became one of enumerative inductivism (the sometimes exhaustive enumeration of instances consistent with the premise).

From a clinical point of view this is an appropriate strategy. To enumerate examples of the influence of an unconscious pattern is not only a useful adjunct to interpretations (“every time you are feeling such and such you do so and so”) but also helps the psychoanalyst to feel on firmer ground in working creatively to elaborate a picture of the patient’s internal world.

But, remembering Bertrand Russell’s quip once more, it is not persuasive to show that *past* pasts conform to *past* futures; that an association we have already observed is one more instance of a known family of associations. What the clinician’s mind finds much harder to tackle is the identification of negative instances – when A was not followed by B – which may lead him to question the premise that A is always followed by B.

Psychoanalysts are not alone with this problem. All human reasoning is substantially flawed in this regard (Johnson-Laird & Byrne, 1993; Wason & Johnson-Laird, 1972). Even when specifically asked to do so, we are reluctant to recognise the relevance of not observing B following A when evaluating the premise A always follows B. This is referred to as the failure *to negate the consequent*. We neither observe, nor use in psychoanalytic theory building, the many instances where the patient’s reaction is not as we should anticipate it to be on the basis of a specific premise.

To take a deliberately simplistic example, signs of unconscious anger with an ambivalently cathected object are readily identified in cases of depression (Freud, 1915). But what of cases where the inward direction of anger does not appear to lead to depression? If such cases were treated with equal attention as cases where the premise clearly holds, the development of the theory of depression might, just might, have been more orderly. To ask clinicians to pay attention to such negative instances, however, seems to me to be asking them to do something profoundly counter-therapeutic and to be specifying a clinical situation where the therapeutic and research aims can no longer be simultaneously pursued in equal measure. The limitation of human reasoning identified by Wason, Johnson-Laird and their colleagues may be a core limitation on clinical research methodology.

The deliberate polymorphy of psychoanalytic concepts

As clinical material is used in a limited way by theoreticians who are themselves clinicians, new theories tend to be developed and readily obtain confirmation. Unfortunately this process tends to occur without systematic reference to the old as ‘supplemental’ to the original theory. Thus new ideas have been observed to overlap, rather than replace, the original formulation (Sandler, 1983). This very quickly gives rise to partially incompatible formulations which, nevertheless, need to be employed concurrently. To give just one example, Freud’s move from the topographical to the structural model completely reconfigured the nature and role of an object. As psychoanalysts still needed to talk to their patients about issues conveniently taken up in the context of the topographical model (e.g. dreams, drive fixations) at the same time as wanting to address issues of adaptation and relationships (using ideas derived from structural theory), they were forced to extend the definition of the notion of the object.

This strategy was extensively used to deal with the many instances where several partially incompatible or partially applicable frames of reference needed to be used side-by-side (Sandler, 1983). Again, this is neither unusual nor reprehensible. It is the way that human language and, in fact all human conceptual systems, deal with the complexity of the phenomena we require them to signify. Rosch (1978), building on the work of Wittgenstein (1969), termed such fuzzy-edged concepts polymorphous concepts. They cannot be defined by distinctive features (a set of necessary and sufficient features). Rather, exemplars of a category are identified in terms of a required level of similarity with a prototype. Thus “chairs” represent such a heterogeneous category that they cannot be defined in terms of either their function, their structure, their constituent properties, their shape etc. For example what do a barstool and an aircraft seat have in common which differs from a seat at a bus stop? Yet most people would identify the first two as chairs, but rarely the third. The problem of psychoanalytic language is in essence no worse than the problem of every day language.

What is disappointing is that psychoanalysts have tended to accept the argument that complexity precludes unequivocal definition as an adequate reason for rarely attempting operationalisation and frequently embracing ambiguity. Here I would disagree with Roger Perron who also denies the possibility of unequivocal definitions for our concepts. Yet there can be little doubt that while the same term may be used with very distinct scientific meanings, the tendency for fragmentation will be reinforced since the use of the same term in quite different contexts undermines the possibility of explicating important differences between theoretical approaches. We need to reach beyond clinical research if we are to overcome the problem of multiple meanings.

A new epistemic framework for psychoanalysis

The historical perspective

Psychoanalysis has developed in somewhat different ways in most of the countries where it has been practised. Depending on the particular cultural context, it integrated to a greater or lesser degree with local institutional mental health services such as psychiatry, psychology, social work etc. In some countries, as in England, the integration between psychoanalysis and statutory mental health care was minimal. In others, such as Scandinavia, Germany or Canada, the integration with psychiatry has been extensive, with state funding for medical psychoanalytic treatment and in some cases even financial support for training. In the United States, insurance companies have been responsible for funding until relatively recently.

A relatively fair generalisation of international historical trends might be that, in countries where high levels of integration between the standard (statutory) provision of mental health care were established, psychoanalysis grew faster, remained under medical domination, developed politically powerful professional bodies but defined itself in distinction to other branches of medicine. By contrast, in countries where psychoanalysis was rejected by the leaders of the mental health professions (particularly psychiatry), psychoanalysis remained a smaller profession, more inwardly turned, arguably more creative, with a greater influence of non-mental health professionals. In essence, although psychoanalytic identity and epistemology exists for both groups, it is more powerfully established as independent of and unrelated to mental health issues in the latter group, whilst it is subtly and intricately tied to the philosophy surrounding mental health care in the former.

These differences were almost imperceptible until the changes in mental health care which have had very different, yet profound, effects on both types of psychoanalytic groups. The focus here will be on those societies which are highly integrated with the delivery of mental health services, as these are the groups most affected by the pressure to provide outcome information.

First we will review the major developments challenging psychoanalysis in the mental health field over the last half century and then propose a realignment of the relationship between psychoanalytic knowledge and other fields of mental health inquiry.

The isolationism of psychoanalysis

Psychoanalysts over the last 50 years have attempted to define their field independently of two major branches of scientific activity which pertain to their field: (a) neurobiology and (b) psychology. We shall take these two fields in turn.

Psychoanalysis and neurobiology

The original objections

With notable exceptions, psychoanalysts since Freud have repudiated the relevance of neurobiology to psychoanalytic ideas. The pressures of caring for patients and the inadequacy of neuroscience combined to make psychoanalytic science primarily a form of psychology, ultimately only concerned with ensuring that psychological treatment was provided in the most systematic and disciplined manner possible. The rejection of biology was not arbitrary but reasoned – not political but conceptual. These may have been some of the reasons:

- Psychoanalysts were powerfully influenced by Freud's failure to create a psychoanalytic neurobiology (Freud, 1895) and opted for a purely mentalistic model based around verbal reports of internal experience.
- In the 40s and 50s neurobiology was dominated by mass action theory (Lashley, 1923; 1929) which held that the cortex was largely indivisible from a functional point of view and behaviour could not be usefully studied from the point of view of the brain.
- Neuroscientists were, by and large, unconcerned with mental health problems, their focus being on deficits of cognitive functioning rather than affect regulation.
- Psychoanalysis evolved in radical opposition to a prevailing view that mental disorders represented a constitutional vulnerability of the individual, which could not be remedied by environmental manipulations.

- An unhelpful distinction between so-called functional and so-called organic disorder was accepted within psychiatry and other mental health professions, which although rarely scrutinised from this point of view, ultimately implied the acceptance of a mind-body dualism.

Progress in neurobiology

While in general, in terms of the quality of patient care and the development of the discipline of psychoanalysis, particularly the unwavering focus on unconscious determinants, it may have been helpful to isolate psychoanalysis from the brain sciences, a number of by-products of this isolationist stance have created problems as the original objections to a closer link between the two disciplines began to shift. The last 30 years have seen a revolutionary advance in all the neurosciences which negated all the historical reasons for the isolated development of psychoanalysis (Westen, 1998). If Freud were alive today he would have an enormously complex set of findings and theories to draw upon in reconceptualising *The Project* and would be hardly likely to abandon the enterprise of developing a neural model of behaviour. Much is now known about the way the brain functions, including the development of neural nets, the location of specific capacities with functional positron emission tomography and neuroscientists can hardly be said to be exclusively concerned with cognitive disabilities or so-called organic disorders (Kandel, 1998; LeDoux, 1995, 1997).

Genetics has progressed, if anything, even more rapidly and mechanisms which underpin and sustain a complex gene-environment interaction belie original naïve assumptions about constitutional disabilities (Plomin, DeFries, McLearn, & Rutter, 1997). To take just a small sample of significant leaps forward which such scientific progress generates in the delivery of mental health care: the effectiveness of selective serotonin re-uptake inhibitors (SSRIs) in both depression and obsessive-compulsive disorder (Joffe, Sokolov, & Streiner, 1996; Piccinelli, Pini, Bellatuno, & Wilkinson, 1995), the undoubted benefits for children suffering from attention deficit hyperactivity disorder to be treated with methylphenidate (Fonagy, 1997b), the relative efficacy of neuroleptics in psychosis (Barbui & Saraceno, 1996; Barbui, Saraceno, Liberati, & Garattini, 1996), the growing recognition concerning the lack of efficacy of prolonged periods of hospital care and – its counterpart – the benefits of assertive community treatment (Holloway, Oliver, Collins, & Carson, 1995; Johnstone & Zolese, 1998), the potential for early diagnosis via brain imaging of neurosurgically treatable lesions (Videbech, 1997) etc. In fact, for the past 15-20 years the field of neuroscience has been wide open for input from those with an adequate understanding of environmental determinants of development and adaptation.

Obstacles to integration

Paradoxically, the response of psychoanalysts has been defensive rather than welcoming of these remarkable advances in knowledge. Notwithstanding the commitment of most individual analysts to embracing all understanding, however painful and anxiety provoking, by and large the response of the psychoanalytic community has been unnecessarily dismissing and critical. The response has been as to an encroachment, withdrawing further and further into increasingly specialist areas rather than seeking to join and develop together with the evolution of brain science. The irrational prevailing belief appears to be that hard-won psychoanalytic insights could somehow ‘be destroyed’ rather than elaborated and enriched by the new methods of inquiry.

A further obstacle generated by the dichotomization of biology and patient care has been the anti-intellectual tendency of many psychoanalytic groups (Kandel, 1998). There is an assumed incompatibility between an astute and acute attention to the mental state of the patient. It is as if our observation of intellectualisation in our patients could somehow be automatically generalised to our own activities: from observing that a patient who reads and talks about science rather than

feelings is not doing analysis, we appear to assume that an analyst who reads science also cannot be feeling and therefore cannot be practising analysis. There is an obvious element of truth in this attitude insofar that reading and keeping up with science is time consuming and must take away from time devoted to clinical work. However, to claim that the two activities are hostile to one another is clearly an expression of prejudice rather than fact and somewhat self-serving on the part of those who do not wish to engage in such activities. Fortunately, the generation of psychoanalytic clinicians whose original professional training has already encompassed the rapid advances we are discussing neither understands, nor can have much sympathy with, this approach.

None of the major advances in psychiatric care are without their problems. SSRIs may turn out to have a significant placebo component (Verkes et al., 1998); ADHD is overdiagnosed, at least in the US (Goldman, Genel, Bezman, & Slanetz, 1998); there are common problems of compliance with neuroleptic medication (Kasper, 1998); there are well-publicised individual cases which document the failures of assertive community treatment; neuroimaging and genetic investigations have currently only a limited practical value. Arguments such as these should not be used to oppose developments in psychiatry but rather should be seen as opportunities for applying psychoanalytic insights in areas where there are significant shortcomings in the biological revolution. This requires taking a different approach: one of collaboration rather than confrontation. Before spelling out the specifics of such a collaborative approach, we should examine parallel developments in psychology.

The isolation from psychology

The original objections

The psychoanalytic attitude to psychology mirrors the attitude of psychoanalytic psychiatrists to experimental medicine and the rest of biology. Progress in psychology has been largely ignored by psychoanalysts, despite the fact that an increasing number of psychoanalytic practitioners received their basic training in clinical psychology. Again, historically there are a number of valid reasons for this:

- Psychology until the 1960s had an almost exclusive concern with behaviour and its models were largely based on studies of learning in animals (Skinner, 1953).
- Psychology traditionally had an antagonistic attitude to psychoanalysis, seeing it as a major, medically dominated rival in offering psychological care in mental health settings (Eysenck, 1952).
- Psychology retained a positivist influence upon its epistemology longer than most other social science disciplines. In fact its liberation from positivism is as much to be credited to progress in disciplines such as linguistics and sociology as to progress within its own domains (Chomsky, 1968).
- Principally as a consequence of the previous factors, clinical psychology was frequently purposely naïve in its approach to the evaluation and treatment of mental disorder (Ullmann & Krasner, 1969; Wolpe, 1969) – a naivety that was abhorrent to psychoanalysts who had fought hard to acquire a sophistication concerning the nature of mental processes and mental phenomena.

Progress in psychology

About the same time as the revolution began in the brain sciences, psychology underwent a radical transformation, moving it from the periphery of the study of the mind to its current position as the recognised leader in the scientific study of mental processes (Westen, 1999). The chief driving forces behind these changes were:

- The elaboration of the computer metaphor for psychological processes and the use of computer modelling for testing the appropriateness of psychological theories (e.g. Schmajuk, Lamoureux, & Holland, 1998).
- The harnessing of technology for improved quality of observation, including the ready availability of video recordings, improved physiological measurements, endocrine and genetic analysis (e.g. Plomin et al., 1997).
- More sophisticated methods of data analysis including techniques for causal analysis and special methods for analysing large data sets (McClelland, 1997).
- Recognising the limitations of their early attempts at psychological intervention, clinical psychologists have worked hard to provide adequate psychological treatments, rarely seeing themselves in opposition to other treatment approaches, but rather as adjuncts bridging the gaps which cheaper pharmacological treatments left behind (Salzman, 1998; Thase, 1997).
- By contrast to the attitude of psychoanalysts, psychologists embraced and built upon developments in related fields and have undertaken many significant large-scale collaborative investigations (e.g. Offord et al., 1992; Rutter, Tizard, & Whitmore, 1981).

Obstacles to integration

The problems created by the combination of psychoanalytic prejudice against non-medical disciplines in general and psychology in particular have grown over the years. One aspect of the problem is the voluntary abandonment by psychoanalysis of opportunities for major contributions to the behavioural sciences. A good instance of this is the controversy concerning developmental studies referred to by Roger Perron. The attempt to reduce psychoanalytic developmental work to a mere metaphor flies in the face of Freud's intentions as indicated by his own observational studies (see Freud, 1909a; 1919; 1920) as well as the work of some of the most distinguished psychoanalytic clinicians including Anna Freud, Renee Spitz, Margaret Mahler, Esther Bick, Donald Winnicott – all of whom saw value in observing the young child, particularly in interaction with a caregiver. These efforts have been meaningful sources of inspiration to theory building and to draw a sharp line between observational studies and psychoanalytic theory as a matter of principle at this particular time seems arbitrary, unscientific and counter-productive. There is no discernible rationale except apparent incompatibilities between the psychoanalytic theories arising out of psychoanalytic observation and those cherished by certain theoreticians. To suddenly rule out observations because these no longer fit in with preconception is certainly not what Freud taught us about science. The scientific developmental model has never been metaphorical – nor has it ever been closer to empirical validation (see, for example, Westen, 1998). For example, while Anna Freud and Glover criticised Klein for the extravagant developmental claims implied by her theory, more recent observational evidence is by and large consistent with her claims – certainly those in terms of the cognitive capacities of the human infant (Gergely, 1991).

There is an even more problematic area concerning psychological therapies where the isolationist attitude of psychoanalysts has undoubtedly created a long-term problem. The pressure for

cheaper, more cost-effective therapies has prompted some psychoanalytic clinicians to experiment with alternative methods of treatment – briefer, more focussed therapies, special therapies for particular groups (e.g. Malan & Osimo, 1992; Sifneos, 1992). These experiments were, on the whole, poorly supported by the psychoanalytic establishment who may have been over-concerned about the apparent superficiality of brief therapy. The gap was rapidly filled by alternative therapies, with often very limited observational or theoretical basis, borrowing increasingly heavily, and relatively openly, from psychoanalytic discoveries (e.g. Ryle, 1994). This has reached a point where certain schema focused therapies which represent an extension of the cognitive behavioural tradition are hard to differentiate from psychoanalytic therapies (Meichenbaum, 1997; Young, 1990). We have tried to show above, that psychoanalytic technique is only illusorily based on psychoanalytic theory. Both the discoveries and the effects of cognitive behavioural therapy and even behaviour therapy, are as easy to explain in terms of psychoanalytic ideas as in terms of behavioural ones (Fonagy, 1989; Wachtel, 1977). It seems, therefore, regrettable that psychoanalysts were not more vigorous over the last 25 years in experimenting with and evolving new psychotherapeutic techniques, but rather rigidly sticking to the ‘one size fits all’ principle. They abandoned the field of technical innovation to psychologists who, in part at least because of the opposition of psychoanalysts, have come to define themselves as “new and innovative” in contrast to psychoanalytic ideas.

This situation has altered somewhat, but only over very recent years. Many American institutes of psychoanalysis have started training psychotherapy candidates, only some of whom are expected to go on to full psychoanalytic training. Others have accepted directly the challenge of alternative therapies and are either working towards integrating effective components of these into psychoanalytically oriented treatments (Goldfried, 1995) or are working towards differentiating the effective elements of each (e.g. Jones, 1997). There is still a major gap in the integration of psychoanalysis and psychology, particularly in taking on board the major advances that the controlled, experimental study of human mental processes has brought to the psychology of language, perception, memory, motivation, emotion, development, social relationship and so on.

The geneticist, Eric R. Kandel (1998) argued in a convincing way that “the future of psychoanalysis, if it is to have a future, is in the context of an empirical psychology, abetted by imaging techniques, neuro-anatomical methods, and human genetics. Embedded in the sciences of human cognition, the ideas of psychoanalysis can be tested, and it is here that these ideas can have their greatest impact” (p. 468).

Further obstacles

The self-imposed isolation of psychoanalysis from the medical as well as the psychological sciences form but two of the major obstacles in the way of establishing a place for psychoanalysis at the table of the academy of the 21st century. There are several practical and epistemological challenges that need to be overcome if the suggested integration of psychoanalysis with contemporary science is to become a reality.

The case report

The first of these is the unique focus of psychoanalytic writers on single case methodology that, as has been argued, shares a major burden of responsibility for the fragmentation of psychoanalysis as a discipline. There is no question but that single case studies are highly informative and much may be learned from the in-depth study of the single case. Our approach to the study of the single case may be improved, as indeed it undoubtedly has if we compare the quality of case reports from the 40s and 50s to current ones.

The case study by itself, however, is insufficient as a method of investigation. It needs to be supplemented by other confirmatory procedures such as replication, detailed experimental studies, anatomical, genetic and neurophysiological investigations. Roger Perron appropriately underscores the benefits that medicine has derived from intensive single case investigations. This undoubtedly was, and, to a limited extent, remains the case. It, however, should be remembered that the usefulness of some of these single case investigations was not simply in the clinical insights they generated but in the support that they received from independent and objective methods. Neuropsychology, which makes extensive use of the single case (Shallice, 1979), strengthens its conclusions through neuropsychological testing, brain imagery and extensive replication.

Background training

Second, many psychoanalysts, particularly those trained by Institutes where psychoanalysis had limited involvement with the delivery of mental health care, may appear to be at a disadvantage in this new framework for psychoanalytic epistemology. Importantly, many extremely talented clinicians in these societies come to psychoanalysis from disciplines other than psychiatry or psychology – the arts, philosophy, or education. They have contributed enormously to the richness of the discipline with giants such as Erik Erikson, Anna Freud, Melanie Klein and current key figures such as Kit Bollas, Charles Hanly, and many others. They joined a mental health profession appropriately opened by Freud to all-comers (Freud, 1926). The fact that no science background was necessary to practise psychoanalysis in the early decades of the century, does not, however imply, that this remains the case. Societies that train individuals without mental health backgrounds normally ensure that these individuals acquire mental health experience. A similar case could be made for ensuring that those practising psychoanalysis and therefore in a position to develop the subject have adequate grounding in pertinent biological and social sciences. This is perhaps less important than a concerted initiative to identify and cherish a special group of psychoanalytic practitioners who will pursue the development of psychoanalytic science within the framework of the new sciences (Kernberg, 1993).

The dialectic between preserving the purity and enhancing the quality of observation

Roger Perron implicitly invokes the important dialectic between the imperative of making reliable observations and, in so doing, distorting the phenomena to a point where meaningful observation is no longer possible. His commentary is carefully restricted to the study of psychoanalytic process – the patient in intensive psychotherapy. Basically, I agree with Dr Perron in his analysis, even if not in his conclusions.

Audio recordings entail the risk that what is observed is no longer psychoanalysis in much the same way that comparative psychology has found laboratory conditions to constrain the range of animal behaviours which could be subjected to scientific scrutiny (Hinde & Stevenson-Hinde, 1973). I, however, struggle with the prescriptive tone of Perron's analysis and the certainty which it implies. I do not believe that we know to what extent audio-taping might or might not interfere with the psychoanalytic process. We anticipate that it might, but this does not mean that it will. Even if it does, it is not certain that it will do so in ways which would prevent the study of certain key aspects of the process.

What we can be reasonably categorical about is that narrative reports, however carefully crafted, are necessarily selective in ways which clearly undermine their scientific usefulness (Brown, Scheflin, & Hammond, 1998). A core element of our theory concerns non-conscious aspects of psychic functions. Our theory tells us that we cannot and should not expect any participant of an interpersonal interchange to be unbiased, to be random in the errors and omissions they make in

their report. I do not think that any psychoanalyst could seriously defend the claim that the mere fact of having participated in an analytic process themselves guarantees lack of bias in their observations.

Far more important than bias, however, is the degree to which any of us can claim to acquire insight into the detail of interpersonal interaction between patient and analyst, purely from participant observation. We know that for the most part such interactions are governed by non-conscious mechanisms, quite opaque to introspection. There are quite dramatic illustrations of this – but some of the most striking are Rainer Krause's (1997) studies of facial expressions of affect in face-to-face psychotherapy and Beatrice Beebe's (1997) and Ed Tronik's (1989) work on mother-infant interaction.

Imaginative studies making use of the advances in recording and coding techniques and particularly phonetic and linguistic speech analysis could undoubtedly advance our understanding of the psychoanalytic process (Fónagy & Fonagy, 1995). To ban such procedures outright is to tie our hands behind our backs in competing with other psychotherapeutic procedures. To me the issue of recording depends strongly on the research questions being asked. As long as it is kept in perspective as but one of many windows for the study of psychological processes and their change in the context of psychoanalytic treatment, and given the patient's and the analyst's willingness to accept the recording, it is hard to see in what way it may harm. However, if we end up confusing recorded analysis with psychoanalysis per se – i.e. conflate the observation of the phenomenon with the phenomenon itself – we are in trouble on a number of counts, not just those pertaining to the validity of our observations.

Is psychoanalysis a science?

There can be no question but that at the moment psychoanalysis is not a science. It simply does not meet any of the major canons for such activity. Many of these were listed by Roger Perron. The question is more usefully phrased in terms of our vision for psychoanalysis. Should we aim to modify it so it might be more acceptable to the community of scholars who call themselves scientists? Or should we be content to continue to occupy a middle ground between art and science, that we currently inhabit? As usual, there are many strong arguments on both sides of the debate. Most of these, however, are couched in terms of the greater respect which would be accorded to our discipline were it to meet the canons of science versus the sacrifices we would have to make in order to do so. There have always been those who entered the murky waters of the philosophy of science in order to show that by this or that definitional framework psychoanalysis might or might not qualify (Shevrin, 1995).

Important as these debates might be, I think they miss the essence of the issue for three reasons. First, even if we meet criteria for scientificity, there is no guarantee that our theories will be taken seriously. There are plenty of examples of scientific theories which are of little concern to anyone. The question is perhaps as much of perceived relevance as of possession of the label of science. Second, as Roger Perron's review demonstrated, there is obviously a limit to how far the discipline of psychoanalysis can go in meeting these criteria before it ceases to be psychoanalysis. Third, the criteria are abstracted from the properties of disciplines generally agreed to be sciences but there are plenty of exceptions. Which are the criteria that psychoanalysis must take seriously? And which are the ones we can neglect? And who decides which is which?

Shift in attitude towards the scientific

Rather than talking about science, I think it would be more helpful to talk about an attitude or culture which characterises science, but which is by no means exclusive to it. Below we list some aspects of the change in attitude that might be required if psychoanalysis were to decide to adopt a more “scientific attitude” in the hope of addressing some of its epistemic problems.

Strengthening the evidence base of psychoanalysis

Most psychoanalytic theorising has been done by clinicians who have not tested their conjectures empirically. Not surprisingly, therefore, the evidential basis of these theories is often unclear. In asking for evidence, I believe we are not returning to operationalism, verificationism, or other discredited residues of logical positivism (see, for example, Leahey, 1980; Meehl, 1986). By placing the focus of explanation into a domain incompatible with controlled observations and testable hypotheses, psychoanalysis deprives itself of the interplay between data and theory which has contributed so much to the growth of 20th century science. In the absence of data, psychoanalysts are frequently forced to fall back upon either the indirect evidence of clinical observation or an appeal to authority.

The validation of variables implicated by psychodynamic theories poses a formidable challenge to the researcher. Most of the variables are private; many of them are complex, abstract and difficult to operationalise or test with precision. Psychodynamic accounts focus on very remote etiological variables which are unlikely to be readily encompassed within an empirically based psychological model. Even when constructs are apparently operationalisable, they are rarely formulated with sufficient exactness so that they could be submitted to disproof. For example, concepts such as splits in the ego, masochism and omnipotence, are rarely defined with the exactitude necessary for operationalisation.

There is a further major logical problem with the reconstructionist stance adopted by most clinicians (see Perron’s overview). At the simplest level, clinical theories of development are based on the accounts of currently symptomatic individuals who attempt to recall events that occurred during early childhood, the most relevant part of which covers the pre-verbal stages of development. Psychoanalysis has contributed significantly to our current sophistication about sources of bias that can distort memories of early experience (see Brewin, Andrews, & Gotlib, 1993). The clear danger is of a logical fallacy of assuming that something must have gone amiss during childhood, otherwise these individuals would not be in such difficulties. Thus most psychoanalytic developmental theories make recourse to various errors of omission or commission on the part of the mother that would be hard to verify. The converse is also true; the presence of “healthy” aspects in an otherwise severely disturbed individual, may lead clinicians to postulate moderating factors such as the presence of “a good object” in an otherwise devastated interpersonal environment. As we have seen, there is a confirmatory bias inherent to enumerative inductivism, which clinical theories of development find hard to circumvent.

Clinical illustrations have enormous value in summarising central and recurrent themes emerging in a particular patient group. They are also useful in generating hypotheses that can be examined through more formal investigative techniques. Clinical insight, however, is unlikely to be helpful in resolving theoretical differences concerning developmentally remote variables that are considered to place an individual at risk of a disorder. The reason for this, as we hope this chapter has illustrated, is that the observations of perceptive and experienced clinicians do not always converge on common interpretations.

It should not, however, be too readily assumed that the empirical data which are most useful in the context of justification, which allow optimal control of variables, minimise threats to internal

validity and maximise the possibility of causal inference, are also most helpful in the construction of a psychological theory. Westen (1991) points to the relative paucity of rich theories within current psychiatry and psychology that are based on controlled studies. Indeed, many psychological theories of psychopathology explicitly acknowledge their indebtedness to psychoanalytic ideas, which have inspired specific lines of empirical investigation. Clinical data clearly offer a fertile ground for theory building, but not for distinguishing good theories from bad or better ones. The proliferation of clinical theories currently in use is the best evidence that clinical data are more suitable for generating theories and hypotheses than for evaluating them. The convergence of evidence from several data sources (clinical, experimental, behavioural, epidemiological, biological etc.) will provide the best support for the theories of mind proposed by psychoanalysis (Fonagy, 1982).

Thus, future psychoanalytic work should move away from enumerative inductivism and develop closer links with alternative data gathering methods available in modern social and biological science. To gather such data, without obliterating the phenomena which such investigations aim to scrutinise, is an important challenge to the current generation of analysts.

Moving from global to specific constructs

Speaking broadly, psychoanalytic constructs lack specificity. For example, psychoanalytic developmental models have aimed at a level of abstraction where a one-to-one relationship could be identified between a particular pattern of abnormality and a particular developmental course. Thus within each of the major theoretical orientations there is a singular model for borderline personality disorder, narcissistic pathology, antisocial personality disorder and so on. Within modern psychopathology and psychiatry the trend is towards differentiation and specificity. Evidence is rarely found linking entire classes of disorders with particular pathogens, but rather specific pathogens linked to specific sub-classes within diagnostic groups. The single case orientation of clinical research has not served psychoanalysis well in this context. It is hard to generate a specific nosology using many single cases, all observed from slightly different vantage points. Studying case series with reference to a single schema may be more productive in this regard. John Clarkin's (1994) work at Westchester looking at sub-classifications of borderline personality disorder from within a combined DSM-IV and structural object relations theory framework is an excellent example of the value of this approach.

There is a further sense in which psychoanalytic constructs are often overly global. For example, object relationships are often treated as a singular phenomenon yet clearly, even at a descriptive level, they encompass a number of subservient functions. These include empathy, the quality of self-object representations, the affect tone of relationships, the ability to maintain these and to invest emotionally in them, understanding interpersonal interactions and so on. It is understandable from a clinical viewpoint, but probably counterproductive from the point of view of research, to conceive of object relations and similar constructs in such a global way. The meaningful categorisation of forms of pathology will be compromised unless we are able to be more specific about the particular aspects of object relations pathology which we see as common to a specific disorder.

Many current theories fail to distinguish between components of a process and a developmental course and thus create potential ambiguity. It is a regrettable general characteristic of our theories that they rarely explain the specific disorders which an individual is likely to develop given quite general characteristics of early experience. Our models do not regularly identify specific remote or proximal variables which account for the emergence of specific symptoms or the nature of the interaction among predisposing variables and other contributory factors. Thus we are rarely able to comment meaningfully on demographic trends such as recent increases in the prevalence of eating disorders or the varying prevalence of disorders across the life-span – for example the

spontaneous improvement in borderline personality disorder in middle age (Stone, 1993). Psychoanalytic concepts, as we have seen, often have multiple referents (e.g. narcissism). Some of these pertain to the developmental course (e.g. inadequate experiences of mirroring and soothing) others to underlying mental states (e.g. a fragile sense of self) and yet others to manifest presentation (e.g. a grandiose view of the self). Stating this in more general terms, it would seem desirable to aim at shifting from an interest in global constructs and towards a greater concern with individual mental processes, their evolution, their vicissitudes, and their role in pathological functioning. There may be a trade-off between explanatory power on the one hand and differentiation and exactitude on the other. That is to say, analyses at a global level offer an apparent power of explanation. This will be lost if the level of analysis is shifted to a specific mental process. However, the inexactitude of global-level analysis ultimately causes fragmentation and precludes the possibility of integrating findings across reports.

It seems then, that as part of the scientific attitude the preferred level of analysis of the psychoanalytic researcher should be groups of individuals (series of cases) and specific mental processes rather than global descriptive characterisations. A more scientific attitude would require us to be more developmentally and culturally specific about risk factors as well as suggest working in collaboration with other disciplines to address the problems of symptom specificity and specificity across the life course.

The routine consideration of alternative accounts

Again speaking generally, in current clinical research there is a notable lack of serious consideration of alternative accounts when relationships are proposed between clinical observation and theory. It is very rarely that authors genuinely consider how the observations they report may be accounted for by theoretical frameworks other than the one they espouse. There is no tradition of “comparative psychoanalytic studies”, where alternative frameworks are considered side-by-side in a specific context. In fact, it is generally, if informally held that those who have not been trained in a specific tradition might be on shaky ground when using constructs rooted in that tradition. It is hard to imagine how this could lead to anything but fragmentation. Instead, each framework, once established, tends to take on the challenge of incorporating all new data, gradually making them unwieldy and contrasts between theories of little practical relevance.

There are two facets to this problem. The first is that the principle of parsimony (Occum’s razor) is hard to apply as explanations are rarely placed side-by-side. For example, the concept of splitting has been widely used since Freud’s introduction of the notion (Breuer & Freud, 1895; Freud, 1923) and Fairbairn’s (1952) popularisation of the idea. As a behavioural phenomenon, splitting is readily observed in most severe psychopathology, particularly borderline personality disorder (American Psychiatric Association, 1994; Perry, 1992; Westen, 1997). Accounts of the concept, however, vary, from ones tracing its origins to infantile mental states and the need to protect the good object from internal attack to others where any separation of mental state from consciousness is considered under this heading. The conceptual framework within which splitting is considered profoundly influences the range of phenomena which it is used to explain. Yet since Hartmann’s (1964) description of the “genetic fallacy” we understand that the origin of an ego defence has no implication for its current function and use. The most parsimonious account of the phenomenon of splitting might be that it is a normally and naturally occurring cognitive response to extreme levels of conflict and stress (Linehan & Heard, 1993). The extensive use of splitting as a defence may have less to do with a past history of unresolved ambivalence or inaccessible traumata and more to do with the current stress which borderline individuals experience.

The second aspect is the identification of the best-fitting account amongst rival accounts. For example, hostility and destructiveness in borderline patients has been attributed at various times to constitutional aggression, experiences of unempathic caregiving, self-protective defensive manoeuvres etc. It is not clear if these competing accounts should be applied to the same individual at different times, to different individuals, or if just one of these accounts is correct and applies to all individuals in the category.

The challenge for the future must be more fully to explore alternative accounts, identify the appropriate sub-population to which they are best suited or discontinue their use having replaced them with a better-fitting alternative. Such an endeavour requires systematic scrutiny.

Increasing our sophistication concerning social influences

Psychoanalytic theories vary in the extent to which they show concern about the impact of the environment. However, generally speaking, they suffer from a lack of sophistication in considering the impact of the external world. In some respects this is understandable as the focus of psychoanalysis is explicitly upon the intrapsychic. It is this lack of sophistication which leaves psychoanalysis vulnerable to accusations of mother-blaming and the unrealistic over-emphasis on external influences during the first years of life.

It is now generally accepted that influences between the child and the environment are reciprocal. Constitutional and parental risk factors interact in the generation of risk (Rutter, 1993). Such interactional models suggest that risk and trauma are processes rather than events and problems arise when a constitutional vulnerability is combined with a sub-optimal environment thus generating a maladaptive response which in turn might undermine further the adequacy of environmental provision and so on. A scientific psychoanalytic attitude would suggest the elaboration of current psychoanalytic developmental models in the direction of increased specificity concerning transactional aspects of the process of traumagenesis.

There is a further respect in which psychoanalytic views of environmental influences lack sophistication. The wider social and cultural context within which object relations develop are often ignored by psychoanalytic theorists. This observation is only partially accurate in that many individual theorists have paid specific attention to cultural factors (see for instance, Erikson, 1950; Lasch, 1978; Sullivan, 1953). However, the impact of race and culture on development and pathology is rarely a focus for psychoanalytic theorisation, perhaps as a residue of the biological origin of psychoanalytic ideas.

A particularly dramatic example of the influence of cultural factors may be found in approaches to self-development. Psychoanalysts have traditionally emphasised, in their general theories of development, the individuated self (see, for example Kohut & Wolf, 1978; Mahler, Pine, & Bergman, 1975). In generalising these models to other cultures, we may be ignoring the extent to which these ideas are rooted in Western thought. In non-Western cultures, the relational self is far more widely represented than the individuated self (Sampson, 1988). The relational self is characterised by more permeable and fluid self-other boundaries and by an emphasis on social control where this includes but reaches far beyond the person. The unit of identity for the relational self is not an internal representation of the other or its interaction with an ego ideal, but rather the family or the community. In traditional psychoanalytic theories a person who is over-dependent upon, and influenced by, moment-to-moment changes in their inter-personal experience might be considered immature or even pathological. Yet there is nothing universal about this view of the self. These ideas have emerged only gradually even in the Western world over the past 200-300 years (Baumeister, 1987). The well-known gender asymmetry in the

diagnosis of borderline personality disorder may be interpreted as a consequence of the greater challenge experienced by women than by men when faced with the Western ideal of an individuated self (Gilligan, 1982). Placing the individuated self implicitly or explicitly at the peak of a developmental hierarchy may risk ethnocentrism as well as pathologising a mode of functioning which may be highly adaptive given specific social contexts.

The lack of psychoanalytic sophistication concerning the social environment represents a major challenge to the evolution of psychoanalysis beyond the issue of its scientific status. Given the intensive nature of psychoanalytic treatment, its influence will always be restricted to the relatively few individuals who have the benefit of this intensive form of psychotherapy. The decline of the social influence of psychoanalysis since the Second World War may have more to do with the extension of concerns about the mental health to a larger section of the population. Given the numbers now involved, psychoanalysis is bound to be seen as less relevant as a treatment approach. For the discipline to survive and flourish, it is essential that our theories are made relevant to the community at large and that we are able to offer input with problems of concern to our local community. Certainly at the present state of knowledge, such input should never be didactic but rather offered with the aim of learning at least as much as teaching. There are several projects in this spirit already underway in major cities in the US including Michigan, New Haven, Los Angeles and New Orleans. Traditionally our discipline has been highly ethnocentric. For example, psychoanalytic studies of multi-generational traumata have principally focussed on survivors of the Holocaust (Bergmann & Jucovy, 1982; Kogan, 1995). Yet perhaps we could learn as much or more about this process from the study of African-American communities in the US, many of whose current problems could be seen in the context of our failures in terms of their history in North America as an enslaved group (e.g. Belsky, 1993).

In brief, with regard to social influences, psychoanalysis should develop an improved categorisation system to describe environmental influence. Transactional models of development pay more attention to cultural factors, show greater awareness of their cultural context and step beyond ethnocentrism.

Collaboration with other disciplines

For some psychoanalysts, the separateness of the psychoanalytic discipline from others whose subject matter overlaps with ours has been a source of pride to the extent that analysts have been criticised for including too many bibliographic citations to non-psychoanalytic work amongst their references (Green, 2000). The fear appears to be that fields adjacent to psychoanalysis have the potential to destroy the unique insights offered by clinical research. Whilst this is not a dominant view in psychoanalysis, and most psychoanalysts welcome the insights which knowledge from related areas can bring, instances of active collaboration with neighbouring disciplines are patchy, unsystematic and usually focussed on specific findings, discoveries or ideas which are already consistent with a particular author's preconceptions (c.f. Wolff, 1996).

Contrary to the suggestion that closer proximity to sciences with similar interests to ours may destroy psychoanalysis, Kandel (1998) made a strong case that the rich insights from psychoanalysis are most likely to be preserved through closer integration with biological psychiatry. He based his argument on three general principles:

- All functions of the mind reflect functions of the brain. This principle may be maintained even if it is found that, for many aspects of behaviour, a biological analysis may not prove informative. Psychoanalysts may have a certain unease about the notion on two counts. First, that a biological account is invariably reducible to genetics, and second that genetic transmission leaves no space for environmental causation. Kandel, however, convincingly

demonstrates that the ability of a given gene to control the production of specific proteins in a cell is subject to environmental factors and the fact that only 10-20% of genes are transcribed or expressed in each cell leaves plenty of room for social factors: “social influences will be biologically incorporated in the altered expressions of specific genes in specific nerve cells of specific regions of the brain” (p. 461).

- Genes contribute importantly to mental function and can contribute to mental illness but behaviour itself can also modify gene expression. Twin, adoption and pedigree studies have provided ample evidence that genes determine about 50% of what we traditionally call personality. Variables such as tastes, religious preferences, and even clearly environmentally determined neurotic disorders such as post traumatic stress disorder have substantial genetic components. On the other hand, studies of learning in simple animals have demonstrated some time ago that experience can produce lasting changes in the effectiveness of neural connections by altering gene expression. These interactions suggest that the traditional distinctions between organic and functional disorders are unsustainable. All mental disease is organic since functional imaging techniques can reliably demonstrate that the biological structure of the brain is altered (Jones, 1995). This observation is a trivial consequence of the previous principle. The outstanding two-fold question is how biological processes modulate mental events and how biological structure is modulated by social factors. It is in answering the second of these questions that a scientific psychoanalysis has a clear role to play.
- Alterations in gene expression as a consequence of learning impact on the brain by causing changes in patterns of neural connections. By the same token, psychological interventions such as psychoanalysis must also produce changes in gene expression which alter the strengths of synaptic connections. It is possible to argue that both pharmacological and psychotherapeutic interventions produce functional and structural changes in the neural circuitry. The former may be more non-specific than the latter and therefore more effective for some mental disorders than others. Alternatively, the two may function synergistically – each acting on slightly different systems but enhancing the benefit to be derived from the other. The evidence from combined pharmacological and psychotherapeutic interventions implies that there is considerable benefit from an integrated treatment approach (Roth & Fonagy, 1996).

The same set of arguments could be made for the further integration of psychology and psychoanalysis. As long ago as 1982, I proposed that much that has been learned in psychology about mental processes was applicable to psychoanalysis and should be integrated with it (Fonagy, 1982). Since that time, together with a number of colleagues, I have been working on integrating the mental function associated with the representation and understanding of mental states with psychoanalytic ideas. This is just one of a wide range of mental processes or modules (Fodor, 1983). Systematic study could achieve a high level of integration and a great deal of increased sophistication in the way that psychoanalysts talk about remembering, imagining, speaking, thinking, dreaming and so on.

All that is required for both these integrative initiatives is a more scientific attitude, a broader range of methods and an openness to and excitement about new ideas.

SECTION C

Response to Peter Fonagy
by Roger Perron

I am in agreement with Peter Fonagy on certain basic principles: the need to clarify and be more precise about our concepts, in an effort to really attain a common language, and to be more convincing (both to ourselves and to others) about the validity of our theoretical corpus and the efficacy of our work. I second his regret about the chilly isolationism of many of our colleagues towards other disciplines that could be valuable for us, particularly psychology in its modern developments: I have often remarked that, when our psychoanalytical society organises interdisciplinary discussions, it invites immunologists, sociologists, anthropologists, historians, etc., but never psychologists. At the present time in France, psychologists are far more receptive to psychoanalysis than psychoanalysts are to psychology.

However, there are also topics on which we differ or disagree. I shall limit my response to four points:

A. Is psychoanalysis a science or not?

This question roused much controversy among some of our French -speaking colleagues some years ago, and produced some important publications. As a scientific researcher who teaches the methodology of clinical psychology, I must confess to being sometimes irritated by these discussions, because the question was too often discussed according to an implicit model of science which is the one that reigned – and reigns – over physics, chemistry, optics, cinematics, electronics, etc. where the looked for laws are shaped in terms of mathematical propositions. This forces us to discuss the problem in terms of the criteria prevailing in these sciences (quantification, repeatability, etc.).

But there are other models. The main one is the functional model, as laid by Claude Bernard and largely used by Freud. But we must also take into account the taxinomy model used by botany and zoology to produce, from the middle of the 18th century, an enormous bulk of knowledge; the developmental – more widely diachronic – model, in paleontology, embryology, linguistics, child psychology, etc.; formal models as used in anthropology, sociology, linguistics, some currents of cognitivist studies, etc. In all these cases nobody contests that scientific work is being done, even if in many cases there is no quantification of the observed phenomena, or only an accessory quantification. There are plenty of examples. For example, lunar cartography is a scientific enterprise: even if measures of distances, altitudes, etc., are taken, this is clearly not what defines the object and the method. Paleontology draws developmental lines by arraying along time forms of skeletons: even if carbon-14 dating is utilized, the real scientific work is done by the researcher's mind when he looks for similarities and differences and puts them into temporal order.

If we enlarge the discussion to consider the so-called “human sciences” (the very term being disputable) I think that many serious historians, for instance, would be shocked if somebody declared that their work was “unscientific” because they do not measure anything, and cannot deduce mathematical laws...

What is the status of psychoanalysis in these disputes? Psychoanalysis is an endeavour to understand something about mental functioning. But passions are roused when we try to consider the functioning of our own minds: mathematics about other people, yes, but not about me! (It can be very entertaining to hear eminent colleagues proud of their position in scientific psychology arguing, with much passion and ire, that the human mind can be understood only without passion).

In fact, what is at stake is the question of human liberty. We are in a double bind: on one side, the resolute determinism of Freud, which we generally adhere to, and on the other, the evident aim of the psychoanalytic treatment, which is more personal liberty. How to lean on determinism to promote liberty? I have no clear answer to this question, but I think that it is worth pondering.

In fact, I think that the question must be posed in this form if we are not to be trapped in what appear sometimes to be distressingly naïve discussions of the question “is or is not psychoanalysis a science”.

I cannot concur with Peter Fonagy’s discussion in terms of deductive or inductive methods. Of course, psychoanalysis cannot be deductive in the sense of “if A... then B”. Happily so, because this would totally suppress any liberty. I far prefer: “If A, B, C... X, then perhaps Y”: this is precisely what we observe, not because our knowledge is coarse, but because things are so. The statement on p.13 that: “Psychoanalytic practice bears no logical relationship to theory” implies that the deductive method is the only really “logical” method, but there are other ones. As a psychoanalyst I try to be “logical”, i.e. to avoid contradiction. To seek for contradictory observations and hypotheses is an essential principle in every objective approach, including clinical and theoretical work in psychoanalysis. But, this admitted, the question of the relations between contradiction (at the knowing mental apparatus level) and conflict (at the known apparatus level) is an important one for psychoanalysts.

B. The diachronic approach.

Here I differ widely from the position elaborated by Peter Fonagy. As a clinician and a research worker, I have worked in the fields of developmental psychology and child psychopathology. To make predictions in these fields is always highly dubious: happily so, as this is a good proof of human liberty. This is striking in the case of families with an autistic child: why this particular child, and not their brother or sister? Usually we find no credible answer when we try to point to a constellation of factors and conditions prior to and external to the subject himself, considering the psychic functioning of the subject as a mere result of this constellation. This is so because, by adopting such an approach, we ignore a basic principle of psychoanalysis: the psychic dynamics of the subject have in themselves a causal value, proceeding from internal laws. We must therefore strive to grasp the history of the construction of this particular mental apparatus (in this case the mental functioning of an autistic child). Of course, it remains important to know also the history of events and surrounding conditions, but they are to be considered more as an array of conditions than of causes in the strict sense.

From this perspective two points may be underlined. First, we cannot and must no longer accept the model of causality that prevailed in 19th century physics (if A, then B). Even in physics, models of recurring or circular causality, chaos theories, etc., have upset this simplistic approach to understanding causality. In this respect, chaos theories are very fruitful for us. It has been clearly demonstrated that a very large number of non-predictable phenomena occur in the field of events relating to matter and energy (the subject matter of physics, chemistry, biology and other natural sciences). Moreover, the latter are non-predictable not because of a lack of knowledge on our part but by their very nature: a tiny random variation at any given point of the causal chain may lead to a totally different long-term result. Remarkably, this has been very clearly demonstrated mathematically; however, what has been demonstrated is not that a specific event will necessarily occur but, on the contrary, that it is impossible to predict which event will occur. We can therefore no longer define a science on the basis of its capacity to predict phenomena. Psychoanalysis, which is interested in psychic development and its pathologies, often falls into this category; moreover, the same applies to a course of treatment with an adult – while one may have hopes and predictions and seek to establish and direct the analytic process as effectively as possible, the outcome is not – and can never be – certain.

Second, in the psychoanalytic field, it seems essential to consider the role of deferred actions. André Green (who knows a lot about English-speaking authors) has often underlined the fact that we differ widely in our understanding of this term. In French, “Nachtraglichkeit” is translated as

“après coup” (effet en causalité rétrograde, with effects on what came before, or more precisely on what is left of it) whereas the English speak of “deferred” or “differed” action, in a one-way time arrow. On both the clinical and the theoretical level, no matter how credible a patient’s account of an event (for example a violent action of the father against the mother when the patient was 8) we are faced, not of course with the event itself, as it would have been observed by an objective witness (but even such an objective witness would have seen and experienced the event with the same dynamics, the same identifications, projections, etc., as anyone else), but with a *memory* of the event. The question is therefore: why and how was this event seen and experienced by the child at 8, and how and why did it afterwards affect the history of his psychic functioning, his identifications, his drives and anxieties, etc., if it is now being presented in this way? Throughout this history, the original event has been remodeled and rebuilt; it has contributed to assimilate, and sometimes to provoke, other events, other experiences, etc. Only the present event is open to our work, which is: such a thing is said to me, here, now, in this session, in this moment of the treatment: how is it said, why now, why to me? It follows that the questions of how the original event happened (at 8 in my example), and even whether it happened, are secondary. The evolution of Freud’s theory from a theory of “real seduction” to the assumption of fantasy is pertinent here. The history of the patient is the history as it is deconstructed and rebuilt in the course of the treatment; and the very aim of the treatment is precisely to build a new personal history. Serge Viderman, who had a great influence on French psychoanalysis, discussed this with great momentum (Viderman, 1970).

C. Polysemia (multiple sense).

On p.16 it is asserted that I deny the possibility of unequivocal definitions for our concepts. I do not deny this possibility, but aim to raise a question. I agree that the more a concept can be defined without any ambiguity, and the more we can articulate the relationships of these concepts in an unambiguous manner, the better it is for our discipline. But what is lost of psychoanalysis if we go too far in this way? This question may be discussed at two levels.

The first is plainly a semantic one. Yes, we should be in a better situation if we could use words that would not provoke misunderstandings among psychoanalysts. But different words create a trend to think that things are wide apart. Two examples. “Fantasy” is a word that covers all levels of this psychic type of productions, from unconscious to clearly conscious ones. I maintain that the term “fantasy” must be used to point to the continuity of the field, but qualified, to be clear, with adjectives such as “conscious fantasy”, etc. “Identification” is a protean term, and it seems better to qualify it with adjectives (hysterical, adhesive, etc.), but to keep the term “identification” in order not to split the field in tiny pieces.

The second level of the question is far more difficult. It pertains once more to the problem of the relations between the knowing and the known; in other words, to the fact that we know the psychic apparatus by the means of the psychic apparatus. Objectivity of course may be looked for and attained, but only by considering transference and counter- transference. As to the question and to this answer, I think that the status of psychoanalysis is unique (and difficult to understand by non analysts). A consequence is that perhaps some plasticity of our knowledge means (words and concepts connoted by words) is necessary. I fear that in a cure the exclusive use of unequivocal terms (one meaning only for each) would blind the analyst to what s/he ought to see. The model of the computer (which stalls when confronted with ambiguous terms and/or ambiguous relations) is a fallacious one. It is evident that we work with multiple senses of the “same” material, as well in the analyst as in the patient; the productive moments of a cure are those when the senses diverge, and the analyst, thinking about it, finds and suggests something new to the patient. One may add that linguistics (we work with and in language) has demonstrated that each word has several meanings, of which one is selected from its place in a

syntagmatic net, according to the context (verbal and non verbal). If this is ignored, perhaps there is no more psychoanalysis. This of course is largely open to discussion. This idea would ground some objections I could raise about some forms of atomising check lists, grids, etc. (but some forms only). Physics has clearly demonstrated that conventional mechanics does not apply in all cases since some processes are irreversible, in both nature and in thought. Consider the example of the mixture of gases and ash produced by a burning cigarette: it seems impossible to use the spatial distribution of these molecules afterwards to accurately determine the spatial distribution and structure of the cigarette's constituent molecules before combustion.

(cf Atlan, H, *Entre le crystal et la fumée. Essai sur L'organisation du vivant*, Paris, Seuil, 1979; Prigogine, I, Stengers, I, *La nouvelle alliance. Métamorphoses de la science*, Paris, Gallimard, 1979). The same applies to psychoanalytic research: it seems to me extremely unlikely that by using psychic or behavioural fragments, each allocated a place in an analytic framework, we can create a picture of how the whole psyche functions, regardless of how sophisticated our methodology is.

D. Recording data from sessions.

Peter Fonagy objects on p.22 to: “the prescriptive tone of Perron’s analysis and the certainty which it implies”. Yes, I am prescriptive and certain that I should be unable to tape one of my sessions with a patient. Because: either I do not tell him, and this would be an intolerable betrayal of his faith (and could I then be indignant if he himself secretly taped some sessions, as happened some years ago to a colleague, who was publicly denounced as a quack in magazines); or I ask his agreement. Whatever I say and think, he will think that other people will hear or read what he said, so a third party will be from the very beginning and constantly with us, intruding in our relationship. All transference and counter transference processes will be affected. Fonagy says, “I do not believe that we know to what extent audio-taping might or might not interfere with the analytic process”. But can we find that out from a statistical study? (which would be from the very onset distorted). I know, on the basis of all my analytic experience, that between me and my patients this would interfere, in a way I could not properly analyse. All my French colleagues think that way. If one of my trainees told me that he intended to tape a patient, I would tell him not to do so. All the training analysts in our Institut de psychanalyse share this position.

I must add that this is for psychoanalytic sessions proper (armchair-couch). I think it would be possible to tape under other settings (face to face, psychodrama. etc., with some patients (not all, of course). This is to be discussed. But the following question is: With what methods should these data be treated? This is another big chapter, for another day.

SECTION D

The justification of effectiveness studies in psychoanalysis

In this section we shall consider the current climate in health care services which is largely responsible for the drive for effectiveness research and briefly overview some of the methodological issues that confront these studies. In the last part of this section we shall overview studies of psychoanalytically orientated psychotherapies.

Evidence based medicine and its justifications

Reasons behind the insistence on evidence

Psychoanalysis is a clinical intervention. Its aims and ambitions, at least from the point of view of most patients, are clearly associated with those of other healing arts such as surgery, physiotherapy and osteopathy. Admittedly, this is just one aspect of the psychoanalytic enterprise, but one that is crucial to its standing within most of the cultures where it is practised. Over the last ten years, all aspects of medicine have come under scrutiny, where increasingly both commissioners and funders of medical intervention, as well as those managing and directing clinical services, have embraced the values of “evidence based medicine” (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996). Clinical judgement is no longer accepted as sufficient grounds for offering medical treatment. Recommendations at national policy as well as at local health care provider level are expected to be based upon evidence of effectiveness. What factors account for this change?

Ostensible reasons

Evidence based medicine is founded on an ideal – that decisions about the care of individual patients should involve the “conscientious, explicit and judicious use of current best evidence”. Much is claimed in favour of this approach, particularly in North America and Western Europe. The arguments in favour of it include (a) the more effective use of resources, (b) improvements in clinician’s knowledge, and (c) better communication with patients (Bastian, 1994). From an ethical point of view, the strongest argument in support of evidence based medicine is that (d) it allows the best evaluated methods of health care to be identified and enables patients and doctors to make better informed decisions (Guyatt, Sackett, Cook, & the Evidence Based Medicine Working Group, 1994; Hope, 1995). All these are good reasons but all were as relevant to medicine in the past as at the moment. So why the current emphasis?

The political background

The real driving force behind evidence based medicine is unlikely to be a genuine concern for the quality of care. The movement appears to be largely driven by financial consideration and the hope of health care organisation to be able to reduce escalating costs by focussing on the most cost effective option given a range of treatments. Governments and health funds find the notion of allocating health resources on the bases of evidence quite attractive. In North America, D.K. Eddy in an important editorial suggested that healthcare funds should be required to cover interventions only if there was sufficient evidence that they can be expected to produce their intended effects (Eddy, 1996). The Australian Health Minister, Dr Michael Wooldridge, adopted a very similar position stating “[we will] pay only for those operations, drugs and treatments that, according to available evidence, are proved to work” (Downey, 1997).

While we believe that evidence for psychoanalytic interventions are important to derive, we are sceptical about the pressures brought on psychoanalytic clinicians as it seems to us unlikely that even in the face of overwhelming evidence as to the benefits of this relatively expensive treatment, the resources would be available to provide psychoanalysis for a significant proportion

of those who require it. We shall consider the specific issue of cost effectiveness separately. In this context it is important to review the philosophical basis of the search for evidence for psychoanalysis in order to gain perspective on the entire enterprise of outcomes research. Perron's critique has covered some of these issues from a more general epistemological standpoint; here some additional conceptual and practical concerns will be briefly explored.

Philosophical concerns

Evidence based medicine represents a practical example of "consequentialism". Consequentialism refers to the proposition that the worth of an action may be assessed by the measurement of its consequences. There are at least three problems with the consequentialist argument, all of which apply to psychoanalytic outcome research: (a) the difficulty in measuring outcomes, (b) the ownership of outcomes (whose interest should be considered?), (c) consequentialism may lead to unethical conclusions. We shall take these in turn.

Philosophical questions concerning the measurement of outcome

The first concern is with the measurement of outcome. It is indisputable that many important outcomes of any medical treatment are unmeasurable. Evidence based medicine claims to provide a simple logical process for reasoning and decision making: (a) systematic scrutiny of the available evidence, (b) drawing appropriate conclusions leading to (c) a clinical decision as to the appropriateness of a treatment. Within this framework, for any decision to be balanced, all relevant consequences of a treatment must be considered. Unfortunately, in the current state of methods of psychological measurement, many important outcomes can only be very inadequately measured. Psychoanalysis concerns complex internal states such as the degree of distress or pain experienced by an individual. Often these complex states are reduced to simpler, easily measurable ones such as depression (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), anxiety (Spielberger, Gorsuch, & Lushene, 1970) or total symptomatology (Derogatis, 1983). A valid objection to such measures (if used without sophistication) is that they are reified and researchers may conflate the measure with the phenomena they were aimed at quantifying. Thus, the BDI score is not depression and the total symptom distress score of the SCL-90 is not equivalent to mental pain. By having these measurements we have not at all done justice to the complex cognitive, affective and physiological processes which are implicated by these terms.

Even if better measures were found for some of the domains of outcomes entailed in psychoanalytic treatment, other aspects of the process, such as an ethical life, a sense of purpose or social justice, may be inherently unmeasurable. Even more troublesome are key domains which are not even well defined, let alone measurable. One such is the "quality of life". Attempts have been made to provide a metric for this, yet in the absence of a consensus as to what a reasonable quality of life might entail, it is hard to imagine how measurement is possible.

The philosopher Bernard Williams (1972) noted that values that can be quantified in economic terms, may require comparison with values which are not quantifiable. His comments may be easily extrapolated to the current situation of psychoanalysis in some countries: "Again and again defenders of such values are faced with the dilemma of either refusing to quantify the value in question, in which case it disappears from the sum altogether, or else of trying to attach some quantity to it, in which case they misrepresent what they are about and also usually lose the argument, since the quantified value is not enough to tip the scale" (p 103). Some outcomes of psychoanalysis may indeed be costed, but these may be some of the least important. The cost saved may not "tip the balance" in favour of psychoanalysis.

The ownership of outcome

The second common criticism concerns the ownership of outcome: “Whose outcome is the outcome of psychoanalysis, anyway?”. It may be in principle impossible to decide between the competing claims of different individuals. For example, a treatment that enhances the quality of life of one person may be deleterious to a spouse or an employer. This is particularly evident in the case of the psychoanalytic treatment of children where the treated child’s desired outcome may be in conflict with that of the parent’s, or indeed that of the sibling. Ideally, notwithstanding the insurmountable practical problems, all individuals significantly concerned with an analysis should be assessed as part of the outcome study. The research enterprise itself is clinician led. It is the clinician-researcher that decides whose outcome will form the basis of evidence based practice. Thus all outcome investigations, perhaps particularly that of psychoanalysis, will be arbitrary, and limited by the selection of the individual(s) on whom outcome is measured.

An extension of the arbitrariness problem of outcome ownership concerns the status of client choice as an indication of outcome. It could be argued that the client is in a privileged position relative to the investigator in determining whether the treatment is helpful. Interestingly, when user groups are asked they tend to strongly favour approaches to most mental health problems which are psychologically rather than pharmacologically based, or at least they plead for a greater emphasis on psychological help. When individuals perceive their difficulties arising out of psychosocial causes, they understandably seek redress in the same domain i.e. the interpersonal. It is also worth noting that psychoanalytic therapy often has greater *prima facie* acceptability than exposure-based cognitive behaviour therapy (for example with patients with OCD, Apter, Bernhout, & Tyano, 1984). Yet the desire of the user, “client satisfaction” is not generally acceptable as an adequate criterion for outcome. By this criterion, many treatments known to be ineffective and even harmful, (e.g. recreational drugs such as nicotine counteract anxiety) could be selected.

Psychotherapy researchers are particularly conscious of the danger of imposing ethnically rooted cultural biases on what is designated as “needing treatment” and to be a “good outcome” (Bernal, Bonilla, & Bellido, 1995). For instance, the achievement of selfhood through the separation-individuation process is one of the cornerstones of psychotherapeutic interventions. Yet is Lasch (1978) correct that the emphasis on individual achievement in Western culture is excessive and that an appropriate submission to the goals of the family and community (Kagan, 1984) may be a far better indicator of healthy adaptation? Such differences are particularly acute in the area of child development and parenting. Rogler (1989) outlined some of the practical steps which culturally sensitive outcome research requires. In particular, it is important to ensure that interventions are consonant with the subjective culture of the ethnic group to which it is applied and that instruments used are able to integrate cultural meanings with the pertinent scientific categories. In reality, this is an ideal to strive for, but it is rarely achieved.

Ethical concerns

Finally, it is commonly asserted that a uniquely evidence based treatment approach can lead to activities which are at odds with common morality. A good example of this is the success of aversive conditioning and other punishment based techniques in behavioural control of individuals with “challenging behaviour”. The fact that there is evidence supporting the efficiency of these techniques cannot and does not make them right.

More generally, ethical concerns arise out of the implementation of randomised control trials. While such trials have the potential to prevent the propagation of worthless treatments, for example insulin coma therapy, they raise major ethical issues in the context of subject selection, consent, randomisation and the continuing care of subjects once trials are complete. Randomised

control trials require the clinician to act simultaneously as physician and research scientist. Patients are simultaneously invalids and research subjects. It is questionable if the physicians' moral responsibilities towards patients can be consistent with the recommendation that the patient should participate in a randomised control trial, principally because of this conflict of interest (Hellman & Hellman, 1991). It has been suggested that such trials may be recommended by the physician if clinicians are in a state of "therapeutic equipoise", that is they are genuinely in doubt about the value of different interventions (Lilford & Jackson, 1995). Such equipoise may be achieved in the case of treatments with moderate affects which might otherwise be obscured by bias and random effects. However, equipoise may not be achievable when interventions have great benefits and risks and then alternative clinical procedures to be investigated by other methods.

Is therapeutic equipoise applicable to the recommendation of psychoanalytic treatment? Interestingly, neither psychoanalysts nor the opponents of psychoanalytic treatment believe that this is the case. Psychoanalytic clinicians are so firmly convinced of the appropriateness of 4 or 5 times a week treatment that they tend to consider it unethical to recommend less intensive alternatives. Sceptics, on the other hand, feel that the sacrifice demanded of the patient and his/her family is such that randomisation to a psychoanalytic arm is normally ethically unacceptable. In principle, the existence of these opposing views might somehow be combined to construct an attitude of therapeutic equipoise, but in reality it is simply tantamount to what may be an insurmountable obstacle facing a randomised controlled trial of psychoanalysis.

The status of concerns about evidence based medicine

Many other concerns could be raised about the appropriateness of subjecting psychoanalysis to outcome evaluation. We raise some concerns here in part to demonstrate our awareness of the issues and in part to underscore that the clamour for evidence should be met with caution and sophistication. It needs to be recognised that objections to research will not win the day. It is unlikely that the prevailing view which places controlled studies at the top of the hierarchy of evidence will change no matter what the pressures of arguments. The complexities of issues surrounding resource allocation, the drive to seek certainty and simplicity at the level of policy making are such that alternative formulations will not be heard.

Psychoanalysis is not alone among medical treatments with a weak evidence base. Evidence to the standards required is available for relatively few medical interventions (Kerridge, Lowe, & Henry, 1998). The drive for an evidence base for the selection of treatment interventions will inevitably mean a biased allocation of resources to those treatments for which rigorous evidence of effectiveness is relatively easily collected or where funds are independently available to carry out more lengthy and complex effectiveness research. Brief therapy benefits from the former, pharmacotherapy from the latter. Psychoanalysis is further disadvantaged by the opposition to many of its fundamental propositions among fellow mental health professionals and influential leaders (Crews, 1995; Grünbaum, 1984; 1986; Webster, 1995). These kinds of considerations drive us to override our concern and accept the imperfect solution of outcome research with the overriding objective of preserving the discipline.

The best strategy available to us is to collect all the data available rather than enter an epistemological debate amongst ourselves. The debate is inaudible to those outside the discipline. Further, it would sap our energies when this is required for a collaborative effort to make the best case possible for psychoanalysis as a clinical method. Even those of us who are engaged in collecting evidence for the effectiveness of this discipline have major methodological as well as epistemological concerns. These should not be set aside, forgotten about, but nor should they become an alternative focus.

It should be remembered that the debate over the effectiveness of psychoanalysis is one of pragmatics not of principles. There is a clear danger that the therapy that is “without substantial evidence” will be thought by all to be “without substantial value” (Evidence Based Care Resource Group, 1994). Once this idea is allowed to flourish, a cultural change becomes inevitable, a change which at least temporarily has the power to stop the development of our discipline – through the rejection of psychoanalysis as the therapeutic choice, through discouraging young people from entering the profession and through bringing psychoanalytic contributions to mental health disciplines and other subjects into disrepute.

Methodological considerations in evaluating the outcome of psychoanalysis

Methodological problems inherent to evaluation research

Research into psychoanalysis is inevitably a compromise between usual clinical procedures and the demands of scientific influence. Clear thinking about the applicability of research findings rests on an understanding of the nature of these compromises. In this section we shall briefly list some of the issues which must be taken into consideration in interpreting and evaluating evidence for the effectiveness of psychoanalysis. While these issues are well known and obvious to some, they may be less familiar to others. More important, we list them here in part to show that researchers are well aware of these problems and while not necessarily able to resolve the issues, at least it should be clear that they are working towards this end.

Efficacy versus effectiveness

The term efficacy refers to the results a treatment achieves in the setting of a research trial, while clinical effectiveness is the outcome of therapy in routine practice. The discrepancy arises because trials are required to show “internal validity” (Cooke & Campbell, 1979); that is, they permit causal inferences to be made on the basis of the observed relationship between the variables. In this context, the absence of a relationship must imply the absence of a cause.

Achieving internal validity normally requires modifications to clinical procedures, which are rarely seen in everyday practice. The most common of these are: (a) the selection of diagnostically homogenous patient groups, (b) the randomisation of these patients into treatments, (c) the employment of extensive monitoring of the patient’s progress, (d) the careful specification of therapeutic procedures to be used and (e) the monitoring of their implementation. These requirements clearly pose a threat to “external validity”, to the extent to which the inferred causal relationship between variables may be generalised. Thus demonstrations of efficacy are not necessarily demonstrations of effectiveness. The fact that a treatment is highly efficacious under strictly controlled conditions cannot be thought to mean that it will have the same value in the context of ordinary clinical practice.

This problem is by no means unique to the investigation of psychodynamic treatment. To take a simple example, a pharmacological agent with distinctly unpleasant but harmless side effects may be shown to have considerable efficacy in a double blind controlled trial. No one would be surprised that it proves to be ineffective in clinical practice since patients frequently and conveniently “forget” to take this pill. In the trial, serum levels were carefully monitored and subjects whose blood levels indicated that they did not take their drug were excluded from the analysis. The same applies in trials of psychological treatment. Frequently psychotherapy is not delivered in practice as well as it is in the context of a carefully monitored trial. By contrast trials may underestimate the effects of a therapy by randomly assigning patients to treatments they do not wish to have, whereas in clinical practice their preference would be carefully noted by their treating physician.

Spontaneous remission

As relatively few of the individuals who suffer from significant psychiatric morbidity have the benefit of any kind of professional help, it must be obvious that there are many roots to recovery which do not involve psychoanalysis, psychotherapy or indeed any kind of systematic intervention. What any treatment needs to demonstrate therefore, is that it is more effective than the natural processes of healing which human society provides (note for example Freud’s famous comments about the therapeutic potential of Lourdes (Freud, 1933)). From a historical point of view, Hans Eysenck (1952) was the first to raise this issue in connection with psychoanalytic therapy. He claimed, on the basis of insurance statistics as well as Fenichel’s Berlin I Study of the

outcomes of the Berlin Psychoanalytic Institute, that more individuals recovered in a two year period when they were untreated than when they were treated in psychoanalysis. More recently, it was demonstrated that even using Eysenck's data a more sophisticated analysis reveals that whereas half of treated patients improved within a couple of months, only 2% of those untreated improved over the same time period (McNeilly & Howard, 1991).

Whatever the status of Eysenck's own figures, there is no doubt that spontaneous improvement rates are sizeable for most psychological disorders (Bergin, 1971; Lambert, 1976; Subotnik, 1975). For example, from naturalistic follow up studies we know that individuals with borderline personality disorder tend to "burn out" in middle age (Stone, 1990). Thus statements about the effectiveness of psychoanalysis cannot be made on the basis of clinical reports of individual cases, however successful – certainly not without unequivocal knowledge about the course of the disorder. Ideally the course of untreated individuals should be compared with those who receive treatment. It is impractical and unethical to withhold treatment from an individual for the duration of a longterm treatment such as psychoanalysis and this has posed major problems for those intending to carry out outcome studies. As psychoanalysis is not generally available it seems sensible to compare its effectiveness with either the best available alternative treatment or so-called "treatment as usual". The former has the advantage of offering an apparently meaningful comparison from the point of view of a referrer or referring agency, but equally has the potential of prompting meaningless comparisons where the aims of treatment are not comparable and apples are being compared with oranges. Such comparisons also require that the researcher has comparable expertise with both the methods of treatment, as well as large sample sizes as the difference between the two methods is likely to be small. The alternative contrast with a treatment as usual group, has the advantage of telling us how much difference a treatment might make were it to be added to routine care but has the disadvantage of potentially great heterogeneity in the control group and inadequate information concerning the treatment received by the control group (Roth & Fonagy, 1996).

Strategies of psychotherapy research

The choice of a particular research methodology will always be a compromise, reflecting the intentions, interests (and resources) of investigators. Some of the major strategies used in psychoanalytic research, together with their strengths and weaknesses, will be considered in turn. A full account of these issues in psychotherapy research is given in Kazdin (1994).

Single case studies

The belief that knowledge based on groups of individuals is somehow more likely to be generalisable – that is, applicable beyond the specific locus of its discovery – than is the case for knowledge based upon individual cases, is fatally flawed (Fonagy & Moran, 1993). In single case designs the focus is on the individual patient rather than a group average, even where a group of patients were studied. Single-case studies may be descriptive or quantitative. The former group is well represented in the traditional psychoanalytic case history. The method has many strengths, including high communicative value, and the richness of description of particularly complex unconscious interactive processes between analyst and patient. There is no generally accepted format for these reports and the information included tends to be quite variable (e.g. Spence, 1994) which undermines generalisation. Attempts have been made to systematise such qualitative reports (e.g. Klumpner & Frank, 1991) but these have not met with general approval.

In comparison to descriptive accounts of single treatments, quantitative reports undoubtedly lack richness and depth but are more generally accepted because of the greater ease with which the

reliability of the observation can be assessed. Within this latter group some are naturalistic reports of outcome or quasi-experiments (Cooke & Campbell, 1979), while others are reports of the experimental manipulation of interventions. In cases where appropriate baseline measures are taken, or where treatments are applied and withdrawn in a controlled manner, the patient acts as his/her own control. This methodology has been widely used by behavioural and cognitive-behavioural researchers (Morley, 1987; 1989), but is equally applicable to psychodynamic investigators (e.g. Fonagy & Moran, 1993) and to the investigation of process factors in therapy (e.g. Parry, 1986).

Single-case studies have a number of attractive features. They can be combined with the routine clinical practice of private practitioners, they do not (necessarily) require the research apparatus and personnel normally associated with group based research and can be conducted fairly quickly. While of great importance in the demonstration or refinement of clinical technique and especially in treatment innovation, the results of single case studies can be difficult to generalise to the broader clinical population (indeed the design is not intended for such a purpose). Patients are often highly selected (necessarily so where studies are aiming to show the effectiveness of a technique for particular clients). More fundamentally, however, interpretation of results is limited by the fact that (as will become evident in the body of this report) therapeutic interventions have both general and specific impacts on the welfare of patients. A contrast intervention is required in order to be clear that any demonstrated benefits are attributable to specific therapeutic techniques – a strategy adopted in the randomised control trial.

Randomised Controlled Trials (RCTs)

In contrast to the single case study, RCTs explicitly ask questions about the comparative benefits of two or more treatments. Patients are randomly allocated to different treatment conditions, usually with some attempt to control for (or at least examine) factors such as demographic variables, symptom severity and levels of functioning. Attempts are made to implement therapies under conditions which reduce the influence of variables likely to influence outcome – for example by standardising factors such as therapist experience and ability, and the length of treatments. The design permits active treatments to be compared, or their effect contrasted with no treatment, a waiting list or a “placebo” intervention. Increasingly, studies also ensure that treatments are carried-out in conformity with their theoretical description – for example, ensuring that psychoanalytic treatments do not include cognitive-behavioural or supportive elements. To this end many treatments have been “manualised” (a process which specifies the techniques of the therapy programmatically), and therapist adherence to technique is monitored as part of the trial. There are obviously major problems in the manualisation of psychoanalytic treatment (Clarkin, 1998) but some progress has already been made on this front (e.g. Clarkin et al., 1999; Fonagy, Edgcombe, Target, Moran, & Miller, unpublished manuscript; Kernberg et al., 1989; Luborsky, 1984).

Though this design has the potential to distinguish the impact of treatments (and to provide a control for the effects of spontaneous remission), there are inherent limitations to this approach.

Problems of control groups

Although the ideal design of a treatment would be to contrast treatment to no-treatment, it is rarely the case that this is either ethically or practically possible. The alternative of offering a placebo treatment – one which is considered inactive, at least from the point of view of the active treatments offered – is beset by the difficulty of finding an activity which could be guaranteed to have no therapeutic element, which controls for the effect of attention and which is also viewed by patients as being as credible as a psychiatric intervention. Many recent studies restrict themselves to the comparison of active treatments; as evidence has accumulated for the general

efficacy of therapy, institutional review boards (ethical committees) have become unwilling to sanction trials which could be seen to deprive patients of help (e.g. see Elkin, 1994).

Length of therapy

Setting up an RCT is a major undertaking, and consequently a great expense. Although there are exceptions, most trials limit the amount of intervention offered (frequently to around 16 weeks). While this may be appropriate for some therapies (principally behavioural or cognitive-behavioural approaches), psychodynamic therapists (e.g. Fonagy & Higgitt, 1989) could – and do – argue that the techniques they employ were never designed for delivery over such a short time-frame. Psychoanalysis is in most countries an open-ended treatment and it is hard to imagine forcing it into a frame where the number of sessions is determined independently of the individual treatment process.

Generalisability

Few RCTs achieve the implementation of psychological therapies under conditions which might be obtained in routine practice. As noted above, because they are characterised by a concern to maintain internal validity, their applicability could be seen as limited. For example:

- patients will have been selected to conform to diagnostically precise categories
- patients will have been exposed to multiple assessments
- therapies will be applied with some precision, often under supervision
- researchers will often be particularly enthusiastic and particularly expert in the techniques they employ.

Patient preference and random allocation to treatment

Patients are not passive recipients of treatment, and their preferences for differing forms of treatment may be critical to their participation in clinical trials (Brewin & Bradley, 1989). The bias introduced by consequent attrition from treatment is invisible within studies, but may be particularly relevant to clinical practice.

Open trials

This methodology is intermediate between the single-case design and the randomised control trial. Although entry to treatment may be governed by strict criteria, there is no control group. Such designs often reflect a more naturalistic treatment protocol than is the case with RCTs. At the simplest level such studies offer important information concerning:

- the likely benefit the average patient might derive from the treatment
- what features of presentation are likely to be associated with relatively good outcome
- how effective a particular service is in terms of outcome
- which aspects of a patient's problems are likely to be addressed by a treatment
- given a certain natural variability in treatment delivery, what aspects of treatment are associated with felicitous consequences and which are accompanied by equivocal outcomes.

Frequently two or more treatments for the same disorder, as practised in different settings, are contrasted. In principle, such a design could answer the question “what kind of patient benefits most from particular treatment protocols”. In reality differences in case-mix and the failure to control specific components of treatment usually place drastic limitations on the implications which may be drawn from such studies. Given a sufficiently large data-set, it may be possible to derive conclusions about the relative value of treatments even in the absence of random assignment. However, studies on such a large scale are rarely possible.

Resolving conflicts between internal and external validity in research designs

We have already noted that a major problem for outcome studies of psychoanalysis is the tension between satisfying the demands of internal and external validity when developing research strategies. Designs have to reach a compromise between these factors; bridging the gap between them requires innovative attempts at integrating an apparent incompatibility between scientific rigour on the one hand and generalisability on the other. Single-case designs may come to play a more important role in this respect, since external validity is not an inherent problem in designs of this type (Kazdin, 1994). When replicated across randomly sampled cases, they have considerable generalisability. They can be employed to answer most of the questions that concern researchers, such as the appropriateness of a particular form of treatment, the length of treatment required to achieve a good outcome, the relative impact of treatment on particular aspects of the problem or the relevance of particular components of treatment. However, there is one critical exception: within this research strategy patient and analyst factors are difficult to study. If there is no replication across subjects (patients and analysts), the design will not yield information about their influence on outcome.

Thus methodology which is truly adequate to the task of simultaneously assuring internal and external validity in psychoanalytic research has probably yet to be developed. In the meantime, the best – though possibly inadequate – answer lies in reviews (such as the present one), which include critical appraisal of likely threats to external validity posed by current research.

Other considerations

Follow-up

For most conditions the success of therapy may be measured by its ability both to improve patient functioning and to maintain that improvement after therapy ends. Although most trials report follow-up data, the length of follow-up can vary markedly between studies, sometimes being only a matter of weeks, sometimes years. The length of follow-up required to demonstrate a clinical effect is governed by the natural history of a disorder, which will suggest both the probability of relapse and the usual length of time between episodes. Therapeutic efficacy can only be demonstrated in the context of both factors and, for example, three month follow-up for a condition known to show greatest relapse over a period of one year would clearly be inadequate. This aspect of research design is particularly important for psychoanalytic investigations where so called “*sleeper effects*” have been frequently reported (e.g. Kolvin et al., 1981). The term refers to improvements observed after the termination of treatment. Termination is a complex time in psychoanalytic treatment with recurrence of the original complaints commonly reported.

Although this suggests that extended follow-up periods should be the norm, the longer a patient is followed-up the more difficult it is to ascribe change to their original treatment. In part this is because patients will might seek further treatment in the intervening period (e.g. Shea et al., 1992), and also because the relative impact of treatment in the context of life-experiences decreases over time. Ironically, the results of very prolonged follow-up, while desirable, may be difficult to interpret.

Finally, the stability of symptomatic change over the follow-up period may be an issue of concern in its own right. Monitoring of individual patients suggests that a proportion will change their symptom status more than once (e.g. Brown & Kulik, 1977; Shapiro et al., 1995). Reporting of group-averages tends to obscure this variability, leading to an over-estimation of longer-term outcomes in clinical practice.

Attrition

All clinical trials will lose patients at various points in treatment; the point at which they are lost will have differing impacts on validity. Early loss from a trial may disrupt the randomisation of treatment, threatening internal validity. Even where there is no differential attrition from treatments, it may be the case that significant attrition could lead to results being applicable only to a sub-group of persistent patients, threatening external validity. Alternatively, attrition rates across treatment conditions may not be random, and may reflect the acceptability of therapies, suggesting that attrition may be an important variable in its own right.

Significant levels of attrition will restrict the conclusions that can be drawn from a study, and complicate reporting of results. A number of statistical solutions to this problem are available to researchers which utilise the last available data-point to estimate the likely bias introduced by loss of patients (e.g. Flick, 1988; Little & Rubin, 1987). Alternatively data can be reported on the basis of an “intention-to-treat” sample, including all subjects entered into the trial, as well as presenting separate data for those completing all or a specified length of therapy (e.g. Elkin et al., 1989).

Meta-analysis

In the past 15-20 years, techniques have been developed to enable quantitative review of psychotherapy studies. Meta-analysis is a procedure which enables data from separate studies to be considered collectively through the calculation of an effect size from each investigation (Rosenthal, 1991).

Effect sizes are calculated according to the formula:

$$ES = \frac{M_1 - M_2}{S.D.}$$

where

M_1 = the mean of the treatment group

M_2 = the mean of the control group

S.D. = the pooled standard deviation

The terms M_1 and M_2 can stand for the means of any two groups of interest, such as psychotherapy contrasted against a waiting list control, or equally could be the comparison of two forms of psychotherapy. Because this technique converts outcome measures to a common metric, individual effect-sizes can be pooled. In addition to examining the contribution of main effects such as therapy modality, effect-sizes for any variable of interest can be calculated, such as the impact of methodological quality or investigator allegiance on reported outcomes (e.g. Robinson, Berman, & Neimeyer, 1990; Smith, Glass, & Miller, 1980).

Effect sizes refer to group differences in standard deviation units on the normal distribution. Their intuitive meaning is made clearer by translating them into percentiles, indicating the degree to which the average treated client is better off than control patients. Thus an effect size of 1.0 corresponds to a result where 84% of the treated group are better off than the average control patient.

Meta-analysis is a powerful research tool, but some have been critical of the technique (e.g. Wilson & Rachman, 1983). Common criticisms include:

- the fact that reviews do not include single-case studies
- the inclusion of studies of questionable methodological adequacy
- the inclusion of studies not directly relevant to clinical issues, such as analogue studies, and trials of patients whose symptoms are not clinically significant or of great severity
- the fact that analyses can multiply sample measures taken from the same patient and from the same study leads to effect sizes computed on the basis of dependent data
- the fact that using average Z scores assumes that outcome measures are appropriately measured on an interval scale, and that their distribution may be assumed to have insignificant skewness and kurtosis
- sampling of studies will be biased by the tendency for editors and authors to favour positive results
- not all meta-analyses weight the means for sample size.

A major difficulty is, however, that the effect size statistic can only speak to treatment effects for the average client, and though this is informative of general treatment effects, further elaboration of therapeutic impacts is usually required to detail the more specific effects of treatment.

Problems associated with the use of statistical tests in psychotherapy research

Clinical and statistical significance

Much of this report is based on journal articles examining the truth of the null-hypothesis – in essence the proposition that psychoanalysis has no effect, or no effect greater than a control treatment. It is conventional to report the statistical significance of differences between treatments in terms of a confidence level of $p < 0.05$ or $< .01$. However, researchers may be able to reject the null-hypothesis at relatively high levels of statistical significance without simultaneously demonstrating that this finding is worthy of clinical attention (Kukla, 1989). Demonstration of statistical effects may not be equivalent to a clinically significant therapeutic change, and there are a number of strategies which have been used to detect this (discussed further in Kazdin, 1994):

- Comparison of patient change with normative samples
- Measurement of the extent of individual change by reference to a criterion measure of change; for example, that treated clients should be 2 standard deviations from the mean of the untreated group (Jacobson & Truax, 1991)
- The use of a criterion of recovery which enables categorical rather than continuous scoring of outcomes; for example, considering all individuals scoring as low as 75% of the normal population to have benefited from the treatment (e.g. Elkin et al., 1989).

The clinical significance of change is central to the evaluation of psychotherapy outcomes; though recent investigations are more likely to report data in this form, such measures are not always available.

Multiple data sampling and Type-I error

Researchers frequently report numerous results of statistical significance without being clear how each test relates to the prediction they are examining. Dar and colleagues (Dar, Serlin, & Omer, 1994) illustrate this problem by suggesting a hypothetical study in which two treatments for

flying phobias are contrasted, with levels of anxiety and coping skills being the dependent variables. In practice there may be a number of procedures for measuring these variables, all of which are likely to be intercorrelated. Each of these variables could be examined separately, though in reality there are only two hypotheses under investigation – the impact of the treatment on anxiety and its effect on coping skills. More than two statistical analyses are therefore redundant, and represent an overstatement of the data available to the researchers. A real-life example of this process is the much-cited National Institute of Mental Health study of treatments for depression (Elkin, 1994) which shows statistical significance on only some of a relatively large family of variables pertaining to dysfunctional emotional states. A consequence of multiply-sampling related data-sets is to increase the risk of Type I errors – rejecting the null-hypothesis when that hypothesis is false (in practice, for example, claiming that one treatment works better than another when in reality both work equally well).

Because it is well recognised that a series of measures tapping similar domains may be inter-related, investigators often employ multivariate tests, which permit some understanding of relationships between dependent measures. Though this procedure overcomes some of the problems noted above, problems can arise where multivariate tests which indicate overall significance are then followed by univariate tests. Not only does this increase the risk of Type I error, but results can be difficult to interpret, once again because of possible relationships among variables under test.

Atheoretical analysis

Dar et al (1994), in a review of the use of statistical tests in psychotherapy research from the 1960s to the 1980s, note a high level of inappropriate significance testing, which they attribute to the pragmatic concerns of psychotherapy researchers. The determination to find statistically significant associations is seen by them as motivated by “a flight from theory into pragmatics”. As psychotherapy research frequently has very little theoretical guidance leading to meaningful hypotheses and testable predictions, there has been an explosion of exploratory procedures, leading to a state of affairs where, even in the best journals, “much of the current use of statistical tests is flawed”. Psychoanalytic outcomes research is sadly no exception to this trend and many of the studies included in this review have undoubtedly over-exploited their data.

Statistical power

Statistical power is the extent to which an investigation is able to detect differences between samples when such differences exist in the population – in other words when there is a true difference between the groups under test. Power is a function of:

- the criterion for statistical significance, or alpha level
- sample size
- effect size, or the magnitude of the difference that exists between the groups.

Statistical power in perhaps the majority of trials of psychoanalysis may be relatively weak, primarily because of low sample sizes (Kazdin, 1994). Cohen (1962) distinguished three levels of effect size (small=0.25, medium=0.50 and large=1.0), and evaluated the ability of published studies to detect such differences at the conventional alpha level of $p < 0.05$. Power within these studies was generally low – for example, studies had a one in five chance of detecting small effect sizes, and less than a one in two chance of detecting medium effect sizes. Despite the cautionary note struck by Cohen’s paper, and the date of its publication, Dar and colleagues (1994) found that a significant proportion of even recent research continues to neglect these issues. Most particularly, there continues to be a neglect of measures of effect size in favour of

citing statistical significance. The problems inherent in this procedure can be readily illustrated by considering a study with a large sample but a small effect size; although statistical significance may well be achieved this does not speak to the magnitude of the effect, nor its likely reliability or validity. In psychoanalytic studies the reverse scenario is often more likely: too few subjects being compared reducing the likelihood of the demonstration of significant changes, even when such changes are present.

It should be clear that all of the above issues threaten the external validity of psychoanalytic research. Dar et al. (1994) detail a number of strategies for ensuring that such threats are minimised; for example, by employing theory-guided predictions, planned rather than post-hoc statistical decisions, reduced use of omnibus multivariate techniques, stricter control of Type-I error rates by using single rather than multiple tests, employing “families” rather than a multiplicity of hypotheses, the avoidance of step-wise statistical procedures and testing of hypotheses not against a difference of zero but rather against a predetermined interval. While these suggestions are well taken, the opportunities for psychoanalytic research are at the moment so few that many of these methodological niceties will have to remain on a “wish list”, awaiting implementation by studies currently underway.

Introduction

One of the major difficulties facing psychodynamic psychotherapy researchers is the relative lack of developed instruments to assess both the characteristics of patients in terms of their psychodynamic difficulties and to monitor change from a psychodynamic point of view which is beyond behavior and symptom change. No study of psychotherapy process and/or outcome is better than the instrumentation that has been utilized.

There have been several recent reviews of instruments that can be used to characterize patients and their outcome in psychotherapy research (Strupp, Horowitz, & Lambert, 1997) and a large compendium of useful instruments (American Psychiatric Association, 2000). In contrast to the instruments described in those volumes, we focus here on a growing number of instruments that measure constructs relevant to psychodynamic thinkers. With the growing interest in research into the psychodynamic process and outcome, researchers have been forced to construct appropriate instruments for this use. We highlight some of these newly developed instruments here for multiple reasons. First of all it is useful to inform researchers of the existence of these instruments and how they can be obtained. Secondly, in order for an impressive, coherent body of psychotherapy research data to develop, the use of the same key instruments across studies, studies which are often costly and time consuming, will enable some comparison of results.

Instruments reviewed here cover concepts and constructs related to patient variables, various ratings of psychotherapy process, and ratings of facial movements. The patient variables of interest and measurement include psychological capacities, the quality of object relations, and attachment style. Finally, the ratings of psychotherapy process include an analyst assessment of the process, a rating of facial expression, a rating of patient referential process and a rating of the patient-therapist interaction.

Measurement techniques

Requirements of measurement

There is some consensus in psychotherapy research (Kazdin, 1994) that single measures of outcome are unsatisfactory, that measures should be unreactive to experimenter demand and that they should be drawn from:

- differing perspectives (such as the patient, close relatives or friends of the patient, the therapist or independent observers)
- differing symptom domains (such as affect, cognition and behaviour)
- differing domains of functioning (such as work, social and marital functioning).

One relatively comprehensive approach, which has been implemented at the Menninger Clinic is the Functional Analysis of Care Environments (FACE) (1999; Clifford, 1999). In child psychotherapy Fonagy (1997a) recommended that at least the following domains should be monitored:

- psychiatric symptom measures and diagnostic criteria
- adaptation to developmental and social demands
- transactional aspects such as family relationships and the measurement of the impact of the child's pathology on the functions of the family and its individual members
- mechanisms underlying the child's symptoms and adaptational problems either at the physiological or psychological level (e.g. affect regulation on attachment representations)
- service satisfaction and alternative service usage.

There is however little consensus on the precise measures to be employed. This leads to some difficulty in comparisons between studies and, on occasion, to problems of interpretation within trials where measures assumed to converge on similar target areas give discrepant results.

For many analysts this reduction of outcomes to a series of scores is unsatisfactory because it clearly fails to capture the complexity of their work. There is undoubtedly merit to this objection, since the majority of current measures do not address the subtleties of individual presentations or the significance of particular changes to particular patients. There is no agreed set of capacities and attributes which an analyst would argue might reflect change across a group of patients. Many psychoanalytic clinicians are impressed by the way in which, in some patients, therapy promotes the unfolding of developmental processes, step-by-step, in an ordered and progressive way. This would suggest a developmentally rooted measure of some kind. However, the appropriateness of the developmental metaphor is by no means universally accepted by psychoanalysts (Mayes & Spence, 1994). In addition, psychoanalysts have noted that a focus on symptomatic change is inappropriate where personality change – which may be hard to measure – is the object of therapy. Techniques considered to measure this dimension have been developed (e.g. Malan & Osimo, 1992; Malan, 1976; Wallerstein, 1988) although the degree to which they are truly independent of symptomatic change is less clear (Mintz, 1981). The eschewal of existing reliable and valid measures by the psychoanalytic community is a regrettable fact, which will only be corrected by a concerted effort on the part of psychodynamic therapists to identify, in a consensual and measurable way, the outcomes which treatment aims to bring about, and to validate these against criteria that other stakeholders (such as patients, funders and other practitioners) see as important.

There are general objections to the quantification of therapeutic outcome. The uncritical use of quantification is pervasive in social science (Frosch, 1997). Quantification may be thought to inappropriately “fix” meanings where these are variable and renegotiable in relation to the context in which they are applied. The uniqueness of particular human experiences is denied if we obliterate internally structured subjectivities by externally imposed “objective” systems of meanings. It may be argued that the complexity and variability of human meanings is lost if we assume (through the use of quantification) a universal “true” meaning of human behaviour and experience. Psychological data (whether quantitative or qualitative) derived from humans requires interpretation as inevitably they are based on interactive, discursive processes. Undoubtedly, claims to a full knowledge of an objective, fixed reality are specious. This, however, is not a critique of quantification but rather its inappropriate reification, a problem that has already been touched on.

Finally, there may be legitimate concern that some measurement techniques may tap domains of change close to those targeted by a particular therapy, and may therefore indicate greater degrees of change than would be found using broader assessments. For example, the Beck Depression Inventory (BDI) assesses the level of depression largely through more cognitive representations of this disorder. In contrast the Hamilton Rating Scale for Depression (HRSD) has more of a focus on biological symptoms. It has been argued that trials of cognitive therapy could achieve better outcomes using the BDI, and trials of medication better outcomes using the HRSD, reflecting less the “true” outcome than the bias of scoring instruments. A similar argument might be made if psychoanalysts choose outcome measures too closely linked to the progress of therapy (e.g., a measure of transference or of analytic process). On the other hand, measures need to be relevant to the goals of a therapy – the problem is that the aims of psychoanalytic treatment remain controversial (Sandler & Dreher, 1997).

Developments in measurement

There have been major developments in psychoanalytic measurement techniques. Some assessment instruments that have been used in the studies reviewed in this volume are described in detail below. Certain process measures are covered in detail in the Appendix to this review.

Scales of Psychological Capacities (SPC)

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Aim

The aim of the Scales of Psychological Capacities (SPC) is to create a metric for one of the central tenets of ego psychology, and a central concept for the understanding of therapeutic change, namely structural change in the ego. The problem in creating such a metric resides in the theoretical diversity of psychoanalysis, with each psychoanalytic theoretical perspective conceptualizing structure and structural change within a different conceptual and linguistic framework—and each theoretical perspective is itself experience-distant. SPC was created to be an experience-near set of *psychological capacities*, that comprehensively describe character and psychic functioning, and that if changes occur in the configuration of these capacities, adherents of all theoretical perspectives in psychoanalysis would accept that changed configuration as reflecting underlying structural change, however differently they would then describe that structural change theoretically.

Description

There are a total of 17 described psychological capacities, with most of them (13) having two directions of deviation, and one with only one, making a total of 36 subscales being assessed. It is possible to deviate from the norm in both deviating directions of a scale simultaneously, like the person very inhibited in impulse and affect expression, who can nonetheless, when pushed, have an explosive eruption of affect. There are 3 described degrees of departure from the norm on each subscale, with half-way judgments allowed, thus making 7 possible scale placements, from each norm to the severest point of duration. Each point on each subscale is anchored by one or more descriptive clinical vignettes describing the kind of psychological functioning indicated by that point. The SPC ratings are (usually) based on a videotaped clinical interview aimed to elicit a picture of overall psychic functioning, supplemented by a series of semi-structured probe questions designed to elicit more specific information about those areas of functioning not sufficiently illuminated in the prior unstructured clinical session.

Practical issues

The basis for the rating of the scales is a clinical interview followed by a semistructured SPC-interview with a set of probe questions, lasting one to two hours. The audio- or videotaped material will be scored for each subdimension on a 7-point scale from 0 for normal or fully adaptive functioning to 3 for functioning seriously and obviously disturbed, with half points in between. The rating procedure requires an extensive manual with a detailed description of each subdimension together with one or more clinical vignettes to anchor each scale point. The manual for the SPC plus the list of probe questions for the semi-structured part of the interview may be obtained from Robert S. Wallerstein, M.D. The official German translation (with a verified back-translation into English) may be obtained from Drs. Dorothea Huber and Gunther Klug in Munich, Germany. A Swedish translation may be obtained from Dr. Eva Sundin in Umea, Sweden. There also are Finnish, French and Italian translations.

Psychometric properties

Inter-rater reliability (DeWitt, Milbrath, & Wallerstein, 1999; Sundin et al., 1994), content validity (DeWitt, Hartley, Rosenberg, Zilberg, & Wallerstein, 1991), and convergent validity (DeWitt et al., 1999) of the SPC have already been examined in English. A discriminant and convergent construct validity study with 41 SPC interviews of depressed patients was performed in German in 1997. The SPC were compared with instruments that measure interpersonal functioning in order to evaluate convergent validity, whereas discriminant validity was evaluated by comparing the SPC with instruments measuring symptoms.

The SPC was found to be independent of current symptoms and a relevant correlation between interpersonal problems and psychic structure could be demonstrated. For another proof of *convergent validity* experienced clinicians described a hypothetical, prototypical profile of a depressive patient before they rated the SPC. Compared with the empirically found profile of the 36 subdimensions, their prediction was correct for all but one subdimension (Huber, Klug, & von Rad, 2001b).

A *interrater-reliability study* was conducted after a rater-training according to the formal method (Mercer & Loesch, 1979) with the Wallerstein group in San Francisco before three German raters were trained. The inter-rater reliability between the three raters was calculated by means of Intra Class Correlation Coefficient (ICC, Shrout & Fleiss, 1979) for all subdimensions separately. The mean ICC was 0.82 within a range from 0.54 to 0.89. Using as a standard cut-off score a correlation level of .70, according to the recommendations of Lambert & Hill (1994) only 4 of the 36 subdimensions had reliabilities less than .70. All of the 36 subdimensions reached Cohen's cut-off point of .50 (Cohen, 1988).

On that basis an extended *validity replication study* was performed with a homogenous group of 47 depressed patients. Discriminant validity was assessed by means of the Symptom-Check-List (SCL-90-R; Derogatis, 1983) and the Beck-Depression-Inventory (BDI; Beck, 1961), both widely used self-rating symptom inventories. The Symptom Severity Score (BSS; Schepank, 1995) and the Global Assessment of Functioning Scale (GAF, DSM-IV axis 5; American Psychiatric Association, 1994) are both observer-rating instruments.

For convergent validity of the SPC, the Inventory of Interpersonal Problems, (IIP; Horowitz, 1988), the Freiburg Personality Inventory, a personality questionnaire (FPI; Fahrenberg, Selg & Hampel, 1989), the Questionnaire for Coping Strategies (FKBS; Hentschel, 1998), and in addition to these self-rating questionnaires, the psychic structure of the patient rated with the Operationalized Psychodynamic Diagnostics, OPD, axis 4: Structure (Arbeitskreis OPD, 1998) were used.

There were medium range, significant correlations between the FPI scales, the IIP scales, the FKBS scales, the OPD rating for axis 4: structure, and the SPC subdimensions. The data clearly showed no significant correlation between neither the SCL-90-R scales, the BDI, the BSS nor the GAF, and the SPC.

As another test of construct validity the mean SPC profile operated in the theoretically expected way for depressed patients showing highest means for the subdimensions Self-Depreciation, Over-involvement in Relationship, Internalisation, Surrender of Self, and Pessimism.

Summing up the SPC can be regarded as a reliable instrument provided that a clinical interview plus a semi-structured interview with probe questions are administered to yield an extensive database, and a medium-range rater-training and regular recalibration-sessions are performed even with raters without thorough psychoanalytic training. There is substantial evidence that the SPC validly gauge psychic structure, and, provided that its sensitivity to change is proven, are probably a suitable instrument for psychoanalytic process-outcome research.

Clinical utility

The SPC were designed as measures of structural change consequent to psychoanalytic psychotherapy. They should be used at least at the onset and at the termination points of therapy. They can, of course, also be administered during the course of therapy (if appropriate and useful) and at follow-up points.

Object Relations Inventory (ORI)

- Blatt, S. J. (1974). Levels of object representation in anaclitic and introjective depression. *Psychoanalytic Study of the Child*, 29, 107-157.
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- Blatt, S. J., Stayner, D. A., Auerbach, J. S., & Behrends, R. S. (1996). Change in object and self representations in long-term, intensive, inpatient treatment of seriously disturbed adolescents and young adults. *Psychiatry*, 59, 82-107.
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Aim

The ORI is used an open-ended projective method based on an integration of psychoanalytic and cognitive-developmental theories and designed to operationalize and systematically assess the structural organization and thematic content of individual's self and object representations (Blatt, Bers, & Schaffer, 1992; Blatt, Chevron, Quinlan, Schaffer, & Wein, 1988; Blatt et al., 1979; Diamond, Blatt, Stayner, & Kaslow, 1993). An open-ended projective measure developed based on the premise that responses to ambiguous stimuli will be "shaped by the organizing characteristics of the individual's representational world" (Blatt & Lerner, 1983, p. 195).

Description

The ORI is an open-ended projective measure in which subjects are asked to describe without interruption various individuals, most commonly their mother, father, themselves, a significant other, and for clinical subjects, their therapist. Blatt and his colleagues (Blatt et al., 1992; Blatt et al., 1988; Blatt et al., 1979; Diamond et al., 1993) have developed two main scales to assess the structural and thematic aspects of these narrative descriptions: (1) *Qualitative and Structural Dimensions of Parental Descriptions*; and (2) *Differentiation-Relatedness Scale of Self and Object Representations*.

Qualitative and Structural Dimensions of Parental Descriptions (Blatt et al., 1988). Descriptions of people are rated on 7-point scales for the following 12 traits or personal characteristics: Affectionate, ambitious, benevolent, constructively involved, intellectual, judgmental, nurturant, punitive, strong, successful, positive ideal, and warm.

Each description is also scored for the subject's degree of ambivalence about the person being described, length of narrative, the degree of articulation (the number of the 12 personal characteristics included in the description), and the conceptual complexity of the description. Conceptual complexity, derived from psychoanalytic and cognitive developmental concepts (Blatt, 1974) is rated using a 9-point ordinal continuum of increasing complexity from a *sensorimotor-preoperational* level where the parent is described primarily in terms of providing need gratification (scale point 1) through a *concrete-perceptual* (scale point 3) and *external and internal iconic* (scale points 5 and 7, respectively) to a *conceptual level* representation where the parent is described as a unique individual with an integration of external and internal characteristics and traits (scale point 9).

Differentiation-Relatedness Scale of Self and Object Representations (Diamond et al., 1993). Drawing from theoretical formulations and clinical observations about very early processes of boundary articulation (Blatt & Wild, 1976; Blatt, Wild, & Ritzler, 1975; Jacobson, 1964; Kernberg, 1975; 1976), processes of separation-individuation (Coonerty, 1986; Mahler et al., 1975),

the formation of the sense of self (Stern, 1985), and the development of increasingly mature levels of interpersonal relatedness (1996; Blatt & Blass, 1990), Blatt and colleagues identified two fundamental dimensions of self and object representation: (a) the differentiation of self from other and (b) the establishment of increasingly mature levels of interpersonal relatedness. To assess the degree of differentiation and relatedness in descriptions of self and significant others, Diamond and colleagues (1993) developed the Differentiation-Relatedness Scale, a 10-point scale on which to rate the following points: *a lack of basic differentiation between self and other* (Levels 1 and 2); *the use of mirroring* (Level 3), *self-other idealization or denigration* (Level 4), and an *oscillation between polarized negative and positive attributes* (Level 5) as maneuvers to consolidate and stabilize representations; *an emergent differentiated, constant, and integrated representation of self and other with increasing tolerance for ambiguity* (Levels 6 and 7); *representations of self and others as empathically interrelated* (Level 8); *representations of self and other in reciprocal and mutually facilitating interactions* (Level 9); and *reflectively constructed integrated representations of self and others in reciprocal and mutual relationships* (Level 10). In general, higher ratings of differentiation relatedness in descriptions of self and other are based on increased articulation and stabilization of interpersonal schemas and an increased appreciation of mutual and empathically attuned relatedness.

Practical issues

The ORI can be administered to large groups of subjects as a self-report measure or used with individual subjects as an interview measure. When using the ORI as an interview it should be audio-taped and transcribed for coding. The ORI does not require any specialized training to administer as self-report measure or as an interview; however, the interview version is best administered by those with clinical experience, especially with clinical subjects. Coding the ORI requires training that can, in most cases, be obtained using the manuals and scoring for reliability before coding one's actual data set.

Psychometric properties

Qualitative and Structural Dimensions of Parental Descriptions (Blatt et al., 1988). Parental descriptions have been scored reliably for both content and structural variables (Blatt et al., 1979; Bornstein, Galley, & Leone, 1986; Bornstein, Leone, & Galley, 1990; Levy, Blatt, & Shaver, 1998). These variables are stable over time (Bornstein et al., 1990) and are unrelated to intelligence, verbal productivity or socioeconomic status (Blatt et al., 1979; Bornstein et al., 1986; 1990; Wilson, 1982). Blatt and colleagues (Quinlan, Blatt, Chevron, & Wein, 1992) report a stable three factor structure for the ratings of these 12 characteristics which they labeled as benevolent, punitive, striving. The Benevolent factor comprises the attributes affectionate, benevolent, warm, constructive involvement, positive ideal, nurturant, successful, and strong. The Punitive factor includes the attributes judgmental, punitive, and ambivalent. The Striving factor includes the attributes ambitious and intellectual.

Previous research supports the construct and predictive validity of these measures of object representation. Conceptual complexity of descriptions of parents in non-clinical samples has been related to experiences of depression (Blatt et al., 1979), emotional awareness (Lane, Quinlan, Schwartz, Walker, & Zeitlin, 1990), negotiation strategies, attachment patterns (Levy et al., 1998), and self-reported acting out (Schultz & Selman, 1989). In clinical samples, psychotic and borderline patients gave less differentiated and less conceptually complex descriptions (Bornstein & O'Neill, 1992; Marziali & Oleniuk, 1990), and more negative representations of both parents, expressing significantly more ambivalence (Bornstein & O'Neill, 1992). Moreover, conceptual complexity is negatively related to degree of psychopathology (Global Assessment Scale — GAS scores),

presence and severity of hallucinations, and the impairment index on the MMPI (Bornstein & O'Neill, 1992). Increases in conceptual complexity, and degree of articulation (the number of scorable attributes) were related to independent assessments of change in clinical functioning (GAS scores) in long-term treatment of seriously disturbed adolescents and young adult inpatients (Blatt, Stayner, Auerbach, & Behrends, 1996; Blatt, Wiseman, Prince-Gibson, & Gatt, 1990). Most importantly, predicted developmental differences were found between 5-6 year-olds and 9-10 year-olds (Priel et al., 1995). Thus, the content and structure of the representation of parents differ in clinical and non-clinical samples; they are related to independent assessments of level of psychopathology and clinical functioning in clinical samples and to aspects of general functioning in non-clinical samples; and follow a developmental model (see Fishler, Sperling, & Carr, 1990; Stricker & Healey, 1990).

Differentiation-Relatedness Scale of Self and Object Representations (Diamond et al., 1993). Initial validity studies for this scale in both clinical and non-clinical samples are encouraging (Blatt et al., 1996; Levy et al., 1998). The levels of differentiation and relatedness, particularly self representations, were significantly related to independent assessments of clinical functioning. Moreover, changes in scores of representations of mother, father, self, and therapist predicted therapeutic change over a two-year period (Blatt et al., 1996). The relationship between level of differentiation-relatedness of representations of self and other and levels of clinical functioning, as well as the degree of clinical change, were independent of socio-demographic (e.g., intelligence, age) and clinical variables (e.g., length of hospitalization, age of onset). In a non-clinical sample, the degree of differentiation-relatedness was significantly related to attachment patterns in theoretically congruent ways (Levy et al., 1998).

Clinical utility

In developing the ORI method and coding systems, Blatt and colleagues were attempting to advance our understanding of how the content and structure of mental representations are involved in normal personality development, psychopathology, and the assessment of therapeutic change. The assessment of the content and structure of mental representations can also provide a basis for differentiating among various forms of psychopathology (Blatt, Auerbach, & Levy, 1997; Blatt & Levy, 1998). Blatt and his colleagues have used this approach in case studies to provide new ways of understanding various forms of psychopathology like schizophrenia, borderline pathology, and depression (Auerbach & Blatt, 1996; Auerbach & Blatt, 1997; Blatt & Auerbach, 2001; Blatt, Wein, Chevron & Quinlan, 1979; Blatt, Stayner, Auerbach & Behrends, 1996; Diamond, Kaslow, Koonerty & Blatt, 1990; Diamond et al., 1999; Gruen & Blatt, 1990).

Attachment Scanner

- I Fonagy, P., Allen, J., Stein, H., Fultz, J., & Target, M. (submitted). Variations in adult attachment across attachment figures as assessed by Q-sort measure.
- I Allen, J.G., Huntoon, J., Fultz, J., Stein, H., Fonagy, P., & Evans, R.B. (in press). A model for brief assessment of attachment and its application to women in inpatient treatment for trauma-related psychiatric disorders. *Journal of Personality Assessment*, 76, 420-446.

Aim

The measurement of adult attachment is a complex and controversial process. A number of questionnaire measures are currently available (Bartholomew & Horowitz, 1991; Collins & Read, 1990; Hazan & Shaver, 1987; Main & Goldwyn, 1994). A number of papers and chapters have reviewed the current status of adult attachment measures (Hesse, 1999; Stein, Jacobs, Ferguson, Allen, & Fonagy, 1998; submitted).

Assessing attachment in adulthood has been shaped by two disparate traditions: clinical, as represented by Main's Adult Attachment Interview (Main & Goldwyn, 1994), focusing on representational models of relationships with parents, and social-psychological, as represented by Hazan and Shaver's (1987) self-report approach, which spawned a spate of questionnaires assessing various facets of attachment in romantic relationships. The "Attachment Scanner" was designed to assess adults' attachments to a potentially wide range of attachment figures in adulthood, with particular attachment figures rated to be determined by the researcher. To ensure content validity, we selected items representing core attachment styles – secure, dismissing, and preoccupied – on the basis of an extensive study of expert consensus. Moreover, to ensure discriminant validity, attachment items were carefully matched with counterpart non-attachment items of comparable social desirability (i.e., secure attachment versus positive non-attachment; dismissing and preoccupied attachment versus negative non-attachment). These non-attachment items were also selected on the basis of expert consensus. Hence, for example, the measure can assess the extent to which secure attachment characterizes a particular relationship, controlling for global positive valence of the relationship. Thus the Attachment Scanner can measure both the extent and quality of attachment for any variety of relationships.

Description

Questionnaires are vulnerable to bias wherein, for example, respondents may simply endorse desirable items at high levels regardless of content. Hence a Q-sort approach that maximizes discrimination between attachment and non-attachment aspects of relationships was chosen. The measure consists of 60 items divided among five scales: secure attachment, 20; positive non-attachment, 10; dismissing attachment, 10; preoccupied attachment, 10; and negative non-attachment, 10. For each defined target, respondents are instructed to sort each of the 60 items into 7 piles (distributed 3:6:12:18:12:6:3) with respect to the extent to which each item is true or untrue of the relationship. To date, data has been collected with respect to five targets: partner, best friend, mother, father, and acquaintance.

Practical issues

An initial group of participants used a magnetic board to complete sorts, and subsequent participants have done the sorts on a computer program developed by the researchers. The findings for the magnetic board and computer program were similar, and participants showed a slight preference for the computerized version (regardless of their familiarity with computers); hence the computer is now being used for all data collection.

Participants are able to complete the sorts after a brief demonstration followed by minimal instruction and supervision. The data are automatically tabulated. The computer program runs on Windows NT and requires a 17" monitor. Each sort takes from 15-20 minutes, and the whole task usually takes about 1-1/2 hours.

Psychometric properties

Initial studies with a convenience community sample indicate that the Attachment Scanner shows adequate reliability (internal consistency and test-retest reliability over a two-week period), although there is some variability across scales and targets. The Attachment Scanner shows good convergent validity when compared with two self-report measures of attachment styles, the Adult Attachment Scale – Revised (Collins & Read, 1990) and the Relationship Questionnaire (Bartholomew & Horowitz, 1991), and it shows good discriminant validity with respect to different targets. The measure also shows promising construct validity in its relation to measures of psychiatric symptoms and satisfaction in dyadic relationships (e.g., secure attachment and positive non-attachment scores contribute independently to extent of satisfaction in close relationships).

Clinical utility

The Attachment Scanner is ideally suited to psychotherapy process and outcome research. For example, quality of attachment to various attachment figures might be employed to predict formation of a therapeutic alliance or to forecast treatment outcome. In addition, changes in quality of attachment across various attachment figures might be employed as an outcome measure. Furthermore, the psychotherapist or psychoanalyst could be rated as an attachment figure, and the extent and nature of the initial attachment and the changes in the attachment over the course of therapy could be contrasted with simultaneous assessments of other attachment figures.

Patient Therapist Adult Attachment Interview (PT-AAI)

- Diamond, D., Clarkin, J., Levine, H., Levy, K., Foelsch, P., & Yeomans, F. (1999). Borderline conditions and attachment: A preliminary report. *Psychoanalytic Inquiry*, 19(5), 831-884.

Aim

The PT-AAI is a semi-structured clinical interview, which has been adapted from the Berkeley Adult Attachment Interview (AAI; George, Kaplan & Main, 1985; 1996) in collaboration with Mary Main and Erik Hesse. The aim of the PT-AAI is to assess patients' and therapists' state of mind with respect to attachment in the therapeutic relationship. The PT-AAI is also designed to explore patients' and therapists' experience and representation of the therapeutic relationship, and their capacity to mentalize or reflect on that experience.

Description

The PT-AAI follows the same format and order of questions, as does the AAI, with minor changes in the wording of questions to fit the context of the patient-therapist as opposed to parent-child relationship. The interview consists of 29 questions asked in set order, the first 17 of which parallel the questions on the AAI. Speakers are asked to describe their relationship with their patient/therapist generally and then to choose five words describe the relationship with the patient/therapist, supporting these descriptors with specific examples or incidents. Speakers are also asked what they did when upset, hurt or ill in the context of the therapeutic relationship. The interview also includes questions about the individual's response to separations from the patient/therapist, about times when the individual felt rejected by the patient/therapist, and about whether the individual has ever felt threatened by the patient/therapist in the course of the treatment. In addition, speakers are asked why they think the patient/therapist acted the way he or she did in the course of treatment, and are asked to describe and evaluate the effects of psychotherapy. As is the case with the AAI, the technique has been described as having the effect of "surprising the unconscious" (George, Kaplan, & Main, 1985) in that it allows numerous opportunities for the interviewee to elaborate on, contradict, support or fail to support previous statements or generalizations.

Practical issues

The PT-AAI requires specialized training to administer and to score. The technique of administering and scoring the PT-AAI is parallel to that of administering and scoring the AAI. PT-AAI interviewers must be trained in the specific technique of administration by an individual who has taken the Adult Attachment Interview Training Institute certified by Mary Main or Erik Hesse; PT-AAI coders must have taken the AAI training institute and achieved reliability on an extensive set of AAI transcripts (30). The PT-AAI is transcribed verbatim for purposes of analysis, using the same transcription rules that apply to the AAI. An adult attachment classification of the patient and/or therapist may be derived from the PT-AAI using the five-way Adult Attachment Scoring and Classification System (Main & Goldwyn, 1998), which has been slightly modified to fit the context of the patient therapist relationship (Diamond, Clarkin, Stouvall, and Levy, 2001). The interviews are assigned to one of five primary classifications: Secure/Autonomous, Preoccupied, Dismissing, Unresolved, or Cannot Classify. These classifications are derived from three classes of subscale ratings which have been adapted to fit the context of the patient therapist relationship by Diamond, Clarkin, Strouvall, and Levy (2001).

1) Scales that are based on the rater's inferences about the individual's experience of the therapist/patient (e.g., the extent to which there was mutual liking in the patient therapist relationship, the extent to which patient/therapist was rejecting, neglecting, involving, or

pressuring to achieve); 2) Scales that assess the individual's organized states of mind with regard to attachment information (e.g., coherence of transcript, idealization, insistence on lack of recall, active anger, lack of resolution of loss and trauma, and overall coherence of thought); 3) Scales that assess for Unresolved (disorganized/disoriented) states of mind (e.g. the extent to which the individuals are unresolved with regard to loss or trauma).

The PT-AAI, like the AAI, may be scored for reflective function by raters who receive training in applying the Reflective Function Scale (Fonagy, Steele, Steele, & Target, 1997), designed to assess the extent to which the speaker has the ability to think of others in mental state terms or to comprehend and conceptualize the mental processes such as feelings, beliefs, intentions, conflicts, motivations and other psychological states of self and others.

Coders for reflective function must receive training in the application of the Reflective Function Manual, Version 4.1 developed by Peter Fonagy and Mary Target (Fonagy et al., 1997).

Psychometric properties

Since the PT-AAI is an adaptation of the AAI, it is thought to have the similar psychometric properties to the AAI. The AAI has been subjected to stringent psychometric tests of its stability and discriminant validity which have been summarized in a number of articles including Hesse, 1999 ; Main, Kaplan and Cassidy, 1985 . In brief, the AAI has been shown to have a high level of test-retest stability (Main et al., 1985; Sagi et al., 1994), as well as stability (for three adult attachment categories tested over an 18 month to four year period (Ammaniti, Speranza, & Candelori, 1996; Crowell, Waters, Treboux, & O'Connor, 1996) including one study which indicates stability between a prebirth interview and the interviews conducted 11 months after the birth of the first child (Benoit & Parker, 1994). Reliability studies on the PT-AAI adaptation of the AAI subscales are currently in process, as are validity studies that assess the relationship between the PT-AAI attachment classification at one year with independent measures of symptomatology.

Clinical utility

In developing the PT-AAI the aim has been to advance our understanding of how attachment status might affect the quality and nature of the therapeutic relationship, including the formation and maintenance of the therapeutic alliance, and the transference-countertransference dynamics. Bowlby (1977) conceived of the therapeutic relationship at least in part as an attachment relationship, guided by the proclivity of humans throughout the life cycle to seek "proximity to some other differentiated and preferred individual...conceived as older or wiser" especially when the individual is "distressed, ill or afraid" (p.792). Further, like all attachment relationships, the therapeutic one was thought by Bowlby to be inherently bi-directional with attachment-seeking behaviors (proximity seeking, smiling, calling) tending to evoke corresponding adult attachment or caretaking behaviors (soothing, holding, protecting). The PT-AAI is designed to assess how the attachment behavioral system of both patient and therapist contribute to the configuration of therapeutic relationship. The PT-AAI may help to track the transference as it unfolds over the course of a long term therapy by providing a measure of state of mind with respect to the therapist which may be compared with the state of mind with respect to early attachment figures as assessed on the AAI.

Reflective Functioning (RF) Scale

- Fonagy, P., & Target, M. (1997). Attachment and reflective function: Their role in self-organization. *Development and Psychopathology*, 9, 679-700.
- Fonagy, P., Target, M., Steele, H., & Steele, M. (1998). *Reflective-Functioning Manual, version 5.0, for Application to Adult Attachment Interviews*. London: University College London.

Aim

The term reflective function (RF) refers to the psychological processes underlying the capacity to mentalize. Mentalizing refers to the capacity to perceive and understand oneself and others in terms of mental states (feelings, beliefs, intentions and desires). It also refers to the capacity to reason about one's own and others' behaviour in terms of mental states, i.e. reflection. Reflective functioning or mentalization is the active expression of this psychological capacity intimately related to the representation of the self (Fonagy & Target, 1995; 1996a; Target & Fonagy, 1996). RF involves both a self-reflective and an interpersonal component that ideally provides the individual with a well-developed capacity to distinguish inner from outer reality, pretend from 'real' modes of functioning, intra-personal mental and emotional processes from interpersonal communications. This formulation differs from most developmentalists in considering RF not to be a maturational cognitive capacity but rather a developmental achievement which is never fully acquired and is not consistently maintained across situations. It is important that RF is not conflated with introspection. Introspection or self reflection is quite different from RF as the latter is an automatic procedure, unconsciously invoked in interpreting human action. Procedural knowledge of minds in general, rather than declarative self knowledge, is the defining feature.

Description

With the help of a manual, trained raters apply the RF scale to transcripts of the Adult Attachment Interview. The manual describes the range of possible scores that may be awarded, from -1 (negative RF) to 9 (exceptional RF). Codings are anchored at odd numbers: 1 signifies lacking in RF, 3 signifies questionable or low RF, 5 signifies ordinary RF, and 7 signifies marked RF. This is so that where a rater is confident that a transcript falls between 2 of the main categories, it may be assigned the corresponding even number. The manual gives detailed explanations and examples of what constitutes high and low RF, and describes with examples how to decide on the appropriate score. Codings are assigned to the different sections of the interview, and the transcript as a whole is then assigned a rating. The weight of ratings depends on the passage rated. Some passages are characterized, on the basis of the interview question as requiring a reflective response, and narratives that follow these questions are given a greater weighting. The rater has to consider the interview as a whole, alongside the ratings for individual passages. The rater should not take an arithmetic average of the ratings given to core passages or even to all passages in the transcript. Too little is known of the psychometric properties of the individual ratings to permit this simple expedient. The rater has to come to a judgment about the whole text on the basis of the manual and their training, and over time in relation to their experience of other narratives to which they have assigned ratings.

Practical issues

Raters must be trained by Professor Peter Fonagy, Dr. Mary Target, Dr. Miriam Steele or Dr. Howard Steele, or by persons who they have trained and found to be reliable. The manual describing the application of the scale is available on request from Professor Fonagy, Psychoanalysis Unit, Sub-Department of Clinical Health Psychology, UCL, Gower Street, London WC1 6BT, or email p.fonagy@ucl.ac.uk. The training process consists of a two day seminar with preparatory work and reliability takes about 4 weeks to reach. It takes approximately 2-3 hours to code an average AAI transcript.

Psychometric properties

The reliability of the measure was assessed with 100 AAI transcripts rated by 3 judges. The inter-rater agreements were high (.79-.89). On a sample of 200 subjects the RF rating was found to correlate moderately with IQ ($r=.27-.33$) and slightly with education ($r=.19-.35$). There were no correlations with either age or socioeconomic group. As part of establishing the discriminant validity of the Reflective Function Scale, the scale was related to a number of psychometric instruments. Epstein's Mother-Father-Peer Scale (Epstein, 1983) measures independence-encouraging versus over-protective and accepting versus rejecting mothers, fathers and peers, none of these scales related to RF scores (see Table 8). The Eysenck Personality Questionnaire (Eysenck & Eysenck, 1975), concurrently administered to the subjects, showed no relationships to extraversion, neuroticism or psychoticism. The Langner 22 (Langner, 1962), a screening measure for psychiatric caseness, also showed no correlation with RF ratings. The RF scale was also correlated with the Sources of Self Esteem Inventory (O'Brien, 1981). The RF Scale had no significant association with any of the 11 scales of the SOSE.

On the AAI the strongest relationship of the RF measure is with the Coherence scale (combination of coherence of mind and coherence of transcript). This association is expected to be .64 –.74 in a low risk sample. There are a significant number of cases however where RF is high and coherence as measured according to Main & Goldwyn coding system is low. These individuals often had the harshest childhoods. There are also cases of low RF and high coherence, particularly in cases of relatively problem free backgrounds. Factor analytic studies of AAI scales showed RF to load with coherence of mind, subjective experience of good recall, lack of idealisation of mother, and lack passivity of thought. Overall, the psychometric analysis of the AAI, as reported in Steele (1991) revealed that ratings on RF were consistently the strongest contributors to judges' assessment of attachment security, and accounted for more than half of the variance in the secure/insecure distinction.

The validity of the RF scale was initially established in relation to the Strange Situation in a prospective study of parental predictors of infant security of attachment (Fonagy, Steele, Moran, Steele, & Higgitt, 1991). There was a strong relationship between scores on the RF scale and the Strange Situation behaviour of infants, whose mothers and fathers had been assessed using the AAI before the birth of the child (see Table 6). The point biserial correlation between secure classification in infancy and parental RF was highly significant ($r=.51$ for mothers and $.36$ for fathers, $p<.001$ in each case). In a subsequent study on the same sample, it was found that RF was particularly predictive of secure attachments with mothers, in cases where mothers independently reported significant deprivation in childhood (Fonagy, Steele, Steele, Higgitt, & Target, 1994).

In a further study (Fonagy et al., 1996) 82 out of 85 consecutively admitted non-psychotic patient in treatment for severe personality disorder were matched on age, gender, socio-economic status and verbal IQ with 85 normal control participants recruited from an outpatient medical department. The Adult Attachment Interview was administered to all patients and controls and

coded for RF by two raters. The agreement between the raters was .91. Axis I diagnoses did not distinguish high and low scorers on the scale with the exception of eating disordered patients, many of whom also carried an Axis II diagnosis (particularly BPD). Patients without Axis II diagnosis were rated higher on RF than those with ($p < .05$). This was principally due to the low RF scores of patients with a diagnosis of BPD ($p < .001$). Thirty-two of the 53 (60%) cases who reported abuse were independently diagnosed with BPD, compared with 44 of 29 (14%) who did not report abuse. The likelihood of reported abuse being associated with BPD was greater in the group of patients with low RF than those with RF ratings above the median. Only 4 of 24 (17%) patients reporting abuse in the high RF group were diagnosed with BPD, whereas 28 of 29 patients (97%) reporting abuse in the low RF group reporting abuse were so diagnosed. In the group not reporting abuse the prevalence of BPD was the same in low and high RF groups (2 of 17 for high RF vs. 2 of 12 in low RF). Thus RF is predictive of BPD only in the presence of abuse. In line with this argument, the three-way interaction component of the log-linear analysis was significant ($\chi^2 = 8.67, N=82, p < .004$).

Mother's RF, assessed on the basis of the prenatal interviews, was found to be highly predictive of the child's success in the Belief-Desire Reasoning Task ($r(90) = .32, p < .001$). This correlation controls for both the child's and the mother's verbal ability. In a path analysis, which included mother's attachment security, father's attachment security, mother's RF (metacognitive ability), infant-mother and infant-father attachment security, and child's verbal fluency as predictors of the child's performance on a cognitive emotion task, mother's RF was found to predict the child's performance, both via its influence on the child's attachment to the mother, and directly.

Clinical utility

RF is currently used in a number of studies to explore the impact of psychoanalytic psychotherapy on the capacity to envision mental states. Imre Szecsy and the AHMOS group were the first to address this issue in a prospective study (see this volume). It is not assumed that all of the effects of psychotherapy are mediated via this capacity for all patients. Rather, the authors assume that some patients require developmental help in this domain in the context of certain relationships. In a number of clinically oriented papers, Target and Fonagy have explored the clinical applicability of the RF concept (Fonagy & Target, 1996a; 2000; Target & Fonagy, 1996). The measure may be a helpful focus for early interventions as the focus on mother's RF in relation to her infant might well increase the chances of secure attachment. David Oppenheim at the University of Haifa is engaged with such work. Arietta Slade and Mary Target have explored the RF coding of the mother's representation of the infant and her relationship with the child in the context of the Parent Development Interview. Although, this has not yet been explored, groups are obviously possible to code from the standpoint of RF.

Person Representation Coding System

- Lemche, E., Grote, K. et al. (1999). Early parent-child interactions, parental representations, and emotion-regulatory patterns as measured through evoked play-narratives: Results from an exploratory study of 16 preschool children. 1st IPA Research Conference, Santiago de Chile.
- Lemche, E. (2000). *Person Representation Coding System (5th revision)*. Dresden University of Technology, Dresden.
- Lemche, E. (2000). *Guidelines for coding positive and negative self, mother and father action in play narratives. Addenda to the MacArthur Narrative Coding System (10/2000)*. Dresden University of Technology.

Brief summary of approach

Although Freud did not use a notion of representations in the contemporary sense of a stratified network of cognitive entities constituting internal structures, his writings on the theory of the ego contain a number of proposals on how affect-releasing tendencies are inextricably linked to ideational content. A number of theorists from object-relations and ego-psychology traditions have contributed to a house of theory that is concerned with how interaction experiences form mental models of other persons and the self, and how, in return, these models guide expressive, relationship, and action patterns. Attachment research ultimately transposed this theory into experimental design. While attachment theory is hesitant to undertake conceptual elaboration of internal working models, psychoanalytic thinkers such as Jacobson and Fairbairn provide much speculative anticipation for a more thorough scientific investigation of the extent to which hedonic valences of mental representations may influence internal and external behavioral regulations, including symptoms.

With the advent of the play narrative method, it became possible to study intrapsychic processes in very young children by facilitating them with an age-appropriate expressive tool. The Attachment Story Completion Task (ASCT) originated by Bretherton in Boulder in the mid 1980s and the development of the MacArthur Story Stem Battery (MSSB) by the Emde Lab in Denver in 1990 opened up a new major route to conscious and unconscious mental processes in children, including defensive behaviors. Starting with the MacArthur Narrative Coding System (MNCS) in 1995 there are now a number of coding systems and rating schemes in use internationally that allow for the subtle registration of nonverbal expressive displays as well as enacted and/or uttered emotion contents. With the recent fifth version of the Person Representation Coding System (PRCS) (Lemche, 2000b) there are observation criteria at hand for a precise quantification of the differentiation of the self, mother, and father representation, as well as of positive vs. negative valence representations.

Because the preschool period is regarded in the developmental literature as critical for the emergence and stabilization of intrapsychic emotion regulation, they chose to study this developmental span, with the initial explicit intention to learn more about the emotional aspects of oedipal development. A volunteer sample of eight boys and eight girls in the three-to-six-years range was drawn from five nursery schools in Berlin. Children and mothers completed a free-play session for the assessment of dyadic Emotional Availability prior to the administration of the MSSB. A number of data reports were obtained for sociodemographic, linguistic, and family background aspects. Among the parent-report instruments was the Child Behavior Checklist (CBCL), whose evaluation revealed that half of the children exceeded clinical cutoff levels. The sample met middle-class SES, but was biased towards higher education of the parents. Presentation of the story stems was randomized, and both coding instruments and cases were systematically varied among the coder pairs in the team. The first analyses established test-psychological criteria for the instruments MNCS, PRCS, and Emotional Availability, as well as sufficient intercoder reliabilities.

Major results

General strategy of the steps in data analysis was to test possible relations of the emotional and representational measures in the semi-experimental laboratory situation with various outside measures, and of the observational variables among each other. Four directions of analyses were pursued: development of language and narration, depiction of emotion regulatory patterns, prediction of person and valence representations, and exploration of mediator functioning for emotions and psychological symptoms.

Analyses on the aspect of narrative pragmatics indicated that children's narrative-interactive behaviours with the experimenter are not representation-mediated, but rather reflect Emotional Availability, i.e. parent-child interaction quality. In general, narrative coherence as assessed with the MNCS was related to PRCS representations, for the case of the mother representation, however, not without control for measurement error. There was a main effect in coherence by clinical symptom status and a multivariate two-way interaction by Emotional Availability and behavior problems.

The multitude of emotion observation measures suggested making attempts to describe them as conflict-elicited emotion-regulatory patterns (rather than cognitive emotion-regulatory strategies, in contrast). Two factor analyses, one on emotion contents only, and one with inclusion of nonverbal displays indicated sufficient factoriability. Although positive displays and themes are the most prevalent affect expressions, these tend to load on one singular factor, while various facets of negative affect tend to differentiate in further factors. Again, mother, father and self-representation (PRCS) exhibited the largest variance account on four emotion-content latent constructs. In the natural six-factor solution including nonverbal displays, one latent construct "emotion control" emerged that explained highly significantly most pairwise comparisons among overt-behavior regulatory cluster groups.

Efforts to explain the degree of differentiation of person representations can be summarized in the way that parent-child interaction quality, mother-reported language developmental milestones and a number of sociodemographic background variables form the three most important groups of predictors. If, however, valence representations were added, gestural deixis (a joint-attention protosymbolic sign of reference) proved to be the only significant predictor both in canonical correlation and multiple-criterion regression models.

Both a generic canonical correlation and multiple regression models demonstrated the mediator status of representations, influencing the relationship between positive and negative emotion aggregates and internalizing and externalizing behavioral syndromes. Similar as in the case of coherence, a methodological difficulty seems to arise from the fact that representations and emotion topics are elicited from conflict stories; as mother representations are more associated with proximity, soothing and positive affect, they tend to show less variability in distressing context, in majority. However, in a subgroup of about 35.7% they found a strong association of mother and negative valence. The coincidence of this constellation predicted the occurrence of negatively toned hallucinatory-bizarre content, which in turn proved to be related above chance with externalizing behavioral syndromes. Further studies are planned to seek to replicate and extend the findings in larger scaled and longitudinal contexts.

Brief evaluation of the approach

The representational world of the young child is the appropriate focus in the assessment of change in psychoanalysis. The story-stems originally designed and drawn up in Robert Emde's laboratory in Denver, represent a major step forward in creating a relatively standard form of semi-projective assessment for this domain. The material offered by the experimental situation is rich and the coding systems that have been developed are strong. The present studies are a significant contribution to this

Descriptions of studies

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Process-outcome studies 228

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The Berlin I Study – The Fenichel Report (BI)

- Fenichel, O. (1930). Statistischer Bericht über die therapeutische Tätigkeit 1920-1930. In S. Radó, O. Fenichel, & C. Müller-Braunschweig (Eds.), *Zehn Jahre Berliner Psychoanalytisches Institut. Poliklinik und Lehranstalt* (pp. 13-19). Wein: Int Psychoanal Verlag.

This is the first psychoanalytic outcome study and an early indication of the productivity of this field in Germany. This study has been described in detail in Bergin and Garfield, in the chapter on outcome by Bergin (1971). It forms the basis of Eysenck's classical critique of psychoanalysis which has recently been shown to exaggerate the speed of spontaneous remission in untreated patients (McNeilly & Howard, 1991). For a further report from the Berlin Institute see von F Boehm (1942) on 419 terminated psychoanalytic treatments (for a reference see A.Dührssen, 1972).

The New York Psychoanalytic Institute study

- Erle, J. (1979). An approach to the study of analyzability and the analysis: The course of forty consecutive cases selected for supervised analysis. *Psychoanalytic Quarterly*, 48, 198-228.
- Erle, J., & Goldberg, D. (1979). Problems in the assessment of analyzability. *Psychoanalytic Quarterly*, 48, 48-84.
- Erle, J., & Goldberg, D. (1984). Observations on assessment of analyzability by experienced analysts. *Journal of the American Psychoanalytical Association*, 32, 715-737.

This programme of studies was a naturalistic pre-post study using candidates and trained analysts from the New York Psychoanalytic Institute. Outcomes were measured in terms of analysts' assessments.

Sample

In the first study (Erle, 1979) 40 cases were followed, of whom 75% were women. The majority of the patients were young adults and their diagnoses as assessed by a number of senior analysts fitted into the neurotic spectrum. In the second study, a similar group of patients was treated by senior analysts and 160 cases were reported. In this sample, 60% were male and the age range was considerably wider. There were some more severely disordered patients in this sample, but they were a minority.

Treatment

At the time of both studies the New York Institute had a strong ego psychological orientation. In the first study, treatment adherence was ensured by supervision. Two thirds of the treatments ended by mutual agreement and three quarters of the treatments lasted more than two years. In the second study there were no treatment adherence measures but the therapists were all experienced analysts.

Outcome

In the first study there were no formal measures of outcome. Judgements were made on the basis of the candidates' impression of the extent of progress. Both analysts and supervisors provided a measure of change on a specially developed rating scale. In the second study, each treating analyst completed a semi-structured questionnaire where information concerning the justification for psychoanalytic treatment, the treatment process and a general description of the analysis was included. There were no operationalised measures of change but a method akin to individualised goal attainment scaling was adopted. The goals of treatment, however, were not set out in advance. The outcome parameters covered issues of self-esteem, symptomatic change, changes in defences, changes in relationships and changes in personality traits.

Results

In the first study in almost half the cases the diagnosis at termination was more severe than the diagnosis on intake. This is attributable to the use of clinical judgements and increasing knowledge acquired of the patients' pathology in the course of treatment. Over 80% of patients were rated as having 'benefited substantially' if they remained in treatment more than 4 years, but only 12% were rated in this category if they had less than 2 years analysis. Overall, the majority showed some treatment effect but 40% were rated as little changed. In the second study, patients were also noticed to be more disturbed at termination than at intake. Only 55% were judged to have received therapeutic benefit, but all cases who had showed change had been judged to be analysable at intake. Not all cases judged to be analysable at assessment manifested significant change. In both studies there was a strong relationship between length of treatment and outcome.

Evaluation

These studies are principally of historic interest as clinician ratings of outcome are generally regarded as lacking in validity. There was no attempt at assessing the reliability or validity of the measures and it is doubtful if many of the constructs used could actually be assessed reliably with currently available instruments. Perhaps the most interesting aspect of the study is the strong relationship demonstrated between the establishment of a psychoanalytic process (at least as judged by the therapist) and outcome. Of incidental interest is the lack of demonstrable superiority in the success rates reported by experienced clinicians compared with candidates. The absence of difference, however, could be accounted for the greater severity of cases taken on by the former and the arguably greater sensitivity to clinical problems of an experienced clinician.

The Columbia University research project

- Weber, J., Bachrach, H., & Solomon, M. (1985). Factors associated with the outcome of psychoanalysis: report of the Columbia Psychoanalytic Center Research Project (II). *International Review of Psychoanalysis*, 12, 127-141.
- Weber, J., Bachrach, H., & Solomon, M. (1985). Factors associated with the outcome of psychoanalysis: report of the Columbia Psychoanalytic Center Research Project (III). *International Review of Psychoanalysis*, 12, 251-262.
- Bachrach, H. M., Weber, J. J., & Murray, S. (1985). Factors associated with the outcome of psychoanalysis. Report of the Columbia Psychoanalytic Research Center (IV). *International Review of Psychoanalysis*, 12, 379-389.

This was an ambitious study undertaken by the Columbia Center for Psychoanalytic Training and Research contrasting the outcomes of non-randomly assigned psychoanalytic and psychotherapeutic treatments undertaken at Columbia University.

Sample

There were 700 cases referred and treated with psychoanalysis and 885 cases treated by psychotherapy. The researchers excluded cases where information regarding circumstances at termination were incomplete and where the independent clinician judges were uncertain about outcome. These criteria excluded 405 cases from consideration. Of the remaining 295, 32 terminated treatment for reasons such as leaving the city.

Measures

Independent psychoanalyst raters assessed all cases on a range of clinical and demographic variables, as well as nine ego strength scales at the beginning of treatment and at termination. The end point of some of the treatments was the graduation of the trainee analyst. There was a further instrument assessing analysability, completed by the analyst after termination of the treatment. This measure aimed to assess adaptation (the use of resources), psychological mindedness and transference manifestations. Outcome was assessed by the patient's circumstances at termination, clinical judgements of improvement, and changes in scores on the health-sickness rating scale.

Results

Of those completing treatment (52% of the sample), 91% were judged to have improved (62% were much improved). In a group of cases where there was a conversion from psychotherapy to psychoanalysis, 85% were judged to have improved (36% much improved). Premature terminators showed the least improvement and they tended to be with the least experienced analysts. In this category, the largest group remained unchanged (44%). Staying in analysis may be self-selecting insofar that this group may consist of individuals who feel they are getting most out of the treatment or they need analysis more than the prematurely quitting group.

An important finding of the study was that therapeutic benefit did not depend on the development of a full transference neurosis. Nevertheless, those who were rated as having developed a full analytic process were most likely to be rated as having improved (89%).

A spin-off study (Weber, Solomon, & Bachrach, 1985) of 36 patients replicated many of the findings of the original study using analyst and patient ratings rather than clinician judgements. Of the patients who stayed on until termination, 96% were judged to have improved. Psychotherapy cases which were used as a comparison group showed somewhat less improvement. Psychotherapy cases were, however, more severely impaired. Treatment length was strongly associated with therapeutic benefit – perhaps because of its association with the development of an analytic process (Weber, Bachrach et al., 1985b).

Evaluation

Limitations of the measures used in this study suggest caution in generalising from the findings. Although the large effect sizes are encouraging, the absence of a comparison group and the lack of psychoanalytic experience of the therapists impose severe limitations on the applicability of the findings.

Anna Freud Centre studies 2: Chart review of 765 cases treated with psychoanalysis or psychotherapy

- Fonagy, P., Target, M. (1994). The efficacy of psychoanalysis for children with disruptive disorders. *Journal of the American Academy of Child and Adolescent Psychiatry*, 33, 45-55
- Fonagy, P., Target, M. (1996). Predictors of outcome in child psychoanalysis: A retrospective study of 763 cases at the Anna Freud Centre. *Journal of the American Psychoanalytic Association*, 44, 27-77
- Target, M., Fonagy, P. (1994). The efficacy of psychoanalysis for children: Prediction of outcome in a developmental context. *Journal of the American Academy of Child and Adolescent Psychiatry*, 33, 1134-1144
- Target, M., Fonagy, P. (1994). The efficacy of psychoanalysis for children with emotional disorders. *Journal of the American Academy of Child and Adolescent Psychiatry*, 33, 361-371

This was a study of the carefully maintained case records of the Anna Freud Centre, a centre for the psychoanalytic and psychotherapeutic treatment of children under the direction of Anna Freud from 1952 until her death. Case records of the Centre are unusually detailed and to a large extent standardised following Anna Freud's diagnostic profile (Freud, 1962) and incorporating the Hampstead Index (Sandler, 1962). The charts of 763 cases were reviewed by independent researchers and careful attention was paid to achieving reasonable reliability in judgements.

Sample

The 763 cases reviewed represented over 90% of the cases seen at the centre for treatment. Some files were not available for research for reasons of confidentiality. Less than 5% of the files were incomplete. The sample was somewhat unrepresentative of the child and adolescent psychiatric population with an over-representation of middle class professional families. Children ranged from 3 to 18 years of age at the start of treatment.

Treatment

The average treatment lasted about two years. Over 70% of the treatments were 4 or 5 times weekly psychoanalysis, the remainder once or twice weekly psychotherapy. The treatment orientation was strongly Anna Freudian embracing classical psychoanalytical treatment for neurotic disturbance on the one hand and a somewhat more directive supportive treatment intervention, labelled developmental help, for more severe pathologies on the other.

Measures

The key outcome measure was a health-sickness measure - the CGAS score (Shaffer et al., 1983) - manualised for increased reliability as the Hampstead Child Adaptation Measure (Target & Fonagy, 1992). The reliability of psychiatric diagnosis (DSMIII-R) at initial assessment was established with independent raters. A large number of other variables pertaining to clinical presentation, treatment process and outcome were coded. Clinically significant improvement was established using the criteria suggested by Jacobson and Truax (1991).

Results

Of the emotionally disordered children treated for at least 6 months, 72% showed reliable, clinically significant improvements in adaptation and only 24% had diagnosable disorders at termination. Phobic disorders were most likely to change and depressive disorders least likely. Phobias, anxiety disorders and over-anxious disorders were resolved in over 85% of cases but OCD was more resistant, remaining at a diagnosable level in 30% of cases. Depressed children were least likely to remit. Frequency of treatment and the length of the treatment were both independently positively related to good outcome. High frequency treatments, however, appeared to selectively advantage children with more severe disturbance (multiple psychiatric diagnoses,

atypical personality development and pervasive impairments in adaptation affecting social, cognitive and emotional function). These individuals uniquely benefit from intensive therapy. Negative outcomes were most common when non-intensive treatment was offered to this group.

Children with disruptive disorders fared less well than those with emotional disorders matched for demographic characteristics and initial degree of disturbance. A large proportion of these children terminated early (33%) but were more likely to do so in psychotherapy than in psychoanalysis. If children remained in treatment, 70% of them were likely to improve to a level where they could no longer be diagnosed. Co-morbid anxiety disorder was associated with an increased likelihood of improvement, as was more intensive and longer-term treatment.

When children were matched for demographic features, severity of disturbance and broad diagnostic grouping and contrasted across three age groups, it appeared that children who were 6 and younger or between 6 and 12 benefited relatively more from psychoanalytic than from psychotherapeutic treatment. Those over 12, however, appeared to benefit as much from non-intensive as intensive treatment. On the whole, younger children showed far larger treatment effects than older ones.

Evaluation

This was an uncontrolled retrospective study and the authors were careful in highlighting the weaknesses and limitations of their approach, in particular the biased sample, the lack of manualisation and the relatively primitive standardisation of data acquisition, making it difficult to draw generalisable conclusions. Nonetheless, given the scarcity of data concerning the effectiveness of psychoanalytically oriented psychotherapy and psychoanalysis, the Anna Freud Centre retrospective studies are important both in terms of identifying the limitations of the psychoanalytic approach with children (autistic and conduct disordered children) and also in terms of identifying the patient group for whom psychoanalysis may be uniquely effective (multi-problem, young, severely dysfunctional children with at least one diagnosis of emotional disorder).

The Menninger psychotherapy research project (PRP)

- Kernberg, O., Burstein, E. D., Coyne, L., Applebaum, A., Horwitz, L., & Voth, H. (1972). Psychotherapy and psychoanalysis - The final report of the Menninger Foundation's Psychotherapy Research Project. *Bulletin of the Menninger Clinic*, 36, 1-275.
- Wallerstein, R. S. (1986). *Forty-two lives in treatment: A study of psychoanalysis and psychotherapy*. New York: Guilford Press.

The PRP was launched in the 1950s and it was the first prospective study of long-term psychoanalytic psychotherapy in the United States (Kernberg et al., 1972). The investigation was concluded with Robert Wallerstein's report of the long-term follow up, the history of these patients spanning 30 years (Wallerstein, 1986).

Sample

The study was carried out prior to the development of an operationalised diagnostic system or a structured interview for eliciting reliable information related to such criteria. The detailed case records reveal that the vast majority of patients in the trial suffered from severe personality disorders, many meeting criteria for BPD and most meeting psychodynamic criteria for borderline personality organisation (Kernberg, 1977). Forty two patients took part in the study. As the diagnostic category of BPD was under development over the course of the study, it is not surprising that there were real difficulties in arriving at definitive diagnostic decisions. A significant proportion of the patients, at least 50% in the psychoanalytic group, were shown to have borderline ego functioning on projective tests. Over a third (35%) were abusing alcohol or other substances and 33% had paranoid traits.

Treatment

Treatments offered included a number of treatment modalities, psychoanalysis, expressive psychotherapy and supportive psychotherapy. Unfortunately, subjects frequently switched between treatment modes and between therapists. Many of the therapists were experienced, although there were a significant number of novices. Many of the patients were severely ill and referred to Menninger because they proved to be unresponsive to other treatments available at the time. Overall, 27% of the patients were accepted under "heroic indications". These individuals had significant psychotic symptoms and would not be considered normally appropriate for psychoanalytic treatment. Hospitalisation was commonly resorted to in the course of the treatments.

Measures

There were 10 psychiatric interviews, an exhaustive battery of psychological tests, a physical examination, interviews with family members and qualitative analysis of case records giving perhaps the fullest picture of a group of patients in treatment in any study today. An important innovation of the study was the Health Sickness Rating Scale (Luborsky, 1962) which formed the basis of a currently widely used GAS measure (American Psychiatric Association, 1994). The measure permits clinicians to assign a rating between 0-100 which summarises their knowledge of the functioning of these patients. Independent blind raters were used in a complex, double matched pair method for literally thousands of ratings.

Results

Overall on the global ratings one quarter of the patients did not improve. Almost a quarter showed moderate improvement and over a third showed very good improvement. In 14% of the cases it was unclear if patients improved or not. The average improvement on the global measure was 13 points. The overall improvement rate is approximately 60%.

The results of the study were analysed by a number of researchers and the conclusions reached were somewhat different. The original report by Kernberg and colleagues suggested that individuals with borderline features benefited more from expressive than from supportive techniques. The original report, however, excluded analysis of the qualitative data. A reanalysis by Horwitz (1974) suggested that patients with borderline ego organisation did improve significantly in supportive therapy, given the achievement of a powerful therapeutic alliance.

Considerable additional clarity was obtained by Robert Wallerstein's (1986) reanalysis of the data. This study demonstrated that almost all the treatments required very significant modification during the course of the treatment, generally in the direction of offering a less psychoanalytic and more supportive approach. The study also showed that patients who were primarily treated with a supportive approach achieved durable changes of personality (structural change) at least as much as those whose treatment was primarily expressive psychotherapy or psychoanalysis. The study also confirmed the general finding that those with a higher level of ego strength at the start of the study generally tended to have better outcomes.

A further reanalysis was undertaken by Sidney Blatt (1992). Patients were divided into two groups: those with primarily anaclitic problems and those with primarily introjective problems. This categorisation was arrived at using the Rorschach Test using a scale developed by Blatt. Anaclitic patients suffer principally from disruptions of interpersonal relatedness and tend to use avoidant defences. Patients with introjective, counteractive defences have problems primarily related to autonomy, self worth and self definition. Blatt found that anaclitic patients tend to do better in psychotherapy, while those with introjective defences did better in psychoanalysis.

Evaluation

While it continues to be unique, the Menninger Psychotherapy Project has several major limitations that reduce its value and prevent its findings from being considered in any sense definitive. Randomisation was only partially successful: of the 42 subjects in the trial, 38 had treatment in both conditions. Further, the number of novice therapists equalled the number of experienced ones. There was a great excess of measures with the independent blind rating procedure yielding literally thousands of ratings denying the investigators the opportunity of performing legitimate significance testing. Depending on the author of the report, the study appears to yield quite different conclusions concerning, for example, the value of expressive therapy for borderline personality disorder. The reanalysis of the material by Blatt suggests that the sample was heterogeneous in the first place. Notwithstanding these limitations, the study has certainly been productive in terms of publications, yielding 0.7 books and 8.4 scientific papers per patient. The study remains a crucial landmark in the investigation of the psychoanalytic therapeutic process but further larger scale North American studies are now urgently needed.

The Heidelberg study (A): The Heidelberg psychosomatic clinic study – a naturalistic prospective outcome and follow-up study (HSA)

Rad, v M., Senf, W., Bräutigam, W. (1998). Psychotherapie und Psychoanalyse in der Krankenversorgung: Ergebnisse des Heidelberger Katamnesenprojektes. *Psychother. Psychosom. med Psychol* 48, 88-100

In the “Heidelberg Long-term Psychotherapy Follow-up Project”, a naturalistic study design, all types of treatment were included that had been performed at the Psychosomatic Clinic of the University of Heidelberg for a certain period (combined inpatient and outpatient individual and group therapy, as well as outpatient dynamic psychotherapies and psychoanalyses). The specific interest of this project is that - apart from many other, for instance psychological, assessment evaluations - three to five individual therapy goals had been systematically predetermined for all patients before starting their treatment (goal attainment scaling). After the end of therapy and at the time of follow-up (3.5 years later), attainment of these goals was assessed by an independent rater.

Sample

A total of 208 patients were examined who were evaluated according to their diagnosis (neurotic, functional or psychosomatic disorders) and the kind of treatment. There was no attempt at matching cases in the different groups.

Table 1: Description of Treatments Offered

| | |
|--|------------|
| Initial screening (t₁) | 754 |
| Treatment offered (t ₂) | 208 |
| Outpatient treatment | 69 |
| Psychoanalysis (x 3/week) | 36 |
| Dynamic psychotherapy (x 1/week) | 33 |
| Inpatient | 139 |
| Group therapy | 63 |
| Group + individual | 60 |
| Individual | 16 |

Results

With regard to symptomatology, individual therapy goals, psychological assessment and patient satisfaction, the overall results were good (in part very good) and were almost invariably stable during the long term follow-up period. Two particular results are discussed separately: (a) as far as symptomatology was concerned, the group of psychoanalytic patients often did not maintain their outcome at the end of therapy during the long follow-up period; (b) patients with “psychosomatic disorders” attained remarkably good results, particularly if the treatment had initially been an inpatient setting. Results of the analysis of symptom change in outpatient treatment are shown in Table 2 below. The comparison between the beginning and end of treatment showed a high level of success in over half of the psychoanalytic group and a third of the psychotherapy group. By follow-up some of this superiority appeared to diminish although much of this is accounted for by new subjects with more moderate improvements being available for assessment.

Table 2: Symptom change based on a symptom checklist developed in Heidelberg

| | Psychoanalysis n (%) | Dynamic psychotherapy n (%) |
|-----------------------|---------------------------------|--|
| $t_2 - t_3$ | 23 | 20 |
| No or negative change | 3 (13.0 %) | 1 (5.0%) |
| Moderate success | 7 (30.4%) | 13 (65.0%) |
| Good success | 13 (56.5%) | 6 (30.0%) |
| $t_2 - t_4$ | 27 | 18 |
| No or negative change | 6 (22.2%) | 2 (11.1%) |
| Moderate success | 13 (48.1%) | 6 (33.3%) |
| Good success | 8 (29.6%) | 10 (55.6%) |

t_2 = Beginning of treatment; t_3 = end of treatment; t_4 = follow-up

Change was also assessed in terms of individualised treatment goals. These results were more favourable to psychoanalysis (see Table 3). A high level of success was achieved by almost three quarters of those in psychoanalysis in terms of achieving their individualised treatment goals by the follow-up stage of the treatment compared with only half of those in psychotherapy.

Table 3: Individual therapy goals from beginning of treatment to follow-up

| Extent of change (t_2 vs t_4) | Psychoanalysis (N=32) | Dynamic Psychotherapy (N=18) |
|--|----------------------------------|---|
| No success | 3 (9.4%) | 4 (22.2%) |
| Moderate success | 6 (18.8%) | 5 (27.8%) |
| Good success | 23 (71.9%) | 9 (50.0%) |

t_2 = Beginning of treatment; t_4 = Follow-up

Individual Treatment Goals thus proved to be a powerful tool for the measurement of the treatment impact of the psychoanalysis. The results are marred by the significant difference in attrition rates between the psychoanalytic and psychotherapeutic group.

The question at follow-up “How satisfied were you with your treatment?” seems to trigger an interesting and characteristic effect: there is relative disappointment with psychoanalysis as a treatment and overwhelming endorsement of once a week dynamic psychotherapy. The three inpatient modalities - not cited here - lie in-between. It seems that user satisfaction measures are biased against psychoanalysis. This is not surprising in the light of the essential self-questioning nature of the psychoanalytic enterprise (see Table 4).

Table 4: Satisfaction with treatment at follow-up

| | Total sample (including in-patients) N=148 | Psychoanalysis N=32 | Dynamic psychotherapy N= 19 |
|----------------|---|--------------------------------|--|
| Dissatisfied | 18 (12.2%) | 7 (21.9%) | 1 (5.3%) |
| Satisfied | 83 (56.1%) | 20 (62.5%) | 9 (47.4%) |
| Very satisfied | 47 (31.8%) | 5 (15.6%) | 10 (52.4%) |

The Heidelberg Study (B): Observations concerning the dose-response relationship (HSB)

- Kordy, H., von Rad, M. & Senf, W. (1989). Empirical hypotheses on the psychotherapeutic treatment of psychosomatic patients in short and long-term time-unlimited psychotherapy. *Psychother. Psychosom.* 52, 155-163.

There were a large number of additional reports from the Heidelberg project. This report showed a dose-response relationship in the study. The study explored the interdependence of the duration and outcome of psychotherapeutic treatment using outcome data from psychoanalytically oriented group and individual therapy.

Sample and method

The relationship between duration and outcome of treatment was analysed in 209 patients with psychoneurotic and psychosomatic disorders for whom long-term treatment was planned. Along with the International Classification of Diseases (ICD-9) coding, evaluative data from the therapists (ratings of symptom improvement, modified goal attainment scaling) and from the patients (Giessen Test, Giessen Complaints List) were collected about six weeks after the last therapy session. The treatment lasted 2.6 years on the average and included an average of 146 sessions.

Results

The results indicated that the relationship between therapeutic effort (duration of treatment and number of sessions) and effect of therapy can be described by a dose-response model. According to this, a treatment duration of 2.5 years with 160 sessions is the most effective. The model is also valid when the subgroups of psychosomatic and psychoneurotic patients are considered separately. There was a slight tendency in the psychosomatic patients for treatment duration of up to 3.5 years to be accompanied by an increase in success rate.

Evaluation

This study provided important data concerning the value of long-term psychoanalytic treatments. Both symptomatic and goal attainment measures of outcome suggest the superiority of a more intensive treatment in the short term. It seems that longer, more intensive therapies are more helpful, at least for up to 2-3 years. The interpretation of the results is clouded by the naturalistic nature of the study.

The Heidelberg Study (C): Long-term outcome of out-patient psychoanalytic psychotherapies and psychoanalyses: a study of 53 follow-up interviews (HSC)

■ Heuft, G., Seibuechler-Engel, H., Taschke, M., Senf, W. (1996). Langzeitoutcome ambulanter psychoanalytischer Psychotherapien und Psychoanalysen: eine textinhaltsanalytische Untersuchung von 53 Katamneseinterviews. *Forum der Psychoanalyse: Zeitschrift fuer Klinische Theorie und Praxis*, 12, 342-355.

A further paper from the Heidelberg group was a contribution to the development of new strategies for follow-up methodology relying on qualitative text analytic strategies and individualised treatment goals.

Sample

The study reviewed the long-term outcome of psychoanalytic (N=36) and psychoanalytically oriented (N=33) psychotherapeutic treatments in a total of 69 participants, at least 2 years after treatment termination in patients treated as part of the Heidelberg prospective study. Overall, 91% of the sample could be recruited for this follow-up study. Of the recruited patients, 77% agreed to the detailed interview and answered the ITG questions. The sample is described in Table 1.

Table 1: Description of the Sample

| Sample (N=53) | Psychoanalysis | Psychoanalytic psychotherapy |
|---------------------------|----------------|------------------------------|
| Mean age | 31.2 yrs | 31.2 yrs |
| Age range | 20-41 | 19-57 |
| Sex: 73.6 % women | | |
| Education (gained Abitur) | 80% | 20% |
| College level | 45% | 20% |
| Students currently | 48.5% | 35% |

Therapy outcomes were evaluated firstly by an evaluation of the follow-up interview using a qualitative text-analytic methodology and secondly measured by the prospectively determined individual therapy goals (ITG = equivalent to goal attainment scaling).

A further innovation of this study was the development of an integrated measure of outcome – based on a text analytic methodology (the content analysis of the transcribed interviews) – to get a total change score.

Results

The results of the text analytic measure revealed that self-image, which was a dominant concern for most patients, changed in a positive direction. The findings indicate “good” or “very good” outcomes for 55% of the entire sample, indicating that self representation altered in a positive direction as a function of psychoanalytic and psychotherapeutic treatment (see Table 2). The influence of sociodemographic factors, setting variables and thematic interview range were said to be taken into account but details are not clear.

Table 2: Results of content analysis of interviews in Heidelberg Project at 2 year follow-up

| Expert outcome rating based on scoring of follow-up interviews | Psychoanalysis 100 % (n = 33) | Psychoanalytic psychotherapy 100% (n = 20) |
|---|--|---|
| Very good | 12.1 (4) | 10.0 (2) |
| Good | 42.5 (14) | 45.0 (9) |
| Slight | 33.3 (11) | 25.0 (5) |
| Unchanged | 9.1 (3) | 20.0 (4) |
| Deteriorated | 3.0 (1) | - (-) |

The principle underlying Individual Treatment Goals (ITG) is illustrated by the following example. The question which indicated the presence of a problem before treatment might have been “How is your relationship with your father?”, if improvement of this relationship was identified as a treatment goal for a patient. The following illustrate the coding of answers on the ITG Scale:

Deterioration: “I have cut off all contact with him.”

Unchanged (status quo): “Father still is a terrible person. I am still as frightened of him as I was. We quarrel every so often and then I cry.”

Slight improvement: “I somehow have more distance from my father, although I still can’t live without fear in his presence”.

Good improvement: “I no longer have the same fear around my father as I used to. I am able to see him more realistically. My relationship with my father no longer dominates my relationships with other men”.

Very good improvement: “I have a comfortable distance from my father. I can see his positive as well his negative sides and feel free to be involved with him when I want to be”.

Using the ITG rating a slightly different picture is obtained concerning the relative efficacy of psychotherapy and psychoanalysis (see Table 3).

Table 3: Results of goal attainment scaling of follow-up interviews in Heidelberg Project at 2 year follow-up

| Expert outcome rating based on scoring of ITG | Psychoanalysis 100 % (n = 33) | Psychoanalytic psychotherapy 100% (n = 20) |
|--|--|---|
| Very good / good | 72% | 55.6% |
| Slight | 18.7% | 22.2% |
| Deteriorated | 9.6% | 22.2% |

The ITG ratings by an expert observer (the follow-up interviewer) were cross-checked by a group of independent raters who listened to the patients’ tape recorded answers. Overall, 72% of the psychoanalytically-treated versus 55.6% of the psychotherapeutically-treated patients reported “good” or “very good” results. The data provided by the interview text analyses and by the ITG ratings are only partially overlapping because they evaluate different aspects of outcome.

Evaluation

This study underscores the potential importance of individualised measurements for long term and more intensive treatments as operationalised by the ITG. This approach makes clinical sense since the treatment goals of analysis are for the most part difficult to capture using standardised instruments which are more appropriate to the measuring of symptomatic change involved in the treatment of major psychiatric disorders. The study, while uncontrolled, was prospective and carefully designed and implemented. The key finding is that the vast majority of those treated psychoanalytically appear to attain the goals which they and their analysts define as pertinent to them and that this process is maintained for at least two years after the end of treatment.

The Berlin III Study (A) – A multi-centre study of psychoanalytic oriented treatments: The Therapeutic Alliance. Investigations of process and outcome of psychoanalytic therapies (BIIA)

- Rudolf, G. (1991). Free University of Berlin: Berlin Psychotherapy Study. In L. Beutler & M. Crago (Eds.), *Psychotherapy Research. An International Review of Programmatic Studies*. Washington: American Psychological Association.

The Berlin psychotherapy study was a multi-center research project conducted over 10 years (funded by the Ministry of Science and Technology - BMFT), investigating the process and outcome of diverse forms of psychoanalytic therapies.

Sample and treatment

Forty seven psychoanalytically trained therapists offered 2-3 times weekly outpatient psychoanalysis, dynamic psychotherapy, focal therapy or group therapy. Thirty similarly qualified therapists offered inpatient psychoanalytic treatment, sometimes also including group therapy and Gestalt therapy-like, non-verbal treatments. The common denominator was the unravelling of unconscious conflicts. At screening the sample consisted of 739 patients; 348 began in-patient or outpatient treatment and 344 patients were seen in the follow-up investigation. Fifty four percent of them were diagnosed based on ICD-8 as suffering a “psychoneurosis”, 20% as having personality disturbances, 13% as psychosomatic, 5% as having ego weakness and 8% somatopsychic disturbances. The treatment length and drop-out rates for each group are shown in Table 1.

Table 1: Sample of the Berlin III Study

| | n | Mean number of sessions (range) Or length of stay (range) | Drop out rate |
|-------------------------|-----|--|---------------|
| Psychoanalysis | 44 | 265 (160 - 470) | 8% |
| Dynamic psychotherapy | 56 | 60 (5 - 200) | 35% |
| Inpatient psychotherapy | 164 | 2.6 months(1-12 months) | 12% |

The results reflect comparisons at intake and termination. In the case of the long term psychoanalytic treatments, follow-up measurements were taken three years after beginning therapy.

Measures

The following measures were used:

Global change evaluated by therapists involving a rating of patient’s mental and ‘social-communicative’ status, i.e. communication between therapist and patient. (PSKB=Psychischer und sozialkommunikativer Befund: Mental and social-communicative responses). (Rudolf, 1981).

A questionnaire investigating the psychosomatic aspects of the patient’s disturbance. (FAPK=Fragebogen zur Abschätzung psychosomatischen Krankheitsgeschehens).

Scales which the therapist used to make prognostic assessments about the patient – based on motivation, possibility of changing structure of defences and the relationship dynamics.

Results

Inpatients

143 patients had a planned termination of treatment and an average treatment duration of 2.6 months. Based on therapist ratings all the PSKB questionnaires showed positive changes; especially favourable was psychic symptom reduction (e.g. fear and depression). There were

slight to moderate changes on the narcissism and bodily symptoms scales. Results on patients' ratings were similar: 9 of the 13 scales of PSKB showed significant improvements. The psychiatric symptoms showed most marked changes. Ratings concerning pathological relationships showed changes indicating that both the chronicity of the illness and how the illness was built into the life of the patient could be altered. Reality testing and emotional relationships also changed. Putting all criteria together, 64% of the patients had very significant changes in at least one field. At the follow-up investigation, nine months after the end of the treatment, 50% of 161 patients participated. This group rated the impact of treatment extremely positively. Overall, 30% felt significantly improved; 89% rated the impact of the treatment in the clinic and the consequences for them as persons as positive. The usage of psychotropic medication dropped from 69.5% to 24.7% by the follow-up. Therapists rated 70% of these patients as having a good prognosis (based on the criteria of symptom change and ongoing changes of the internal processes).

Outpatient psychotherapy

The research question was whether the intensive, long term outpatient psychoanalytic therapy would have better results than the comparative inpatient treatment. The average number of sessions of psychoanalytic therapy (two to three times a week) was 265, with 115 group sessions. The sample consisted of 60 patients who had at least 160 sessions or a treatment duration of 30 months at minimum. Changes in the PSKB were more marked than with the inpatient group, with the most pronounced reductions in anxiety symptoms and depressive helplessness. Smaller changes, but still higher than was found with inpatients, were revealed for narcissistic traits. The scales relating to bodily symptoms showed highly significant improvements. Outpatients, as well as their therapists, rated the success higher (on 5 scales of PSKB) than in the inpatient group with the main change in the bodily symptoms, anxieties, reality testing and emotional relationship capacities. Ninety percent of the therapists reported a pronounced positive restructuring of the personalities of their patients. Pronounced symptom change was found in 83% of the outpatient group compared to 50% of the inpatient group. Thus, overall, 96% of the outpatient group had successful treatments, compared with 64% of the inpatient sample. It can be claimed that all the patients in long term psychoanalytic therapy who did not leave treatment were significantly improved. The quoted drop-out rate of 8% was low.

Three years after the original diagnostic interview all groups (including the non treated patients) were interviewed again. Those patients who received long term, outpatient psychoanalytic treatment had the best results. Their symptoms had reduced in 97% of the cases and more than half of the patients felt not at all or only very slightly distressed. Of the group who had received inpatient treatment, only 60% still reported symptom improvement and only 20% were symptom-free. Therapists' prognostic ratings concerning future development of the patients showed a similar picture: only 2% of the long term patient group was considered as suffering from a risk of relapse, whereas 36% of the inpatient group and 38% of those patients who did not finish therapy were considered at risk.

Evaluation

This study suffers from the problems of internal validity because of the non-independent rating of outcomes and the lack of randomisation of the treatment groups – assuming that the groups were at least comparable, it is striking to observe the effectiveness of outpatient intensive treatment.

Further analyses of the same study have been reported by Grawe and colleagues (Grawe, Donati, & Bernauer, 1994), focusing on poor outcomes, particularly for psychosomatic symptoms, in the group who received psychoanalytic treatment.

Berlin III Study (B): Results of psychoanalytic therapies (BIIIB)

■ Rudolf, G., Manz, R., & Ori, C. (1994). Ergebnisse der psychoanalytischen Therapien. *Zsch Psychosom Med*, 40, 25-40.

Within a naturalistic design, 44 psychoanalytically treated patients were examined with regard to both qualitative and quantitative outcome. The results are compared to those for 56 patients receiving outpatient psychodynamic therapy and 164 patients who were treated with inpatient dynamic therapy. A comparison of symptoms, diagnoses and motivations prior to therapy leads to the conclusion that very different patient groups are seen in these different settings. Randomisation seems to be an inappropriate strategy to compare groups in different settings given that patients who are normally offered these treatments differ significantly clinically as well as demographically.

Results

Using different criteria of outcome it could be demonstrated that psychoanalytically treated outpatients improve markedly and to a larger extent than do psychodynamically treated outpatients or inpatients. Different outcome measures and different perspectives (patients/therapists) revealed further interesting differences. Patients primarily reported improvements in somatic, anxiety and depressive complaints. Therapists, however, report substantial improvements in interactional symptoms and behaviour. Global change (rated by therapists) showed the most marked improvement in the outpatient psychoanalytic group (see Table 1).

Table 1: Therapist rated improvements across 3 groups in Berlin III Study

| | Improved: Symptom improved & no structural change or no symptoms & structural improvements | Much improved: No symptoms & positive structural development | Total improvement |
|----------------------------|--|--|--------------------------|
| Out-patient psychoanalysis | 13% | 83% | 96% |
| Out-patient psychotherapy | 30% | 60% | 90% |
| In-patient psychotherapy | 28% | 31% | 59% |

Global satisfaction rated by patients at follow-up (3.5 years later) were 96% for out-patient psychoanalysis and 65 % for in-patient treatment. Table 2 shows the effect sizes (pre and post values on PSKB-scales divided by the standard deviation of pre values) for PSKB-scales for psychoanalytic treatments. Highest effect sizes were for anxiety and depression related symptoms in both self-rated and therapist rated measures.

Table 2: Effect sizes for specific dimensions for therapist ratings and self ratings

| PSKB Self Rating | | PSKB Therapist Rating | |
|--------------------------------|------|------------------------------|------|
| Bodily anxieties | 1.36 | Anxious symptoms | 1.08 |
| Depressive-suicidal complaints | .94 | Depressive impotence | 1.0 |
| Functional complaints | .80 | Over-protectiveness | .75 |
| Social phobic symptoms | .78 | Bodily symptoms | .66 |
| Regressive clinging | .62 | Poor relationships | .66 |
| | | Orderliness | .65 |
| | | Anxiousness | .56 |

The Berlin III Study (C): The prognostic relevance of a working alliance as seen by patients and therapists (BIIC)

- Rudolf, G., & Manz, R. (1993). Zur prognostischen Bedeutung der therapeutischen Arbeitsbeziehung aus der Perspektive von Patienten und Therapeuten. *PPmP, Psychother. Psychosom. med. Psychol.*, 43, 193-199.

In general, the prognostic relevance of working alliance for both the course and the outcome of psychotherapy is no longer a matter of dispute. A further spin-off study examined the prognostic power of the initial working alliance. Since a working alliance is considered as an interactional variable, the authors considered it from the perspective of the investigator, therapist and patient over the course of the therapy.

Design and method

Using the data available from the Berlin Psychotherapy Study (Gerd Rudolf, 1991), the study investigated the prognostic relevance of diagnostic and treatment related working alliance variables for the various dimensions of outcome for 239 patients (inpatients and outpatients who received psychoanalytically oriented therapy in the study). A complex correlational statistical method (latent trait modelling) was used to investigate inter-relationships between working alliance and outcome, taking account of time structure and diagnostic variables.

Results

The results suggested that the therapist's own perspective on the working alliance was most relevant to eventual outcome. The initial assessment of alliance was influenced by or may have influenced diagnostic judgements. In turn those assessments predicted eventual therapeutic outcome. The patient's perspective on the therapeutic alliance was a relatively weak predictor of outcome.

Evaluation of the Berlin III Study

The Berlin III Study is an important and relatively sound assessment of the effectiveness (not efficacy) of three modes of psychodynamic intervention (out-patient intensive, out-patient non-intensive and inpatient). The fact that the treatment is offered to different groups of patients makes comparisons difficult to make. Nevertheless, all three psychodynamic treatments appear to do relatively well both according to therapist and patient ratings. All treatments were associated with a reduction in psychotropic medication, particularly in-patient treatment. Out-patient psychoanalysis did appear to have relatively strong long-term impact on symptoms but less impact on relationship variables. The study also yielded challenging results concerned with the concept of the therapeutic alliance (working alliance). It seems that, in this study at least, the concept is closely related to diagnosis and perhaps influences (or is influenced by) the therapist's expectations concerning the patient's likely response to treatment.

The Stockholm outcome of psychotherapy and psychoanalysis (STOPP) study

- Sandell, R., Blomberg, J., Lazar, A., Carlsson, J., Broberg, J., & Rand, H. (2000). Varieties of long-term outcome among patients in psychoanalysis and long-term psychotherapy: a review of findings in the Stockholm outcome of psychoanalysis and psychotherapy project (STOPP). *International Journal of Psychoanalysis*, 81 (5), 921-943.
- Sandell, R. (1999). Long-Term Findings of the Stockholm Outcome of Psychotherapy and Psychoanalysis Project (STOPPP). Paper presented at the Psychoanalytic Long-Term Treatments: A Challenge for Clinical and Empirical Research in Psychoanalysis, Hamburg, Germany.

Background of the project

In 1988, the health authorities in Sweden decided to subsidise psychoanalysis and long-term psychotherapy with private non-medical practitioners. Psychoanalysis was defined formally as 3-5 sessions per week with a member of one of the two psychoanalytical societies and psychotherapy as 1-3 sessions per week with a licensed psychotherapist. The subsidisation of an analysis or a therapy was time-limited to three years, but treatment itself was not: patients were free to apply even if they were in ongoing therapy and free to continue financing it in other ways after expiration of the subsidy. From 1990 to 1993 some 70 to 140 treatments were subsidised annually from a waiting-list that eventually was more than 1100 persons long.

Method

Design

The main question, in accordance with the goals of the insurance authorities, was whether it would be possible to discern any beneficial effects of the treatments offered. The basis for the design was a three-wave panel-survey in a sample of 430 persons at different stages in psychoanalysis or psychotherapy. Treatment modality was self-selected. Stage in treatment was in effect a randomised factor, because the timing of the outcome measures was totally independent of whether any person actually was in ongoing treatment, had terminated, or had not yet begun. Having three panel waves, time in treatment could be measured “ordinally”, in units of seven gross stages of treatment. The groups were: early before, late before, at assessment, ongoing, late ongoing, early after, late after. In contrast to real time, ordinal time is only a matter of before or after, earlier or later. Sampling occurred in three consecutive years covering 1994-1996. Thus time points are virtual, in the sense that at various stages of the treatment process different individuals provide outcome information. They may be regarded as suitable for assessing outcome if it is assumed that patients have been randomly drawn from the same population of patients. More than 20 relevant variables were tested for differences between the samples at different time points, and none were found to be significant.

Patients

The initial patient sample consisted of (a) 205 patients who had been subsidised in 1990 or 1991 and (b) the first 550 persons on the waiting-list for subsidisation, assuming that some of these already were in treatment. Of over 700 persons a little more than 430 responded in a usable way to the questionnaire on all three occasions. Seventy-six were psychoanalytic patients for two or more years, 345 in long-term psychotherapy two or more years, and 13 in various low-dose therapies, of low frequencies or short durations.

To assess the clinical significance of the findings, two control groups were included in the design, both of them “healthy” and “normal” groups. In sum, these numbered 650 persons. The design is illustrated in Table 1.

On the basis of pre-treatment assessments, Axis I syndrome diagnoses were found to be quite frequent (63%), GAF (M = 57. SD 13) and SPDS (M = 54. SD 24) were in the borderline region. The GAF score was in the neurosis range (M =64. SD 8). The groups varied on social factors. In particular, patients receiving psychoanalysis (PSA) were more likely to have received university education.

Table 1: Summary of the study design

| Treatment Group | Comparison groups |
|---|---|
| N = 700 persons at various stages of treatment (before, ongoing or after) | N = 650 persons |
| n ₁ = 60, subsidised for psychoanalysis 1990-1992 or 1991-1993 | n ₄ = 400 in community random sample |
| n ₂ = 140, subsidised for long-term psychotherapy 1990-1992 or 1991-1993 | n ₅ = 250 university students |
| n ₃ = 500, on waiting-list for subsidy in 1994 | |

Assessment Procedures

Patient's battery

Among several sections, dealing with family, health, work and other conditions, the questionnaire battery contained the following standard instruments: the Symptom Check List (SCL-90); the Social Adjustment Scale (SAS); and the Sense of Coherence Scale (SOCs). The battery was distributed to all patients three times, in May 1994-1996, and the contrast groups completed the questionnaire once, in May 1994.

Therapeutic identity questionnaire

In order to gain some general idea of the therapeutic milieu in which the treatments took place, a questionnaire was distributed to all of the 313 analysts and therapists who had patients in the project. The questionnaire included questions about therapeutic training and experience, training analysis or training therapy, and therapeutic orientation. Another three sections were included with the intention to chart, using altogether about 75 self-rating scales, the therapist's beliefs about curative factors in psychotherapy, the therapist's general style of working in therapy, and the therapist's more basic assumptions about the nature of psychotherapy and the nature of the human mind. For standardisation purposes, the questionnaire was also distributed to a random sample of 325 licensed psychotherapists throughout Sweden.

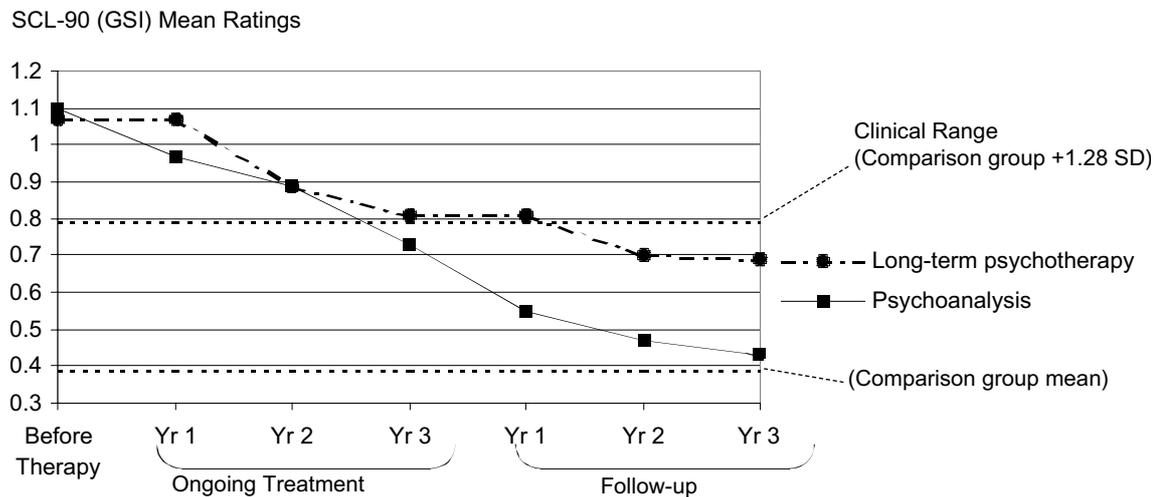
Results

Therapeutic outcome

Figure 1 displays mean SCL-90 Global Severity Index summary scores at the different phases of treatment for both psychoanalytic (N=74) and psychotherapeutic (N=313) treatment. SCL-90 scores were high to begin with; they were well above the line which separates the worst-scoring

10% in the combined norm group from the rest, which is 1.28 SDs over the mean in the norm group. The latter line may be considered “the clinical significance line.” There was a steady decline overall when treatment started and after the end of treatment both groups were well within the normal range. The two groups started out at almost exactly the same level but a large difference emerged after treatment had ended. The psychotherapy group levelled out after termination, whereas the psychoanalysis group continued to improve and closely approached the mean in the norm group. This was a very large pre-post effect by any standard, even in the absence of a control group, whereas the effect was moderate in the psychotherapy group. Even when initial differences between the two groups were controlled for, the differences remained – or rather increased. Assuming further development would continue linearly, it would take the psychotherapy patients nine years to reach where the analysands have reached in three. The few patients (N=13) in brief therapies showed a slight worsening over the same period.

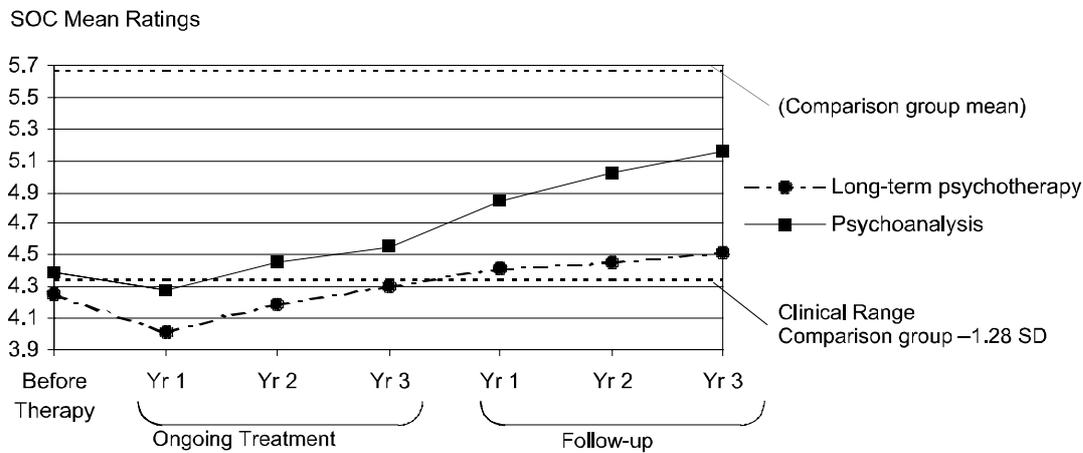
Figure 1: Mean SCL-90 Global Severity Index before treatment, during therapy and during follow-up



Data from the Sense of Coherence Scale (SOCs) is plotted in Figure 2. It shows broadly the same pattern as the SCL-90, although not as dramatic.

On the SAS improvement was rather modest and almost the same in both groups. The present data suggest that psychoanalysis is quite powerful in producing long-lasting and increasing alleviation of symptoms. It was a surprise to find that the development in social adjustment was virtually the same whether a patient had been in psychotherapy or psychoanalysis. The SAS is a measure of social relations rather than of object relations. Sub-scales of the SAS did yield further interesting information. Greatest improvements were observed on the work scale; the relatives scale (parents, siblings, extended family) showed almost no changes. There was an initial deterioration on all scales except the work and the friends scales. This *may* reflect an initial narcissistic withdrawal of object relations, a distancing from, primarily, close persons. In some cases, as with the children, the pre-treatment level is hardly recovered.

Figure 2: Mean SOC Ratings before therapy, during therapy and in follow-up



The authors summarize their findings by counting the proportion of patients in each group at each point of time with better scores than the worst-scoring 10% in a non-clinical norm group. In the psychoanalysis group this percentage increased from 10 to 75% (comparing before treatment to three years after termination) and from 30% to 55% in the psychotherapy group. When group means of the SCL-90, SOC, and SAS measures were regressed on a seven-step time scale, slopes indicated small to moderate change during and after psychotherapy (effect size $d=0.3$ to 0.6) and moderate to very large changes during and after psychoanalysis (effect size $d=0.5$ to 1.8).

Therapist factors

Data was obtained from 325 treatment couples, 264 psychotherapies, 53 analyses, and 8 low-dose therapies. Older therapists achieved on the whole better outcomes with their cases, irrespective of therapist or patient gender and irrespective of whether the treatment was psychoanalysis or psychotherapy. Interestingly, the *second youngest* group – *not* the youngest – tended to do worst. The amount of time a person has been working as a therapist was positively related to patient outcome in these treatments. But if this time is split into two periods, one before licensing, (in supervision), and one after licensing, it was only the post-licensing period which made the difference. These findings indicate that simply doing psychotherapy is not enough – formal training is necessary if one is going to be able to make use of the experience.

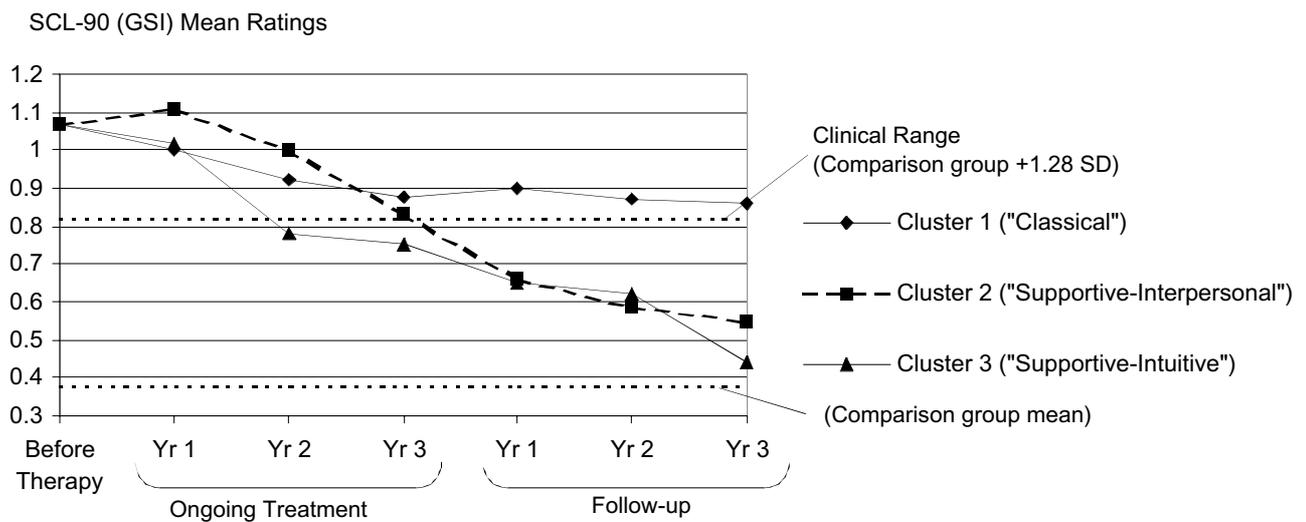
Psychoanalytic training did not appear to be beneficial for the effective practice of *psychotherapy*. Caseload, in terms of number of previous patients in individual psychotherapy, did not seem to matter, nor psychotherapeutic experience in the public health system. Being in supervision at the time of the therapy and having spent a long time, in this case more than 10 years, in training therapy or training analysis was negatively related to the outcomes of one's therapies or analyses. Supervision and long training therapy are almost certainly selection effects, where therapists with professional or personal problems are particularly likely to seek supervision or reanalysis or retherapy and are less adequate in their functioning as mental health professionals. Further, it is possible that the "good patients", (those likely to improve) are better equipped to select the more experienced therapists. In the absence of random assignment of patients to therapists, causal accounts must remain speculative.

The therapist questionnaire included a battery of roughly 75 different self-rating items about therapeutic style, beliefs in curative factors, and assumptions about human nature. Factor analysis

yielded nine orthogonal factors. A cluster analysis of factor scores led to the identification of four kinds of therapists or analysts on the basis of their beliefs and values. The first cluster of therapists valued mastery, support, kindness and openness in psychotherapy relatively little, whereas they valued technical neutrality and insight most. In this cluster, there is an over-representation of people with psychoanalytic training, although there are also a large number of psychotherapists. This is a group with classically psychoanalytic ideals. The second cluster, which was not represented in this sample of therapists, put *high* values on mastery, support, kindness, and openness but do *not* value neutrality or insight as much (mostly cognitive or behavioural therapists). The two other clusters were called eclectics, because they scored high on *all* scales, both the more interpersonal scales and on the insight scale. The difference between the two clusters is mainly a matter of their attitude towards openness, which seemed to be related to training. There were some psychoanalysts belonging to these clusters, in addition to ordinary psychotherapists.

This is what was found for the SCL-90. When the outcome trajectories for patients of the three different clusters of therapists were plotted, irrespective of whether the modality was therapy or analysis, the psychoanalytic cluster deviated negatively from the other two (see Figure 3).

Figure 3: Outcome trajectories across therapy and follow-up for three clusters of therapists



There was practically no change in patients treated by therapists who subscribed to classical analytic values. These treatments were, however, not *all* analyses and the therapists were not *all* analysts, but their attitudes were indeed classically psychoanalytic. When the patient sample was split into psychotherapy patients and analysands and the therapists in the three clusters were compared, it was found that whereas psychoanalysis is about equally effective with analysts of either classical or eclectic values, psychotherapy is not. There is hardly any change in psychotherapy patients treated by Cluster 1 therapists and they end up well above the clinical cut-point. Classically psychoanalytic kinds of therapeutic attitudes do not appear to be conducive to change in psychotherapy – although it is effective in psychoanalysis. The critical issue seems to be that the classical psychoanalytic point of view – under the pretext of the abstinence rule – seems to neglect or devalue the positive relational components of being friendly, personal, and caring. This seems to matter less in the psychoanalytic setting, but it seems to determine the success of psychotherapy.

Evaluation

This, most impressive, study made use of an imaginative sampling procedure to overcome the usual problem of small sample size in long-term studies of psychotherapy and produce some stimulating findings. Although the combination of between and within subjects measurement has made statistical analysis of the data challenging, the authors seem to have succeeded in using ANOVA and regression models to extract interesting trends. Comparison of the samples from different time points using possible confounding variables has so far suggested that the analyses are valid, though it is impossible with the current design to know for sure if the observed effects represent the average time course of individuals. The authors are currently preparing their data files for an HLM (hierarchical linear modelling) analysis, as a way to best deal with the complicated study design. The measures were relevant and, at least as far as the SCL-90 is concerned, in standard use in psychotherapy research permitting comparison with other studies. Results of the HLM analyses should provide a validity check on the data analytic methods used in this study.

The Heidelberg-Berlin Study: The Heidelberg-Berlin practice study on psychoanalytic long term therapy (HBS)

- Grande, T., Rudolf, G., & Oberbracht, C. (1997). Die Praxisstudie Analytische Langzeittherapie. Ein Projekt zur prospektiven Untersuchung struktureller Veränderungen. In: Leuzinger-Bohleber, M., Stuhr, U. (Eds). *Psychoanalytische Katamnesenforschung*. Psychosozial Verlag, Giessen.
- Rudolf, G., Grande, T., Oberbracht, C. (2000). Die Heidelberger Umstrukturierungsskala. Ein Modell der Veränderung in psychoanalytischen Therapien und seine Operationalisierung in einer Schätzskaala. *Psychotherapeut* 45. 237-246.
- Rudolf, G., Grande, T., Dilg, R., Jakobsen, Th., Keller, W., Oberbracht, C., Pauli-Magnus, C., Stehle, S., Wilke, St. (2001). Strukturelle Veränderungen in psychoanalytischen Behandlungen – Zur Praxisstudie analytische Langzeittherapie (PAL). In: Stuhr, U., Leuzinger-Bohleber, M., Beutel, M. (Hrsg.): *Langzeitpsychotherapien – Perspektiven für Therapeuten und Wissenschaftler*. Kohlhammer: Stuttgart, 238-259.
- Rudolf, G., Grande, T., Dilg, R., Jakobsen, Th., Keller, W., Oberbracht, C., Pauli-Magnus, C., Stehle, S., Wilke, St. (in press): Structural Changes in Psychoanalytic Therapies - The Heidelberg-Berlin Study on Long-Term Psychoanalytic Therapies (PAL). In: Leuzinger-Bohleber, M., Target, M. (Eds.): *Longer-term Psychoanalytic Treatment. – Perspectives for Therapists and Researchers*. Whurr, London.

In planning this study, the authors assumed that the specific effects of long term psychoanalytic therapy (e.g. structural changes in the personality) take time to develop and that these are rarely measured by conventional psychometric instruments (such as the SCL-90).

Measures

In this study, the measurement of structural change is based on the newly developed dynamic instrument called the OPD – (Operationalised Psychodynamic Diagnostics; Arbeitskreis OPD, 1996). It is hypothesized that the three axes tapping (a) the maladaptive interpersonal core pattern, (b) the life-long conflicts and (c) the structural capacities relating to particular vulnerabilities will turn out as useful measures of change produced by psychoanalysis. A semi-structured interview - performed by specially trained researchers and not by the analyst themselves - generates 30 ratings. Five of these ratings are selected as specific for a particular patient. The changes in the predefined problematic areas are measured by a Heidelberg version of Stiles et al.'s (1992) "Assimilation of Problematic Experiences Scale (APES)". This scale has seven steps; each step marks a therapeutically important move from lack of awareness through emerging awareness of a not yet understood conflict up to a full therapeutic "working through". Using this scale, patients can be evaluated with regard to the degree of structural change in respect of the five selected problematic areas.

Design

In the first year of the psychoanalytic treatment, this assessment is repeated three monthly; later in treatment it is performed at six month intervals. Additionally, each patient completes a number of psychometric questionnaires (SCL-90, PSKB-s, IIP, INTREX) at the same time points. The treating analysts systematically record on a three month basis various dimensions of the analytic process such as therapeutic alliance, kinds of transference and counter-transference and report on individual sessions in a free format.

Sample

In order to demonstrate the varieties of common analytic processes, the study compares three or more sessions per week psychoanalytic treatments with once-a-week face-to-face psychotherapy. The sample which is not yet fully recruited will comprise 36 patients in each group. In order to maximize expected differences in outcome, the study aims to select severely disturbed patients (although the criteria for severity are not specified).

Hypothesis

The main hypothesis under investigation is that with such patients, low frequency psychotherapy only achieves better coping whereas psychoanalytic treatment brings about structural change. In order to minimize the impact of the study on the ongoing treatments, no randomized selection is performed; however, a match between the two groups with respect to age, sex and education is aimed for. Furthermore, at no time is the patient interviewed about the treatment process itself and the analyst does not receive any feedback on the findings during the course of the treatment.

Present status

Recruitment of the analytic cases was completed in early 1998, recruitment of the psychotherapy cases in early 2001. Papers dealing with the research concept and single case studies have already been published (see the literature above). First results with respect to a comparison between the psychoanalysis and psychotherapy group will be available at the end of 2002.

The Latin American effectiveness study: Effectivity and efficiency of psychoanalytic treatments of long duration and high frequency as compared with long duration and low frequency (LAES)

- Lancelle, G., Bernardi, R. & Epstein, R. (1996). *Planning a long-term psychotherapy research study. Experience from the pilot phase of the Latin American Multicenter Study*. Stuttgart Kolleg. Forschungsstelle für Psychotherapie. Stuttgart

This research project is the comparison of the progress and therapeutic outcome of two groups of patients in psychoanalysis: (a) those with a session frequency of three or more sessions a week and (b) those with one or two sessions a week. The study is a response to the scarcity of data on the relation between frequency of sessions and outcome. As one of the major problems in recruiting psychoanalysts for participation in studies of outcome is the concern about introducing external “influences” into psychoanalytic treatment, the study has the secondary aim of exploring the perceived effects of study participation on psychoanalysts and patients. Bachrach and colleagues (Bachrach et al., 1991) have set out methodological requirements for evaluating research on psychoanalytic treatment outcome. A key problem not addressed by these authors relates to recruiting adequately trained psychoanalysts to participate. This problem is particularly acute in studies which examine the effect of psychoanalysis as it is practised (i.e. non-institutional treatments).

Design and method

The design of this study is naturalistic (Kazdin, 1994). Patients are not assigned but are self-selected for the two groups. While the investigators recognise that this design creates problems of causal inferences it does have strengths in the design enabling the independent evaluation of results, unbiased by the treating analyst and the inclusion of a baseline assessment for diagnosis as well as for symptom and other outcome variables.

As there is no universally accepted operationalised conceptualisation for measuring the outcome of psychoanalytic treatments (Wallerstein, 1997), a rather large battery of well standardised and validated instruments have been adopted. The use of these instruments is justified by the wish to compare outcomes with other ongoing psychotherapeutic and psychoanalytic investigations and the hope that variations in outcome will be captured by these means. A final aim of the comprehensive assessment is hopefully to contribute to a Latin-American archive of psychoanalytic treatments.

Sample

Thus far the study has recruited 18 patients to treatments with 23 completed questionnaire assessments. Further patients have agreed to participate. The demographic breakdown of the sample reveals 13 women and five men, ranging in age from 21-48 years (average 32.8 years). Fourteen of the patients are in the low and four in the high frequency treatment groups.

Evaluation

This is a naturalistic quasi-experimental study of great importance, being the first large-scale study in Latin America. The effort made by the researchers to use instruments validated in the Northern Hemisphere should also be highlighted. A further almost unique aspect of the study is the focus on private practice where very little research is available from other studies and where methodological challenges are greatest.

The Norwegian prospective study (NPS)

- Monsen, J., Odland, T., Faugli, A., Daae, E., & Eilersten, D. E. (1995). Personality disorders and psychosocial changes after intensive psychotherapy: A prospective follow-up study of an outpatient psychotherapy project 5 years after the end of treatment. *Scandinavian Journal of Psychology*, 36, 256-268.
- Monsen, J., Odland, T., Faugli, A., Daae, E., & Eilersten, D.E. (1995). Personality disorders: Changes and stability after intensive psychotherapy focussing on affect consciousness. *Psychotherapy Research*, 5, 33-48.

This was a relatively small-scale uncontrolled study of psychotherapy outcome for personality disorder. Long-term monitoring of persons followed prospectively for about seven years is a particularly strong feature.

Sample

There were 25 patients in the study, 23 of whom had one or more diagnosis of personality disorder. A quarter of the sample met criteria for BPD and 10% met criteria for each of three other PDs (passive-aggressive, dependent or mixed). There were also individuals with diagnoses of schizoid, schizotypal, narcissistic, paranoid and avoidant PD.

Treatment

Patients had once or twice weekly psychodynamic psychotherapy based on object relations and self-psychological principles. The authors indicate that the focus of the therapies was upon interpersonal relations, consciousness of affect, self image and parental images. The treatment was long term, with the average length of treatment somewhat over two years. Most of the patients had received other, less intensive forms of treatment prior to being offered psychodynamic psychotherapy.

Measures

Patients were assessed at the beginning of treatment, termination and at five years follow-up. Measures included MMPIs, symptom scores, self-report measures of defences and a measure of consciousness of affect.

Results

At termination there was a substantial reduction in diagnosable psychopathology with 75% and 72% of the patients no longer meeting criteria for Axis I and Axis II disorders respectively. At five year follow-up, 68% of the patients had no Axis II diagnoses. Thus improvements were, by and large, maintained. Improvements were observed in the domains of interpersonal relations (particularly in being able to establish and maintain intimate relationships), reduced usage of statutory services, and improvements in general adaptation.

Evaluation

This study, while weak in design (absence of control group, poorly specified treatment, convenience sample with heterogeneous diagnoses), does suggest that improvements associated with psychodynamic therapy are maintained in the long term. The improvements demonstrated are clinically significant both in terms of the kinds of changes achieved and size of these changes.

The New South Wales study of personality disorder (NSW)

- Stevenson, J., & Meares, R. (1992). An outcome study of psychotherapy for patients with borderline personality disorder. *American Journal of Psychiatry*, 149, 358-362.
- Stevenson, J., & Meares, R. (May 1995). *Borderline patients at 5 year follow-up*. Paper presented at the Annual Congress of the Royal Australia-New Zealand College of Psychiatrists, Cairns, Australia.

This was a naturalistic study of the effectiveness of psychodynamic psychotherapy based upon object relations and self psychological principles. It used a pre-post design, with a baseline assessment that extended over 12 months.

Sample

Thirty patients were interviewed by three psychiatrists using a standardised, structured, clinical interview for borderline personality disorder (Gunderson, Kolb, & Austin, 1981). Patients had been involved in other forms of therapy unsuccessfully for not less than six months in order to be selected for the trial. In addition to meeting DSM III-R criteria for BPD, patients also displayed persistent social dysfunction and had a chronicity of at least 12 months.

Treatment

The therapists were trainees working with a Winnicottian-Kohutian orientation. Therapy was offered twice a week and lasted 12 months. Treatment was not manualised but there was extensive supervision for trainees. After the 12 months of therapy there was a one year follow-up and a further 5-year follow-up was reported in 1995.

Outcome measures

There was a self-report measure for symptomatology (the Cornell Index) administered at assessment, six months, 12 months and on follow-up. Behavioural measures included days away from work, episodes of self harm, use of medical services, use of prescribed and illicit drugs, hospital admissions and time as inpatient.

Results

There was a significant decline of the number of DSM IV criteria met by these patients (17.4 to 10.5) with 25% of treated patients no longer meeting criteria for BPD. There was a dramatic decrease in visits to medical professionals (3.5 to .47 per month). Episodes of self harm fell from 3.77 episodes per year to .83 episodes per year. Hospital admissions fell from 1.77 to 0.73 per annum and the mean number of months spent as inpatient was halved to 1.47 months. The score on the Cornell Index was reduced from 43 to 29. Improvements were maintained on follow-up to 5 years with the exception of employment, which might have been affected by a concurrent economic downturn.

Evaluation

This was an uncontrolled study of unmanualised treatment delivered at a probably sub-clinical dose by inexperienced therapists. The measures were, however, carefully collected and the changes observed are evidently clinically significant. There is a suggestion in the paper that the treatment was cost effective in so far as it was associated with reductions in the use of costly medical treatments. The sample size is also considerable for this type of population.

Tavistock study of fostered or adopted children (TSFC)

- Lush, D., Boston, M., Grainger, E. (1991). Evaluation of psychoanalytic psychotherapy with children: Therapists' assessments and predictions. *Psychoanalytic Psychotherapy* 5, 191-234.

This study focused on a particularly needy and costly group, fostered or adopted children.

Sample

Thirty five children who were fostered or adopted aged between 2 and 18 years were compared with 13 children for whom psychotherapy had been recommended but did not start. Over half the sample were girls. For ethical reasons they could not be randomly allocated to treated and untreated groups.

Treatment

Kleinian trained child psychotherapists carried out the treatment. There was no attempt at ensuring treatment integrity although most of the therapists were in supervision.

Measures

Only informal assessments of progress were reported but some objective outcome information was available in terms of the persistence of fostering or adoption arrangements.

Results

Therapists, parents and independent clinicians all reported that all but 4 out of 20 of the children in treatment improved, whereas none of the comparison group of children did so. Significantly more breakdowns of adoption and fostering arrangements occurred in the comparison than in the treated group.

Evaluation

There is insufficient information in the report to permit full evaluation of the study. The results suggest that long-term psychoanalytic therapy may be of value to this needy group of children.

Anna Freud Centre studies 4: The comparison of intensive (5 times weekly) and non-intensive (once weekly) treatment of young adults (AFC4)

■ Fonagy, P., Gerber, A., Higgitt, A., & Bateman, A. (in preparation) The comparison of intensive (5 times weekly) and non-intensive (once weekly) treatment of young adults.

This was a prospective study where two groups matched for age, socio-economic status and DSM diagnosis were sequentially assigned to five times weekly or once weekly psychoanalytic treatment by experienced psychoanalysts. Assessments were made at 18 month intervals by independent raters. The study is still underway and is likely to be completed in 1999.

Sample

Thirty young adults (aged 18-24) referred to the Anna Freud Centre were sequentially assigned to psychoanalysis or psychotherapy. Diagnostic assessments were made by two experienced psychiatrists using structured interviews (SADS-L and SCIDII). All patients in the study had at least one Axis II diagnosis, with narcissistic and borderline personality disorder being the most common. All patients had at least one Axis I diagnosis (mostly mood disorders). No patient had a diagnosis of psychosis and less than half the sample were on psychotropic medication. A significant number of the patients had histories of violent episodes or self harm. About 20% had previous psychiatric hospitalisations.

Treatment

Treatments were delivered by qualified psychoanalysts (all Members of the British Psychoanalytical Society) trained in the Contemporary Freudian tradition, strongly influenced by the work of Joseph and Anne-Marie Sandler. The treatments were strongly transference focused. All analysts participating in the study attended a once-monthly supervision meeting chaired by Anne-Marie Sandler. The supervision concerned both the intensive and the non-intensive cases. Analysts had to provide a full narrative account of one session per month which was circulated to the research group and formed the basis of the group supervision. Analysts also completed a weekly rating scale which was a 500 item checklist where they reported the main themes of the treatment and their interpretive work. There was no tape-recording of sessions. Treatment continued in an open-ended way with average treatment length being 3.5 years.

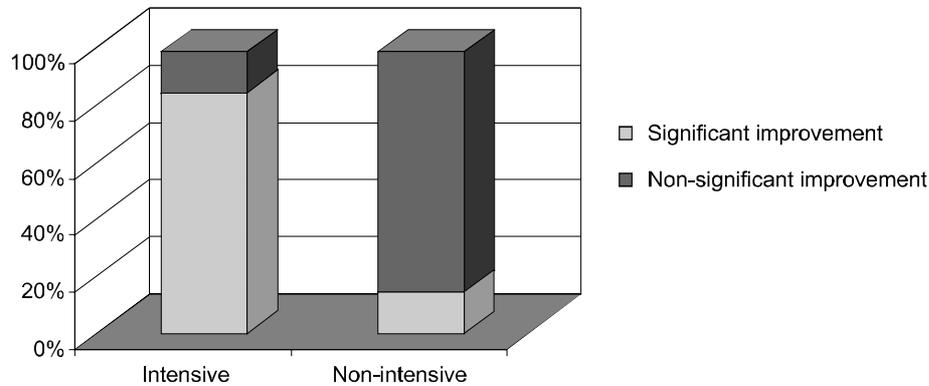
Measures

At entry to the study all patients completed the SCL-90, the Beck depression inventory, the Spielberger State and Trait Anxiety Inventory, the Social Adjustment Scale, the National Adult Reading Test and the Eysenck Personality Questionnaire. They were also administered the Adult Attachment Interview, the SADS-L and the SCID II. The battery was repeated at 18 month intervals. Patients showing significant improvement on at least three measures were regarded as having improved.

Results

The results are in the process of being analysed. The key comparison between the outcome of intensively and non-intensively treated patients awaits the completion of a number of psychotherapy cases. The results so far indicate that analytic treatment is superior in achieving clinically significant symptomatic changes (see Figure 1).

Figure 1: Significant and non-significant improvement in patients completing intensive and non-intensive treatment



Preliminary scrutiny of the data indicates that improvers in terms of the psychiatric measures could be differentiated from non-improvers on the basis of aspects of the analytic process, particularly analyst's reports of aggression taken up in the transference and the extent and diversity of emotional reactions reported by patients. Transference in successful treatments is characterised by anxiety, guilt, fear of rejection, idealisation and projected aggression. By contrast, failed treatments are typically associated with shame, humiliation, existential anxiety and a sense of boredom and 'cut-offness' on the part of the analyst. There was a relatively high rate of premature termination and this was more common in the non-intensively treated group. Of great importance was the observation that unsuccessful treatments showed differing trends as the analysis unfolded. For example, in poor outcome treatments, the quality of the analytic material gradually deteriorated, affects decreased in intensity, immature mental functions increased together with primitive transferences, and the use of sexual fantasy to support identity. Sadly, there was evidence for the analyst responding by increased disengagement by, for instance, failing to comment on timekeeping problems and concentrating on extra-analytic issues. Table 1 summarises aspects of analyses associated with poor outcomes.

Table 1: Trends across analyses associated with poor outcomes

- Deterioration of analytic material
- Decrease in level of all affects
- Increasing immaturity of mental functions
- Increasing primitive transferences and boundary problems
- Increasing use of sexual fantasy to support identity
- Increasing aggressive themes
- Decrease in interpretation of aggression
- Decrease in interpretation of problems with timekeeping
- Increasing importance of the external world

Evaluation

This study has a number of major weaknesses including the small sample, non-random assignment, lack of tape-recording of therapeutic sessions, lack of manualisation of treatment and unequal treatment lengths. It, however, has a number of strengths such as the independent assessment of outcome, the use of standardised instruments and the attempt at integrating process and outcome measures.

The Uruguayan Agora Institute study: Subjective and objective assessments of process and outcome in focal psychodynamic psychotherapy

- Bernardi, R., Montado, G., Rivera, J., Defey, D., Fossatti, G. & Sas, A. (1995) Psicoterapias Focalizadas: Percepción del Proceso y los Resultados. In Jiménez, Buguñá y Belmar (eds) *Investigación en Psicoterapia: Procesos y Resultados (Investigación Empírica 1993-94)*. Santiago de Chile: SPR (South American Chapter) and Corporación de Promoción Universitaria.
- Montado, G., Defey, D., Darakjian, W., Lodeiro, M., Peña, M., Rubio, C., Bernardi, R. (2000) Psicoterapia dinámica focal: evaluación de resultados a través de múltiples evaluaciones. In Gril, Ibáñez, Mosca, Sousa (eds) *Investigación en psicoterapia. Procesos y resultados*. Pelotas: SPR. Educat.
- Montado, G. (2001) Psicoterapia focal psicoanalítica: investigación de procesos y resultados. In Bernardi, R et al (eds). *Psicoanálisis, Focos y aperturas*. Montevideo: Agora/Psicolibros.

Sample

Since 1993 free-of-charge treatments have been carried out in a community-based clinic run by Instituto Agora of Montevideo as part of the service that the City Council offers openly to the city inhabitants. Treatments are provided to potential patients as brief therapies suitable for consultations emerging from the saga of life events or critical situations. Potential patients are assessed initially by a clinical psychologist (who is not the therapist) as to the adequacy of the kind of treatment offered to their particular condition and are then taken up for therapy or referred to other services. Two hundred treatments have been completed so far. The therapists are graduated psychologists who are completing their two-year post-graduate training in Focal Dynamic Psychotherapy. Each graduate must complete two treatments and is supervised by his/her mentors, also undergoing regular group discussion of his work with his colleagues as the treatment advances.

Treatment

First developed in USA by Alexander and French and also proposed in the United Kingdom by Balint and Malan, Focal Dynamic Psychotherapies have been further developed in theory and technique by Latin American authors (mainly H. Fiorini) and encompass Thomä and Kächele's conceptualization of psychoanalytic treatment as a succession of foci which are progressively dealt with by patient and therapist.

The treatment being assessed is focused on the patient's chief complaint and its underlying core conflict. Thus, therapy is guided by explicit goals, which patient and therapist discuss and agree to work upon. This kind of treatment stresses what has been termed a "situational approach" which takes into account both past and present relevant issues, as well as both intrapsychic as outer-world elements at play. The therapist plays an active role and, since these therapies are often brief, strives not to induce regression or transference neurosis but to work, instead, in an atmosphere of positive transference and a working alliance that emphasizes parity between patient and therapist. The main indication for these therapies are crisis situations such as divorce, grief, migration, etc., but they have also proved to be most useful in settings where the patients' interest is not centred upon a global revision of his life and inner world but a more constricted motivation to review, undergo changes and gain better adaptation in a given field (sterility, a close relative's psychiatric illness, a forthcoming surgery, overdemanding work conditions, etc). Though also supportive in most cases, this kind of therapy strives to increase the patient's insight about the problem and has been proved to have long-lasting effects, especially in certain fields such a mother-infant interaction.

Measures

Before beginning treatment, patients complete a Symptom Checklist (SCL 90-R; Derogatis 1983), which is given to them again at follow-up. The latter takes place at an average eight months after termination and is conducted by the person who initially assessed the patient as suitable for this type of treatment. At that time, the patients are extensively interviewed and fill in a questionnaire which is an adapted version of Howard's Generic Model (Howard, 1988).

Upon finishing their work with each patient, therapists are asked to fill in a questionnaire which closely resembles that of the patients.

Results

Process and outcome results were analysed in 1994, 1998 and 2000, and each of these reports has been published. The results to be analysed here belong to the 2000 sample.

Process

Therapists were mostly female (90%), averaged 33 years of age, and had graduated not long before the study (mean 5 years earlier). 26 % had had no previous experience as therapists.

As to the patients, 875 were female, with a mean of 37 years of age, 44% had undergone previous psychiatric or psychological treatments at an average time of 10 years before consultation. Their most frequent presenting complaints were marriage problems and family conflict, with employment issues ranking third. 82 % were clinically assessed as undergoing the acute stage of a crisis, and 78% of the total sample was assessed as having a basically healthy personality (i.e. without gross acute or chronic manifestations of severe psychopathology).

Treatments took an average of 20 sessions, and the focus most frequently selected was marriage problems, followed by family conflicts, employment issues, grief processes and conflicts related to self-esteem. Therapists freely described most frequent treatments goals as helping the patient "gain better understanding and insight about his/her problems" and "strengthen their self-esteem."

Outcome

Eighty-two percent of therapists and 94% of patients were satisfied with the outcome at varying degrees between "moderate" and "extreme" satisfaction.

Therapists rated the most successful interventions on their part to be those aimed at providing empathic understanding (86%) and support (76%), while those aimed at insight or active advice were assessed as less effective. Most treatments, however, were conducted along a combined strategy of providing both support and insight at varying degrees.

The best predictor of treatment outcome was the therapist's capacity to actively stimulate therapeutic alliance.

As to outcome figures provided by the SCL 90-R, since no standardization has been made in any Latin American countries, values are analysed contrasting each patient with him/herself at beginning and end of treatment. The Global Severity Scale shows significant improvement in 96% of the total population. Positive Symptoms and Anxiety Positive Symptoms also show significant changes in 94% of cases, with very significant figures in some of the patients.

Evaluation

This is a naturalistic study which is one of the two outcome studies ever performed in Uruguay and the only one which includes objective measures to complement subjective patient and therapist assessment of outcome. Being a goal-oriented brief therapy, initial evaluation of feasible changes partly explain the high degree of satisfaction and symptom change. This can also be attributed to the fact that therapies were offered free of charge (an unusual practice in a country where practically all therapeutic services must be paid by the patient) and were controlled as to quality of the service provided, with the follow-up interview being part of this (again an unusual practice). The fact that patients were undergoing crisis situations in many cases may have also contributed to good outcome, since spontaneous curative mechanisms may have contributed substantially to the outcome. The absence of a control group enhances the limitation of this study, whose worth lies mainly in starting the practice of outcome research in the country and of assessing the effectiveness of a relatively new therapeutic technique.

The Oslo I Study: Schjelderup (1955) – An early proponent of combined questionnaire and personal follow-up interview (OIS)

■ Schjelderup, H. (1955). Lasting effects of psychoanalytic treatments. *Psychiatry*, 18, 109-133.

“Evaluation of therapeutic results is a long-term task which can only be accomplished on the basis of very comprehensive and critically sifted material...Strangely enough, none of the older analysts with experience over a considerable period of time has thus far issued any systematic follow-up study of his patient material. I believe that such investigations, even though they may not satisfy the ideal standards of methodology, would make a significant contribution to the evaluation of analytical therapy” (Schjelderup, 1955, p.110)

Results

Schjelderup, the analyst, treated 28 psychoanalytic cases between 1926 and 1943 - then the Nazi occupation stopped all clinical work for a brief period. After the war a questionnaire was sent to the patients; after the questionnaire had been returned there followed a personal interview with the analyst himself “in which the answers to the questionnaire were discussed in great detail and necessary additional information ...was obtained” (p.110).

In 9 of these cases the follow-up shows a lasting symptomatic cure, and in 14 others, a substantial improvement. The commonest personality changes found are changes in interpersonal relationships (25 cases) and in capacity for work and enjoyment of work (22 cases). Changes in capacity for sexual adjustment and in perception of reality have also been very common.

Evaluation

It is perhaps to be regretted that there are not more such reviews of psychoanalytic practice as carried out by busy, real practitioners over many years. Kächele and colleagues report (Kächele, Wolfsteller, & Hössle, 1985) a replication of the study by Strupp and colleagues (Strupp, Fox, & Lessler, 1969): “Patients view their psychotherapy”. Distributing a revised version of Strupp’s questionnaire to 150 patients, 91 questionnaires were returned. Among them were 15 patients treated by an analyst with more than 20 years clinical experience. Factor analysis revealed a three factor solution, two of the dimensions of which were empathy and acceptance, and confidence and feeling appreciated. Fourteen of this analyst’s 15 patients reported positive experiences in these two dimensions, while other patients from other analysts did not express such positive experiences. Results such as these suggest that the routine administration of standardised outcome instruments could teach us a great deal not only about the extent of benefit that patients derive from psychoanalytic treatment but also about differences between analysts which are associated with the size of these changes.

The Berlin II study (BII)

- Dührssen, A. (1962) Katamnestische Ergebnisse bei 1004 Patienten nach analytischer Psychotherapie. *Psychosom Med* 8, 94-113

In 1946, amid the ruins of post-war Berlin, Kemper and Schultz-Hencke broke new ground by founding the Central Institute for Psychogenic Illnesses, which was financially sponsored by the local insurance society, the later General Communal Health Insurance (*Allgemeine Ortskrankenkasse*). Baumeyer (1971) and Dräger (1972) rightly emphasise the great social significance of this pioneering advance: “This was the first step in the recognition of neurosis as illness by a German public institution. For the first time one of the institutions in the social insurance system paid the costs of psychoanalysis and other psychotherapeutic treatment” (Dräger 1972, p.267). For the first time, insured patients were able to receive psychodynamically oriented therapy at no direct cost, and this on a far greater scale than in the outpatient clinic at the old Berlin Psychoanalytic Institute (Thomä & Kächele, 1987).

Sample and treatment

Great credit is due to Dührssen (1962) for her pioneering analysis of the follow-up of 1004 patients who successfully had received analytic psychotherapy at the Central Institute, in which she showed the effectiveness and efficiency of the treatment. (However, the 152 patients that were judged to have been unsuccessful did not enter the follow-up). The duration of treatments was on the average about 100 sessions (10-15% up to 200 sessions, 10-15 only 50-60 sessions).

The original sample consisted of 1004 improved and 152 non-improved patients. At follow-up - five years later - only the improved patients were traced. From these patients 84% (845 patients) were seen for follow-up. Ten percent (101 patients) could not be located; 45 patients (5%) did not show up for follow-up appointments, and 13 patients had died.

Results

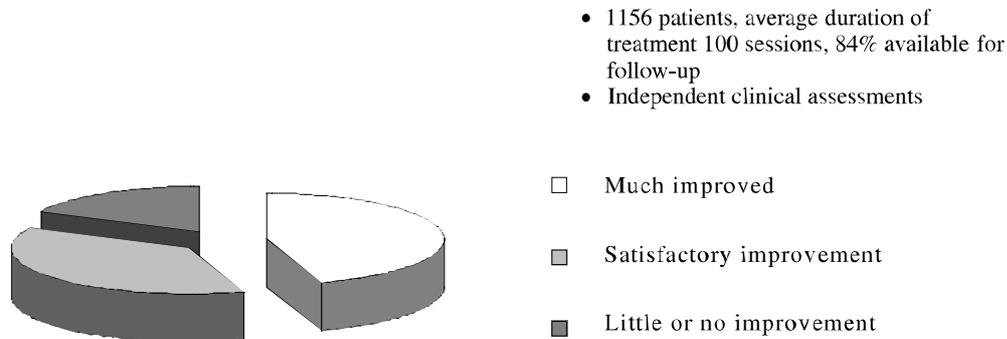
The evaluations by independent assessors at termination and at follow-up are listed in Table 1. According to the categories of outcome, while 55% were rated as improved at termination, 58% were similarly rated at follow-up. The percentage of patients showing no improvement at all was very small at termination and somewhat larger (15.5%) at follow-up.

Table 1: The comparison of evaluation at termination and follow-up (N =845)

| Outcome | % termination | % follow-up |
|-------------------------|---------------|-------------|
| Very much improved | 43.0 | 28.5 |
| Much improved | 9.0 | 17.0 |
| Satisfactorily improved | 3.0 | 13.0 |
| Little improved | 41.0 | 26.0 |
| Not really improved | 2.0 | 4.0 |
| Not Improved | 0.0 | 9.0 |
| Without statement | 2.0 | 0.0 |
| Unclear | 0.0 | 2.0 |
| Misdiagnosed | 0.0 | 0.5 |

The evaluation by the therapists at the end of treatment seems to have been handled as a dichotomous judgement. A summary chart of improvements is shown in Figure 1.

Figure 1: Improvement by follow-up in Berlin II Study



The ratings by the follow-up (independent) interviewer were more diversified. As the 152 non successful patients were omitted in the Dührssen (1972) tabulation, this cannot be considered an intent to treat analysis; assuming, as Dührssen does, that they have not improved they should be included in the final evaluation to get a realistic estimate. Table 2 contains the figures adjusted for these individuals. Improvement rate remains just below 50% but rises to 82% if those whose improvement was satisfactory are included.

Table 2: Outcome of analytic psychotherapy in the Berlin II study

| Outcome | N | % |
|-------------------------------|------------|------------|
| Very much and much improved | 441 | 45.04 |
| Satisfactorily improved | 367 | 37.49 |
| Very little or no improvement | 171 | 17.47 |
| Total | 979 | 100 |

Based on very positive findings with the sick leave in the first study, Dührssen and Jorswieck (A. M. Dührssen & E. Jorswieck, 1965) re-analysed a sample of 100 patients who had terminated their treatments in 1958. A second group of patients from the waiting list was added as well as a third group of patients from the general file of the insurance company (normal controls). Table 3 illustrates that hospitalisation was similarly reduced in the treatment group relative to untreated neurotic and normal controls (see Table 3 and Figure 2).

Table 3: Mean number of days hospitalisation in the five years before and five years after psychoanalysis

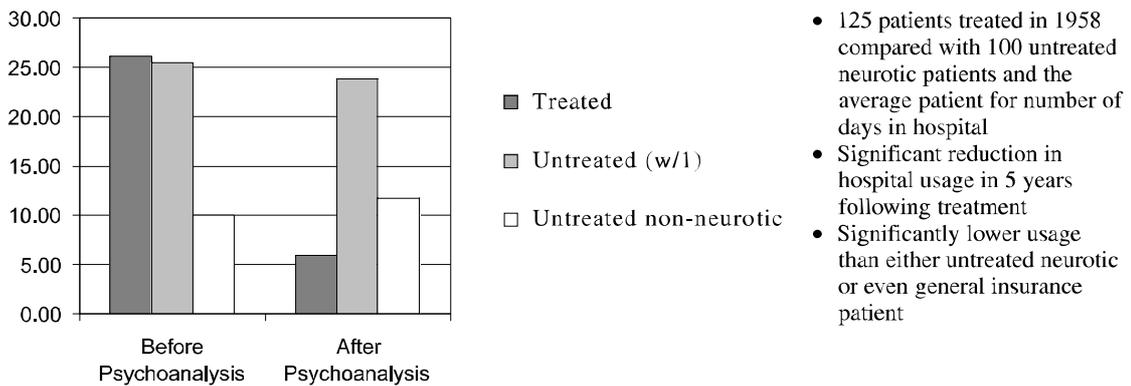
| | number of patients | mean (SD) number of days in hospital | |
|--|--------------------|--------------------------------------|------------------------|
| | | 5 years before | 5 years after |
| Neurotic patients | 125 | 26.09 (26.87) <i>a</i> | 5.9 (14.16) <i>b,c</i> |
| Untreated neurotic patients | 100 | 25.55 (30.40) <i>a</i> | 23.91 (28.65) <i>a</i> |
| General population of insured patients | 100 | 10.04 (18.20) | 11.70 (19.45) |

The statistical comparison for the three groups:

a Significantly higher than general insured patients ($p < .01$)

b Significant drop relative to pretreatment ($p < .001$)

c Significantly lower than general insured patients ($p < .01$)

Figure 2: Days hospitalisation before and after psychoanalytic treatment in Berlin II study compared with control groups

Evaluation

The overall success rate of psychoanalytic treatment appears to be high, although in the absence of a comparison group these figures are difficult to interpret. This investigation demonstrated with straightforward data on days in hospital available from the insurance company files, the superior work capacity of individuals who had the benefit of analytic psychotherapy in comparison to an untreated control group and to the normal population. The untreated group probably received some treatment and the assignment to groups was not random. However, the comparison with a non-neurotic control group is impressive.

The Boston Psychoanalytic Institute study (BPIS)

- Sashin, J., Eldred, S., & Van Amerowgen, S. T. (1975). A search for predictive factors in institute supervised cases: a retrospective study of 183 cases from 1959-1966 at the Boston Psychoanalytic Society and Institute. *International Journal of Psycho-Analysis*, 56, 343-359.

This was a study monitoring the outcome of a significant number of patients treated by trainee analysts under supervision. The patients were selected as good training cases and are therefore not necessarily representative of psychoanalytic cases in general.

Sample

130 patients with diagnoses of neurotic disorders were reported on retrospectively by treating analysts. The majority of the patients were either diagnosed as hysterics, obsessive-compulsives or mixed neurotics.

Measures

Outcomes were reported, after the termination of the analyses, on a global change scale, a scale assessing life situation at termination, and six clinical scales covering symptom restriction and discomfort, work productivity, sexual adjustment, interpersonal relations and insight.

Results

Over a quarter of the patients terminated treatment prematurely – at least from the analyst's point of view. Three quarters of the patients treated were judged to have improved; 6% showed a significant worsening of their condition associated with the analysis. Those who had longer treatment were more likely to show favourable outcomes. The analyst's agreement that the termination of treatment was appropriate was associated with good outcome.

A spin-off study (Kantrowitz, 1987; Kantrowitz, Paolitto, Sashin, & Solomon, 1987a, 1987b) describes a prospective investigation of 22 patients who were administered a battery of psychological tests. The study yielded a number of important findings including further evidence on the variations of psychoanalytic technique amongst psychoanalysts (Kantrowitz, 1987) and the importance of the match between patient and analyst as a predictor of long term outcome (Kantrowitz, Katz, & Paolitto, 1990b). Another important finding to emerge from this study was the observation that analysts were somewhat more optimistic about the outcome of their patients than was supported by independent psychological tests (Kantrowitz et al., 1987a). Further, these studies offered suggestive evidence – albeit on a relatively small sample – that while some patients showed improvement subsequent to termination, in other instances patients revealed that improvements at termination were not maintained over the long term (Kantrowitz, Katz, & Paolitto, 1990a; 1990b).

Evaluation

The use of trainee analysts and retrospective design places a major limitation on the generalisability of the findings concerning outcome. The spin-off studies, however, generated considerable interest, particularly in the issue of patient-analyst match.

The Stuttgart study: The Stuttgart psychotherapeutic hospital follow-up study (TSS)

- Teufel, R., & Volk, W. (1988). Erfolg und Indikation stationärer psychotherapeutischer Langzeittherapie. In W. Ehlers, H. C. Traue, & D. Czogalik (Eds.), *Bio-psycho-soziale Medizin* (pp. 331-346). Berlin: Springer- PSZ.Drucke.

Background

Since its inception in 1967, the Stuttgart Psychotherapeutic Hospital has been an exclusively psychoanalytically oriented inpatient treatment facility. It offers 102 beds with a staff of 17 therapists and treats about 300 patients per year (for a clinical description see Beese). Average length of stay is about 6 months.

Method

Sample and treatment

The treatment offered by this institute was 3-4 times weekly individual psychoanalysis and group therapy with minimal adjunctive treatments. Patients admitted suffered from severe personality disorder, psychosomatic or neurotic conditions. For details of the patient group and treatment program see Teufel (1988). In the years 1986-1987, a follow-up study on 248 patients was planned; 147 patients were recruited who could be interviewed at least 3.9 years following termination of treatment. The follow-up study was performed by scientists from the Forschungsstelle für Psychotherapie¹ (Center for Psychotherapy Research). This research centre is based on the same campus as the hospital but acts quite independently.

Treatment outcome

The operationalisation of treatment outcome distinguished four dimensions of outcome:

- a Treatment goals attainment (Therapieziele) rated by therapist at end of treatment;
- b Symptom reduction by comparison of patient's symptom questionnaire from start of treatment to follow-up;
- c general well-being according to patient's report at follow-up;
- d capacity for work – according to patient's report at follow-up.

Results

Table 1 contains the success rates of patients in terms of per cent of goals attained and percent of presenting symptoms remitting. About two thirds of patients achieved more than 50% of their therapeutic goals and nearly half achieved two thirds. In terms of symptom reduction, one quarter of the sample achieved 75% symptom reduction while the majority achieved 50% reduction of symptoms or better.

¹ Directed until March 1988 by Helmut Enke, since then by Horst Kächele

Table 1: Patients attaining required percentage of treatment goals and percentage of symptom reduction

| | Attainment of treatment goals | | Symptom reduction | |
|-------|-------------------------------|-------|-------------------|-------|
| | Number of patients | | | |
| | N | % | N | % |
| 95% | 9 | 6.12 | 13 | 8.84 |
| 85% | 11 | 7.48 | 10 | 6.80 |
| 75% | 14 | 9.52 | 11 | 7.48 |
| 65% | 30 | 20.41 | 13 | 8.84 |
| 55% | 25 | 17.01 | 11 | 7.48 |
| 45% | 16 | 10.88 | 31 | 21.09 |
| 35% | 11 | 7.48 | 9 | 6.12 |
| 25% | 16 | 10.88 | 14 | 9.52 |
| 15% | 6 | 4.08 | 9 | 6.12 |
| 5% | 9 | 6.12 | 27 | 17.69 |
| Total | 147 | 100% | 147 | 100% |

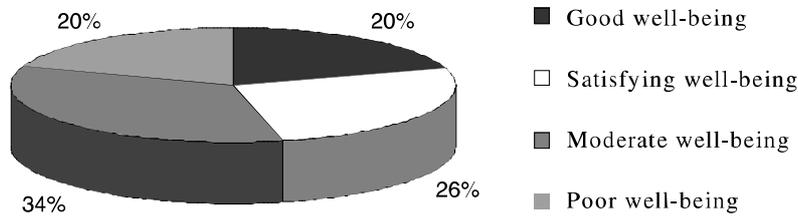
Table 2 displays the findings in a slightly simplified form. The percentages from 95-85 and 75 were considered good results, from 65-45 were considered moderate and from 35 and below are poor. Approximately one quarter achieved good results and almost three-quarters achieved moderate results or better in terms of goal attainment and half achieved the same level of outcome in terms of symptom reduction.

Table 2: Attainment of treatment goals and symptom reduction organised in three outcome groupings

| | Attainment of treatment goals n = 147 | Symptom reduction n = 147 |
|------------|--|------------------------------|
| 95%.- 75% | 34 = 23 % | 34 = 23 % |
| 65% - 45 % | 71 = 48 % | 55 = 37 % |
| 35% - 5 % | 42 = 29 % | 59 = 40 % |

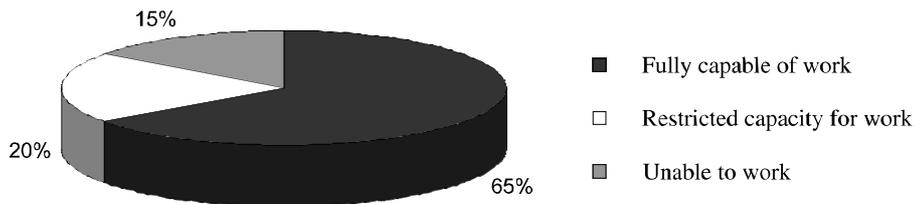
The third outcome criterion, “general well-being”, was divided into four groups: good, satisfactory, moderate and poor. Almost half (46%) of the follow-up sample had good or satisfactory quality of well-being and only 20% reported that their well-being was poor.

Figure 1: General well-being at follow-up



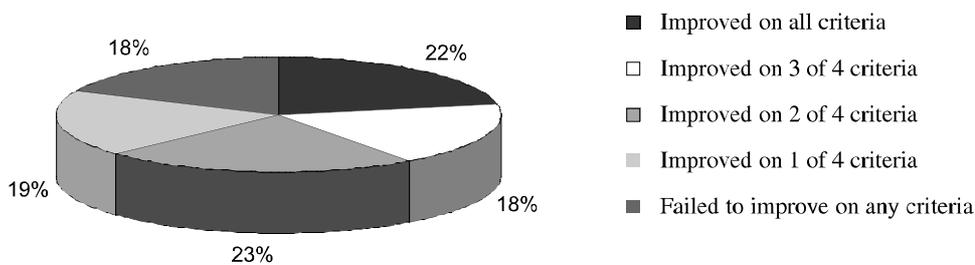
A similar breakdown of work capability is presented in Figure 2. Two thirds of the sample reported being fully capable of work and only 15% were unable to take on gainful employment.

Figure 2: Capacity for work at follow-up



A summary across the findings is shown in Figure 3 by dividing results on the four criteria, so that patients fell either into the improved or the worsened category. Almost one quarter of the sample improved on all criteria and 63% improved on at least two. Only 18% failed to improve on any criteria.

Figure 3: Overall outcome at follow-up



Evaluation

The results suggest that the capacity for work is the most likely criterion to improve in in-patient psychoanalytic treatment. The treatment also seems efficacious in terms of the attainment of treatment goals. Well-being was observed as comparable to that in the general population. Patients responded less well in terms of symptom reduction. This may or may not reflect the truly psychoanalytic focus of this hospital over the years of the investigation (1969-1975) where symptom reduction was rarely considered a priority. No psychotropic medication was given and very few paramedical interventions were used, indicating that psychoanalytic in-patient treatment can be relatively beneficial for severe conditions even without adjunctive treatments aimed more directly at symptom reduction. The study has major limitations in not using standardised measures and results from individual goal attainment scaling is hard to interpret in the absence of a comparison group. However, the good results with regard to functioning at work are robust to such criticism. Work is the most important aspect of social adaptation in terms of social costs and the fact that four years post-treatment the large majority of this severely handicapped group was able to fulfil a useful social function speaks well of the effectiveness of in-patient psychoanalytic therapy.

The Berlin Jungian study: On the effectiveness and efficacy of outpatient (Jungian) psychoanalysis and psychotherapy - a catamnestic study (BJS)

- Keller, W., Westhoff, G., Dilg, R., & Rohner, H. H. (1998). *Studt and the study group on empirical psychotherapy research in analytical psychology*. Berlin: Department of Psychosomatics and Psychotherapy, University Medical Center Benjamin Franklin, Free University of Berlin.

Despite a large number of studies on the effectiveness of psychodynamic psychotherapy, there are so far no studies on the efficacy and effectiveness of long-term psychoanalysis as performed in a naturalistic setting including Jungian psychoanalysts and psychotherapists in private practice. The reasons for this paucity of research include the long duration of prospective case studies and the high costs involved, as well as methodological difficulties involved in research in the field of private treatment practice. Psychoanalysis and psychoanalytic psychotherapy increasingly come under pressure to offer convincing evidence of their effectiveness. The study presented here is an effort to close this gap for Jungian therapy. This study was financed by independent funding (Bosch Family Foundation).

Objectives

There were three objectives for this study:

- 1 To prove the effectiveness of long-term analyses (more than 100 sessions) in routine treatment practice and to examine the stability of treatment results by a follow-up study 6 years after the end of therapy.
- 2 To evaluate some aspects of cost-effectiveness.
- 3 To implement research strategies in the area of outpatient psychotherapeutic care for quality assurance purposes.

Recruitment methods and design

All members of the German Society for Analytical Psychology (DGAP), the umbrella organisation of Jungian psychoanalysts, were asked to participate in this retrospective study. Over three quarters (78%) responded to this request and 24.6% participated. Reasons for refusal to participate are listed below in Table 1. Over 40% refused (actively or passively) to participate and a further 15% discontinued participation.

Table 1: Therapists' reasons for declining to participate in outcome research

| Total number of the members of DGAP (adult psychoanalysts) invited to take part in the study | N (%) |
|---|-----------|
| Did not respond to invitation | 49 (22.0) |
| Responded but refused to participate | 48 (21.5) |
| Therapists initially agreed to take part and later refused or failed to contact their terminated patients | 32 (14.4) |
| Therapists with documented agreement of the patients to participate and complete follow-up assessment of these patients | 35 (15.7) |
| No finished cases in 1987/88 | 59 (26.4) |

The remaining sample (both therapists and patients) is described in Table 2. The patient sample thus recruited was less than one third of those in the sampling frame while the therapists recruited were less than 16% of those who could have participated.

Table 2: Selection of participating therapists and patients

| | Therapists n(%) | Patients n(%) |
|--|-----------------|---------------|
| Total number of contacted therapists | 223 (100) | |
| Therapists who sent back the invitation questionnaire | 174 (78) | |
| Therapists who assessed the pre-treatment status of their finished cases in 1987/1988 (drop-outs included) | 55 (24.6) | 353 (100) |
| Therapists who contacted their patients who terminated in 1987/1988 | 42 (18.8) | 259 (73.4) |
| Therapists who provided documented agreement of participation from their patients terminated in 1987/1988 | 35 (15.7) | 152 (43.1) |
| Therapists who provided complete follow-up assessment from their patients terminated in 1987/1988 | 35 (15.7) | 111 (31.4) |

Measures and sample

On the basis of their clinical notes, participating therapists in private practice documented all their cases (including dropouts) which terminated in 1987 and 1988. They completed a basic questionnaire regarding clinical and sociodemographic data and setting characteristics at the onset of therapy and gave a retrospective global assessment of their patients' state at the end of therapy.

Based on the diagnosis given in the funding claims of the former therapists, two independent raters reached a consensus concerning a retrospective ICD-10 classification. Additionally, the severity of disease before treatment was assessed using the Schepank method of impairment severity index (BSS, 1987, 1994).

In 1994 111 former patients, who had finished either psychoanalysis or long-term-psychotherapy in 1987 or 1988 and who agreed to take part in the study, were sent a follow-up questionnaire which included measures of life satisfaction, well-being, social functioning, personality traits, interpersonal problems, self rated health care utilisation and some psychometric tests (SCL-90R, VEV, Gießen-Test). In 33 cases (in the Berlin region), a follow-up interview was carried out and actual health status was rated by two independent psychologists trained in Jungian psychoanalysis.

Additionally, objective data on the utilisation of health care services was recorded from health insurance companies (number of days off work through sickness and inpatient hospital days) 5 years before and after therapy. Data were unavailable for a significant proportion of patients. In this comparison only those cases with complete pre and post data were included. Thus, for this calculation, the sample was reduced to 47 (for analysis of sick days) and 58 (for analysis of hospital days). Neither subgroup differed from the entire sample in socio-demographic data, pre-treatment characteristics or other criteria of treatment success.

The selection of the follow-up sample was controlled by comparing the study patients with the total of 358 therapist-documented therapies that finished in 1987 and 1988 with respect to socio-demographic and clinical characteristics. The selection of therapists participating in the study was controlled by an independent survey of all DGAP members with respect to therapist's and setting characteristics. There was no difference between the groups, supporting the assumption that the study sample was representative of the clinical population.

Patient characteristics

Table 3 gives details of the sample followed up in the study. The mean age at follow-up was 44.5 years (range 27-69). More than two thirds (69.1%) were women. Compared with the reference sample, the follow-up sample contained a higher proportion of unmarried (26% vs 8%) or separated patients, a higher education level, fewer manual workers (4% vs 15%) and a lower level of unemployed individuals (38% vs 87%).

Table 3: Characteristics of follow-up sample

| Follow-up sample (n=111) | Mean (SD) |
|---|--------------|
| Age at follow-up, 1994 (yrs) | 44.5 (4.8) |
| Age at start of treatment (yrs.) | 35.0 (8.8) |
| Age at the end of treatment (yrs) | 37.0 (8.0) |
| Time of follow-up (yrs) | 5.8 (0.79) |
| Treatment length (0.3-8.3 yrs) | 2.9 (1.7) |
| Number of therapy sessions (range 15-399) | 161.9 (94.9) |

Treatment characteristics

Table 4 includes information concerning treatment characteristics. Mean post-treatment follow-up time was almost 6 years. Taken together with the average treatment length of just under 3 years, the patients at follow-up were about 10 years older than at the beginning of therapy. Three quarters (76%) had received psychoanalysis with an average of 193 sessions and a mean duration of 3 years; 63% of the psychoanalytic patients had more than 100 sessions. Overall, 17.5% of the patients included were drop-outs, finishing treatment at various points of therapy. Thus the results reported constitute an intention to treat analysis. This figure further validates the representativeness of the selection procedure indicating that the treating therapists did not exclusively select their successful patients.

Table 4: Characteristics of the treatment

| Type of therapy | Mean (SD) |
|---|--------------|
| Psychoanalysis (%) | 76.0 |
| Treatment length (0.3-8 yrs.) | 3.0 (1.6) |
| Number of therapy sessions (range 17-399) | 192.9 (88.9) |
| Psychotherapy (%) | 16 |
| Treatment length (0.8-8.3 yrs.) | 2.4 (1.9) |
| Number of therapy sessions (range 30-200) | 78.3 (40.5) |
| Drop-outs (%) | 17.5 |

Status before treatment

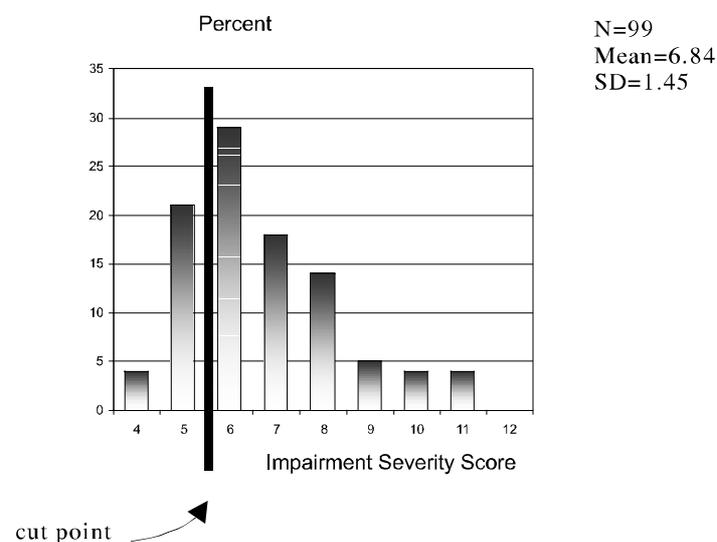
Table 5 gives information concerning the principal ICD-10 diagnoses of the follow-up sample. A third (34%) of the patients had had symptoms for more than 10 years; 17% had a personality disorder and 46% were classified as affective disorders according to ICD-10.

In 96% of the patients psychotherapy was necessary because disturbance of emotional, psychosocial and physical functioning was above the clinical cut-point. The mean impairment severity score (BSS) for the total sample was 6.8. The clinical cut-off point for this measure is 5.0 or above (Schepank, 1987, 1994). Figure 1 shows the distribution of BSS Impairment severity score prior to therapy and indicates that a substantial proportion of the sample were very severely handicapped, normally warranting hospitalisation or partial hospitalisation (score of 9 or above).

Table 5: ICD-10 Classification prior to treatment (retrospective expert rating n=100 main groups only)

| | | n | % |
|--|---|----|------|
| F3 Affective disorders | F31 bipolar affective disorder | 1 | 1.0 |
| | F32 depressive episode | 13 | 13.0 |
| | F33 recurrent depressive episode | 13 | 13.0 |
| | F34 cyclothymia | 19 | 19.0 |
| F4 Neurotic and somatoform disorders | F40 phobic disorder | 4 | 4.0 |
| | F41 anxiety disorder | 10 | 10.0 |
| | F42 compulsion disorder | 3 | 3.0 |
| | F43 stress reaction | 3 | 3.0 |
| | F45 somatoform disorder | 8 | 8.0 |
| F5 Behavioural disturbance with physical symptoms | F50 eating disorder | 3 | 3.0 |
| | F52 sexual dysfunction | 3 | 3.0 |
| F6 Personality disorders | F60 specific personality disorder | 17 | 17.0 |
| | F61 complex or other personality disorder | 1 | 1.0 |
| | F63 abnormal habits | 2 | 2.0 |

Figure 1: Total mean of impacts on emotional, psychosocial and physical functioning prior to psychotherapy.



Self-assessment of the patients at follow-up

Compared with their state before therapy, 6 years after the termination of treatment 70-94% of the former patients reported good to very good improvements with respect to physical or psychological distress, general well-being, life satisfaction, job performance and partner and family relations as well as social functioning. The distribution of some responses are presented in Table 5.

Table 5: Global self reports of the patients at follow-up compared with presentation prior to therapy

| | n | Better % | Unchanged % | Deteriorated % |
|---|-----|----------|-------------|----------------|
| How did the problems, which brought you into treatment, develop? | 111 | 93 | 6 | 1 |
| How do you see your emotional condition today? | 111 | 94 | 5 | 1 |
| How do you compare your physical health status to that before treatment? | 111 | 66 | 24 | 10 |
| How did the physical problems, which brought you into psychotherapy, develop? | 63 | 83 | 10 | 7 |
| Compared to pre-therapy, how satisfied are you with your partnership today? | 80 | 74 | 19 | 7 |
| Compared to pre-therapy, how satisfied are you with your job conditions? | 111 | 75 | 17 | 8 |

Global health-state

The self reported global health state of the patients at follow-up was compared with a representative randomly assigned calibration sample drawn from a “normal” population (Gerdes & Jäckel, 1992) adapted to the study with regard to sex and age. Overall, 88% of the follow-up sample’s ratings fell within the 75th percentile of the reference sample, indicating that 88% of this study’s sample’s global health state could be seen as “normal health” as rated by 75% of the calibration sample.

Clinical significance of global well-being

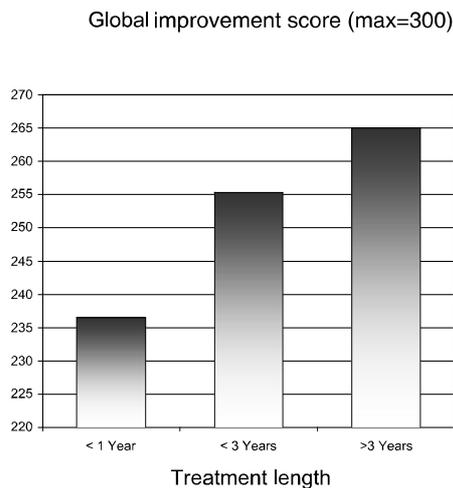
Global well-being was assessed by a 6 point Likert-scale (from very poor to very good). Of 60.4% (n=67) of patients reporting their well-being as very poor prior to therapy, 86.6% (n=56) rated their global well-being at follow-up (6 years after termination of psychotherapy) as very good, good or moderate. This indicates improvement in global well-being long after the termination of treatment. These results have been confirmed by the “Consumer’s Report-Study” by Seligman (1995).

Relation between global success and treatment length

The addition of 3 total scores (ranging from 0 to 100) of different self reported global ratings (degree of improvement of the complaints leading to need for psychotherapy, how much psychotherapy helped the patient, satisfaction with actual psychological and emotional state) created a global variable of therapy success. Figure 2 shows the relationship of therapy success to treatment length ($p < 0.05$), indicating the longer the treatment, the better the treatment success 6 years after termination of psychotherapy.

With regard to this criterion, long-term psychotherapy was more successful than short-time psychotherapy. Similar results were found by Seligman (1995) and Sandell (1996).

Figure 2: Treatment length and global therapy success (improvement-score composed of the addition of 3 different global self-assessments of success)



The global assessment by former therapists

The global assessment by former therapists of the patients' state at the end of therapy shows a comparatively good agreement in terms of distribution with the patients' own assessment at the time of follow-up 6 years after the end of therapy (therapist: 64.9% good, 29.7% moderate, 5.4% unchanged or deteriorated overall state; patients: 70.3% good, 22.5% moderate, 7.2% unchanged or deteriorated).

Results of psychometric test examinations at follow-up

SCL-90R: On standardised psychometric tests of state of health at follow-up, the sample tested lies within the range of healthy standard random samples and compares favourably with other clinical groups with respect to the relevant alteration qualities of symptoms. Figures 3a & b show the means of the 9 subscales and global severity scores on the SCL-90R for the study sample compared with relevant standardisation samples.

Figure 3a: Mean SCL-90-R-Scales on follow-up compared to standardisation samples

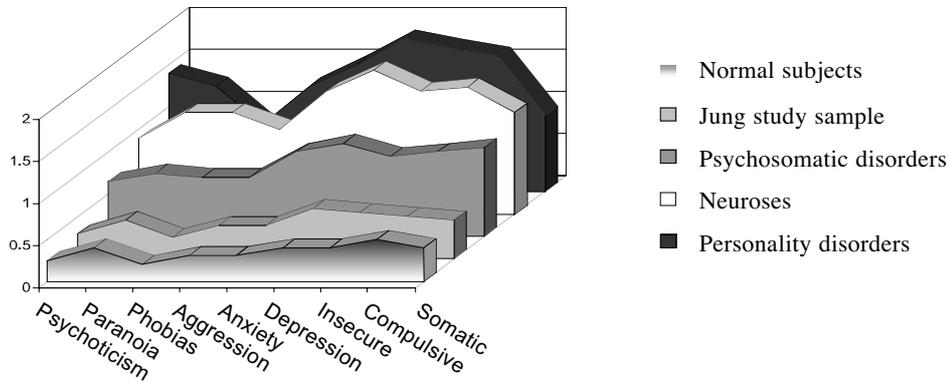
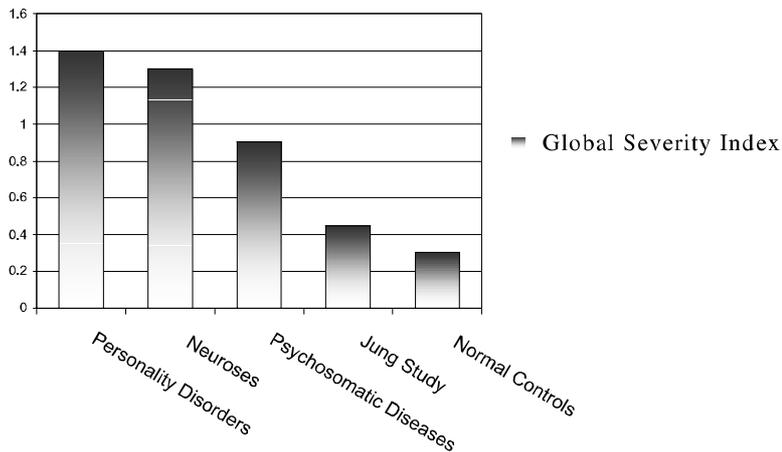


Figure 3b: Mean SCL-90-R-Global Severity Index on follow-up compared to standardisation samples



The global severity scores and the sub-scale scores of the Jung Study sample indicates that 6 years after treatment this group with a relatively severe set of diagnoses pre-therapy were quite well-adjusted on all scales of psychopathology and more like the normal comparison group than any of the clinical groups with which they shared diagnoses prior to therapy.

Gießen personality test:

Standardised for sex and age, the Gießen test scales (T-values) range within the calibration values of two SD's from 50, for normal sample. Clinically significant disturbance is indicated by deviations greater than two SDs from the mid-point of 50. The results obtained from the Jungian Study follow-up indicate that the means of these subjects fell within the normal range on all scales.

Table 6: Mean values on the Gießen Personality Test for the Jungian Study sample

| | Mean (N=11) | Std Dev |
|------------------|-------------|---------|
| Dominance | 44.23 | 9.68 |
| Social resonance | 46.83 | 9.81 |
| Control | 51.05 | 9.14 |
| “Permeability” | 51.27 | 11.40 |
| Social potency | 51.84 | 8.70 |
| Basic mood | 58.51 | 10.18 |

Changes in experience and behaviour (VEV)

A questionnaire measure of change (VEV), covering a range of behavioural and subjective items, was administered on follow-up. On this scale of “Change in Experience and Behavior” (VEV), the test subjects showed significant improvements in various areas of life ($p < 0.01$) compared to the calibrated random sample. Compared to a one year follow-up of another clinical sample treated with inpatient cognitive behavioural therapy, there are no marked differences (Table 7). Both treatments appear to bring about positive change in about three quarters of a clinical sample.

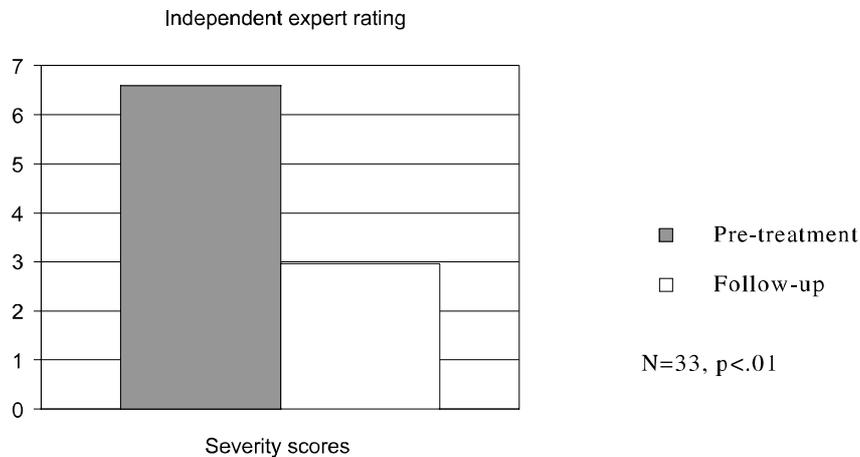
Table 7: Results for VEV questionnaire of Change in Experience and Behavior: Comparison of the Jungian follow-up sample (N=111) with a 1-year follow-up sample of inpatient cognitive behavioural treatment (N=142, Zielke, 1993).

| | Jungian sample (N=111) | | CBT sample (N=142) | |
|--|---------------------------|------|-----------------------|------|
| | N | % | N | % |
| Positive change (>187) | 78 | 70.3 | 105 | 73.9 |
| Moderate change (value between >150 and <187) | 31 | 27.9 | 34 | 24.0 |
| Negative change (value<150) | 2 | 1.8 | 3 | 2.1 |

Change of the impairment severity score (BBS)

In the comparative pre- and post-treatment expert rating of the actual state of disturbance by clinical interviews during the follow-up, an examination of a sub-sample of $n=33$ patients (regional sample of Berlin) by independent raters showed a significant ($p < 0.01$) decrease of the severity of the disturbance on the Schepank Impairment Severity Index. The effect size was 2.1 (see Figure 4) which is large, although in this instance the comparison was not a control group, which may explain why the ES is larger than usual.

Figure 4: Impairment severity score (BBS) prior to and post psychotherapy (follow-up)

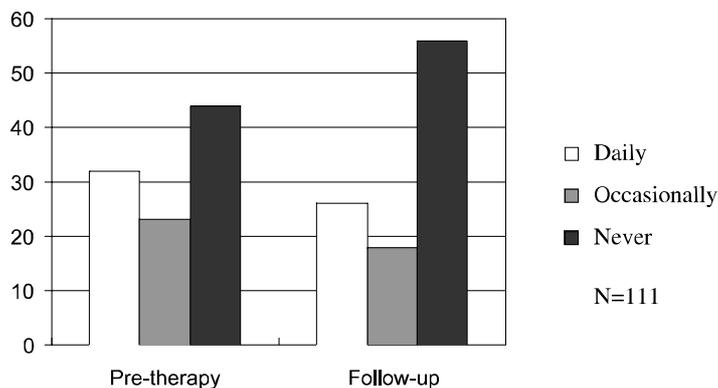


Health care utilisation

Health care utilisation was looked at in a number of ways. Psychotropic drug use significantly reduced over the course of the post-therapy period (Figure 5).

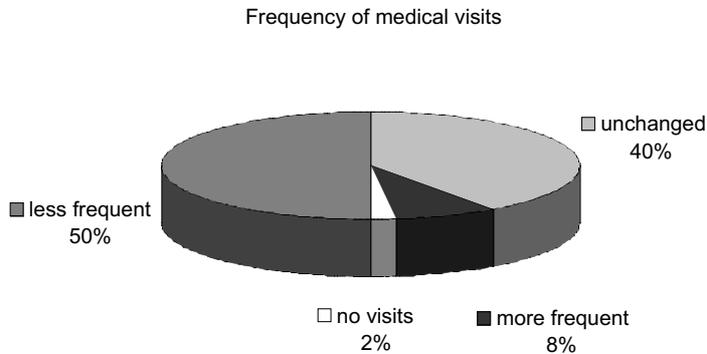
An increased percentage of the patients no longer use psychotropic drugs compared to pre-psychotherapy and the proportion of those taking medication regularly reduced most substantially.

Figure 5: Intake of psychotropic drugs prior to psychotherapy and at follow-up



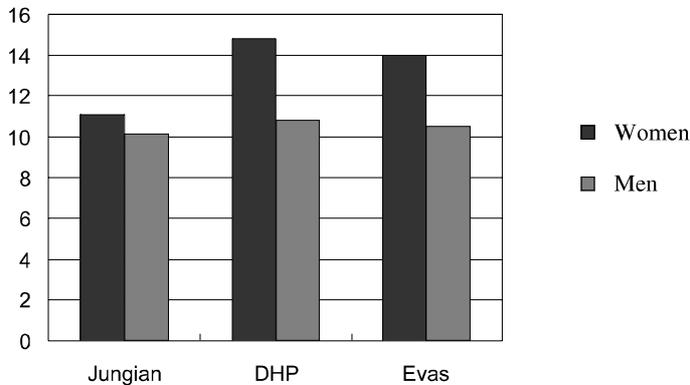
Neurotic and personality disordered patients often use resources by presenting at primary care physicians for physical symptoms or support. More than half of the patients reported a substantial reduction in the frequency of doctor visits compared with the frequency of visits prior to psychotherapy. Only 8.1% had a higher frequency and nearly 40% reported an unchanged frequency in the year before the follow-up.

Figure 6: Frequency of medical visits (comparison of the year prior to psychotherapy and the year prior to follow-up)



The frequency of medical visits in the year before follow-up were substantially below the frequencies that would be expected on the basis of two representative studies of private practice patients (Hoffmeister, 1988; Schacht, 1989) (Figure 7).

Figure 7: Frequency of medical visits in the past year compared with two German studies of general practice attendance (DHP and Evas-Study)



Perhaps the most meaningful index of resource use is days lost from work due to illness (sickness absence) and cost of hospitalisation. An examination of the data recorded by third party payers (national insurers) before and after treatment revealed a substantial reduction of working days lost due to sickness. Sickness absence dropped by 50% (from an average of 16 to 8 days). At the same time an even greater reduction in hospitalisation days was observed. The reduction was 87.5%, from an average of 8 days per year before therapy to an average of 1 day per year after (Figures 8 and 9).

Generally, a reduction of sickness absence and hospitalisation days after psychotherapy can be regarded as an important indirect measure of therapy success. However, in order to assess the number of days of sickness using insurance records, the study participants had to be continuously employed. Part of the sample therefore could not be included in this analysis. Thus the sample was reduced from 111 to 47 patients for analysis of sickness absence and to 58 patients for days hospitalisation. This detracts from the persuasiveness of the findings.

Figure 8: Mean number of work days lost per annum due to sickness 5 years before and five years after psychotherapy

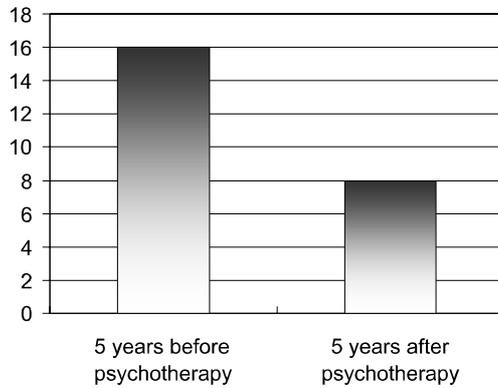
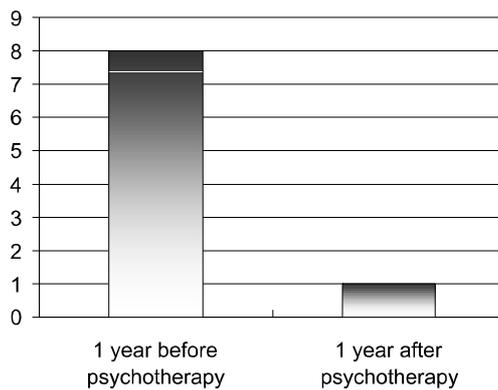


Fig. 9: Mean number of days of hospitalisation (one year before and after psychotherapy)



Conclusion and evaluation

The effectiveness of Jungian psychoanalysis and psychotherapy was determined on the basis of a number of different perspectives and success criteria in a selected and not necessarily representative sample. Three quarters (76%) of the patients examined had Jungian psychoanalysis so that empirical proof of the effectiveness of long-term analyses could be examined after an average of 6 years. Even after 5 years, the improvement in the patients' state of health and attitude toward the disease resulted in a measurable reduction of health insurance claims (work days lost due to sickness, hospitalisation days, doctor's visits and psychotropic drug intake) in a significant number of the patients treated. This suggests that psychoanalysis is related to a reduction of health care and related costs. Cost effectiveness aspects increasingly play an important role as outcome criteria for health care purchasers and providers. This retrospective study demonstrated that psychoanalysis also has long-lasting effects on the patients' psychological wellbeing. There are numerous major methodological problems with these data including the lack of comparison sample, the non-representativeness of the sample, the unreliability of pre-treatment data, the high rate of attrition, the need for multi-variate statistics, and uncertainty about the actual treatments offered. However, limitations of design and methods aside, the data here provide some convincing arguments for the effectiveness of psychoanalysis. This is encouraging as the design could be readily replicated on other patient populations.

The Konstanz study – A German consumer reports study (TKS)

- Breyer, F., Heinzl, R. & Klein, Th. (1997). Kosten und Nutzen ambulanter Psychoanalyse in Deutschland (Cost and benefit of outpatient analytical psychotherapy in Germany): *Gesundheitsökonomie und Qualitätsmanagement*, 2, 59-73

This retrospective questionnaire study included former patients of a randomly drawn 20% sample of members of two German analytical psychotherapy associations (DGPT & DGIP) with a total membership of 394 who had terminated their analytical therapy between 1990 and 1994. The return rate of the anonymous questionnaire from therapists was 66%. Overall 183 responses (46.4%) were received; 91 declared their readiness to participate (23.1%) and 92 explained why they could or would not take part (23.4%). Reasons for therapist non-participation is shown in Table 1a. One subject filled out two questionnaires for his patients, reducing the sample of participating therapists to 90. The theoretical orientation of the participants is shown in Table 1b.

Table 1a: Reasons for non-participation

| | N | % |
|---|----|-------|
| No terminated treatments during 1990-1994 | 48 | 52.2% |
| Disease, age | 8 | 8.7% |
| Shortage of time | 12 | 13% |
| Participation in other study | 5 | 5.4% |
| Unable to contact patients | 5 | 5.4% |
| Unwilling to contact former patients | 1 | 1.1% |
| Rejection of study design | 11 | 12% |
| No reasons given | 2 | 2.2% |
| Total | 92 | 100% |

Table 1b: Theoretical orientation of therapists participating in the German Consumer Report Study

| | |
|--------------------|----|
| Freudian | 61 |
| Jungian | 10 |
| Freudian & Jungian | 4 |
| Adlerian | 15 |

Sample

The 90 therapists were asked to send out 979 questionnaires - 789 to former patients in individual therapy and 190 to former patients in group psychotherapy. The return rate was 66%. Forty two questionnaires were excluded, as the actual termination time turned out to be more than 6 years earlier. Thus, the final analysis was based on N = 604 patients.

Due to the naturalistic design, the large sample and the relatively high return rate, the results of the study may be taken to be representative for insurance based psychoanalytic therapy as it is currently practised in Germany; it is much more representative than the similar Consumer Reports study is for the United States. A further interest of the study is the relatively long treatments included in the study as well as some three or more times weekly treatments.

Treatments

Table 2 contains the mean length of treatment and treatment duration of the sample from which treatment density (frequency of sessions per week) may be derived. Treatment density was, not surprisingly, higher for Freudians and Jungians than Adlerians and eclectics and somewhat higher for psychologists than for psychoanalysts. Group therapy rarely took place more than once per week.

The length of the treatments with the relatively small standard deviation points to a certain selectivity of the sample. Patients mostly terminated their therapy when their insurance funding was exhausted rather than for other reasons. This is in contrast to the sample from the Ulm outpatient centre when duration of treatment is widely varying (Kächele et al., in preparation). Subjects were asked retrospectively to report their self-assessed physical, mental, social and overall health status at three points of time: at the beginning and end of their therapy and at the time of follow-up questioning.

Table 2: Mean number of sessions, length of treatment and estimated treatment intensity for 604 patients in psychoanalytic therapy followed up for up to 6 years after termination

| | Mean number of sessions (SD) | Duration in months (SD) | Estimated no of sessions per week |
|--------------------|------------------------------|-------------------------|-----------------------------------|
| All | 238.65 (7.55) | 41.04 (1.02) | 1.58 |
| Psychologists | 276.66 (13.70) | 42.60 (1.38) | 1.77 |
| Physician | 213.77 (9.66) | 39.28 (1.72) | 1.48 |
| Others | 191.15 (23.37) | 31.10 (2.65) | 1.67 |
| Freudians | 255.92 (10.05) | 40.85 (1.29) | 1.71 |
| Jungians | 232.79 (15.19) | 39.11 (2.28) | 1.64 |
| Adlerian | 171.90 (11.35) | 39.80 (2.72) | 1.18 |
| Eclectic | 197. 03 (14.86) | 44.97 (3.45) | 1.19 |
| Individual therapy | 261.28 (8.41) | 42.42 (1.05) | 1.68 |
| Group therapy | 119. 79 (9.07) | 32.67 (2.98) | 1.00 |

Results

Table 3 displays the mean well-being scores as rated retrospectively by study subjects. There seems to be a substantial shift in well-being from bad to good associated with therapy. The change is interestingly most clearly marked for physical health. It is also interesting to note that the full impact of change on the relationships variable mainly emerges at the follow-up stage whilst the other two dimensions improve only to a limited extent between termination and follow-up.

Subjects also reported on their health care utilisation (physician's visits, hospital days, drug consumption) and on their days lost from work. Table 4 displays these data.

Table 3: Retrospective reports of subjective well-being from start of treatment to follow-up

| | Start of treatment | Change by termination | Change by follow-up | Change from termination to follow-up |
|--------------------------|--------------------|-----------------------|---------------------|--------------------------------------|
| Total well-being | 4.33 | - 2.06** | - 2.17** | - 0.11** |
| Somatic well-being | 3.21 | - 1.01** | - 1.08** | - 0.07* |
| Psychological well-being | 4.44 | - 2.16** | - 2.26** | - 0.10* |
| Quality of relationships | 3.66 | - 1.19** | - 1.52** | - 0.33** |

scale: 1 = very good 5 = very bad

** p< 0.001 on related t-test (one tailed)

* p< 0.05 on related t-test (one tailed)

Table 4 displays mean values for medical visits at the start of therapy, changes by termination and changes during the follow-up period. There were reductions in both primary care and specialist care visits over both time periods with both types of consultation being almost halved by follow-up assessment. Consistent with these observations, sickness absence was reduced by 60% at follow-up and hospitalisation by 66%.

Table 4: Changes in health utilisation parameters (mean values and percents relative to the year previous to therapy, at therapy termination and follow-up)

| Indicator | Start of therapy | At termination (% reduction) | At follow-up (% reduction) | % change from termination to follow-up |
|--|------------------|------------------------------|----------------------------|--|
| Number of visits to family doctor | 6.28 | 3.76** (40%) | 3.03* (52%) | 19%** |
| Number of visits to medical specialist | 3.97 | 2.65** (33%) | - 1.59** | 10%* |
| Days of sickness absence | 14.48 | 8.46** (42%) | - 8.62** | 31%** |
| Days of hospitalisation | 3.39 | 1.17** (66%) | - 2.22** | 0% |

** p< 0.001 on related t-test (one tailed)

* p< 0.05 on related t-test (one tailed)

Generalisation of these findings might be problematic because several selection biases may be operating. There may have been an oversampling of successful therapists in the recruitment procedure and an over-sampling of “good” former patients by these therapists. Further there may have been bias in patients’ self-selection with those who feel improved being more likely to agree to participate. To check for selection bias due to selection of “good” patients by therapists, the correlation between mean success rate and number of questionnaires sent out by a therapist was computed. This provided no evidence to suggest that fewer questionnaires sent out was associated with better outcome. Nevertheless, the results should be interpreted with some caution.

Bearing in mind these concerns, the study offers substantial evidence that the self-assessed health status of patients improved significantly associated with psychoanalytic therapy, and this effect did not weaken and in some respects even increased over the follow-up period (up to six years). The self-reported utilisation of other health care services also decreased significantly, notably the number of physician visits and hospital days. Although the validity of such retrospective reports is open to doubt, events such as sickness absence are normally accurately reported, but no attempt could be made by the study to validate these figures given the anonymous nature of the survey.

An econometric analysis yielded the expected results. The size of savings was bigger, the worse the patient's self-assessed health status at the beginning of the therapy. Importantly, savings increased with greater number of sessions and was greater for younger patients. There were no significant differences of the effects between the different professions of the therapists (psychologists vs physicians) or the analytical schools (Freud vs Jung vs Adler) or even between patients of individual and group therapy. Hence, the results are in important respects similar to the ones found in the Consumer Reports study. Savings in health care utilisation were costed and the reduced work loss and its consequent contribution to GNP was allowed for, and it was shown that in the two years (on average) between the end of the individual therapy and the time of follow-up questionnaire the monetary benefits of therapy alone added up to one-quarter of its costs (see Table 5).

Table 5: Savings accrued as a result of individual and group psychotherapy in the first two years after therapy

| Savings | Expected reduction in health care events (individual therapy) | Cost of events (individual therapy) (DM) | Expected reduction in number of health care events (group therapy) | Cost of events (group therapy) (DM) |
|--------------------------|---|--|--|-------------------------------------|
| Family doctor visits | 7.3 | 130.90 | 7.5 | 134.70 |
| Speciality doctor visits | 3.0 | 101.30 | 7.1 | 235.40 |
| Days sickness | 19.5 | 6,906.10 | 26.0 | 9,198.00 |
| Days in hospital | 3.0 | 1,339.50 | 10.74 | 759.90 |
| Total savings | | 8,477.80 | | 14,330.00 |
| Costs of treatment | | 33,235.00 | | 4,305.00 |
| Savings/costs ratio | | 0.255: 1 | | 3.32:1 |

These figures suggest that analytic group psychotherapy is more cost-effective than individual analytic psychotherapy by a ratio of almost 13:1. The main source of this difference is the higher costs of individual analytic psychotherapy as opposed to group therapy: 7.5:1. This was a result of both the higher unit cost and greater number of individual sessions (2.5 times) relative to group therapy. Medical cost reduction is less dramatic in this study: group patients turned out to have 1.7 lower costs than the patients in individual therapy. The sample of group therapy patients was, however, too small (N=59) to justify generalisations about the relative cost-effectiveness of these treatments.

Evaluation

This study is an interesting replication of the well-known “consumer survey study” carried out in the USA several years ago. Seligman’s (1995) report did not include long term or intensive treatment. The current report demonstrated that long term therapy works and may be shown to pay for itself in terms of reduced health care costs given follow-up studies of sufficient length. The weaknesses of the consumer survey methodology have been extensively discussed in the literature. The absence of a comparison control group makes attribution of improvement and savings to the psychotherapeutic experience problematic. Controlled studies of psychotherapy have their own methodological problems, however, and consumer surveys undoubtedly add an important perspective to evaluations of the efficacy of psychoanalytic therapy.

Taking a psychoanalytic perspective, the problems of the consumer oriented approach may soon be seen in a different light. Long term treatments, particularly those interrupted as a consequence of funding restrictions, are likely to leave significant unresolved transferences which would bias subjective evaluation in unknown ways. Untangling the relationship of objective measures and subjective reports in the context of long term therapy may be an important field of investigation as the methodology of consumerism is adopted in the field of outcome evaluation.

The German Psychoanalytical Association study – Long-term effects of psychoanalyses and psychoanalytic therapies: a representative follow-up study (GPAS)

- Chairs: M. Leuzinger-Bohleber. U. Stuhr. M. Beutel. Consultant for Statistics: B. Rüger. Consultant of the IPA Research committee: H. Kächele
- Leuzinger-Bohleber, M. (in press-b). The Psychoanalytic Follow-up Study (DPV): A Representative, Naturalistic Study of Psychoanalyses and Psychoanalytic Long-term Therapies. In M. Leuzinger-Bohleber & M. Target (Eds.), *The Outcomes of Psychoanalytic Treatment*. London: Whurr.
- Leuzinger-Bohleber M, Stuhr U, Rüger B, Beutel M (2001) Langzeitwirkungen von Psychoanalysen und Psychotherapien – eine multiperspektivische, repräsentative Katamnese studie. *Psyche* 55:193-276
- Stuhr U, Leuzinger-Bohleber M, Beutel M (2001) Langzeitpsychotherapie. Perspektiven für Therapeuten und Wissenschaftler. Kohlhammer, Stuttgart
- Leuzinger-Bohleber, M. (Ed.). (1997). "...die Fähigkeit zu lieben, zu arbeiten und das Leben zu genießen." Zu den vielen Facetten psychoanalytischer Katamnese forschung. Giessen: Psychosozial Verlag. (Chairs: M. Leuzinger-Bohleber. U. Stuhr. M. Beutel. Consultant for Statistics: B. Rüger. Consultant of the IPA Research committee: H. Kächele)

In order to respond to the political situation in their country, the German Psychoanalytic Association (DPV) formed a research committee in 1992. This group, of 19 members of the DPV, decided to carry out a naturalistic follow-up study of long term psychoanalytic treatments. The major aim of the project is to study patients' retrospective views of their psychoanalytic experiences and their effects at least 6 years after termination of psychoanalysis or psychoanalytic long term treatment. The question to be addressed is whether the subjective views of the former patients correspond to those of their former analysts, those of independent observers and to the results of tests and questionnaires used in psychotherapy research.

Recruitment and sample

In the first months of 1997 a questionnaire was sent out to all members of the DPV to test the feasibility of the study. The researchers endeavoured to ascertain co-operation of the members of the DPV, in order to estimate the total number of patients available for the study, and how representative this group might be. Overall, 91% of the members responded to this "baseline-assessment". A great majority (89%) was in favour of the study. A representative sample (N=401) of patients who had terminated their psychoanalytic long term treatment with DPV members between January 1990 and December 1993 agreed to participate. These included (a) former psychoanalytic patients and (b) patients who received long term psychoanalytic psychotherapy.

Method

Three follow-up questionnaires (SCL-90, Sense of Coherence Scale, Life Satisfaction) plus open-ended questions regarding goals, causes of treatment and relationship with analyst, well-being, utilization of medical services before, during and after treatment and treatment satisfaction were used to study all the former patients available as well as their analysts. Of those patients who only received questionnaires (n=207), 44 did not respond. 9 were excluded leaving a sample of 154 patients (75%) for whom only questionnaire data was available.

In the second part of the study two psychoanalytic follow-up interviews were administered to the other 194 patients. In the first unstructured psychoanalytic 90-minute interview, patients had the opportunity to discuss their views of their experiences in psychoanalysis with an experienced analyst. Topics such as the patient's motives for treatment, their subjective evaluation of the therapy, and their motivation for participating in the study, were addressed. Interviews were tape-recorded. Afterwards, the interviewing analyst tape-recorded his impressions of the interview, and determined what information still needed to be gained from the second interview. S/he then met with a member of one of the 9 local research groups (62 analysts in total) for a supervision,

enabling the interviewer to formulate the questions to be explored in the second interview more clearly. The second interview again began in an unstructured way, and the interviewer then asked a semi-structured set of questions about the patient's view of the former therapy, the therapist-patient relationship, the symptoms, the personal significance of the treatment for the patient, the life events before, during and after therapy, and their overall evaluation of the therapy.

Another member of the research group (who had no information about the patient) interviewed the patient's former analyst. Finally, the local research group met with the interviewers of patient and analyst to discuss the information gathered (the session was tape recorded). The group also rated some global outcome items and the Scales of Psychological Capacities (Wallerstein, DeWitt, Hartley, Rosenberg, & Zilberg, Unpublished manuscript, 1996).

The reports of the follow-up interviewers and the tape-recorded interviews of 129 cases are currently being analysed by a wide range of qualitative and quantitative methods, including narrative single case studies, the use of narrative case presentation to illustrate questionnaire findings, systematic evaluation of qualitative findings by the "bottom-up procedure of clinical clustering" (Klinische Typenbildung; see Leuzinger-Bohleber, Beutel, Stuhr & Rüger, 2000 for details); the specific, elaborated qualitative method of "Verstehende Typenbildung" (Stuhr, 1995) which studies the image of the analyst using the representative sub-sample of transcribed follow-up interviews; and systematic analysis of the transcribed interviews by a modified form of a theory-guided, computerised content analysis developed some years ago (Leuzinger-Bohleber, 1989a) to compare the extra-clinical, non-psychoanalytical analysis of the follow-ups with the researchers' psychoanalytic expert evaluation (expert-ratings on the psychoanalytic follow-up view of the treatments, content analyses, text analyses, qualitative analyses etc).

Additionally, the total costs of health care for the patients before and after treatment were assessed based on the records of health insurance companies, taking into consideration the diagnoses and the severity of disturbances before and after treatment.

Results

Questionnaire results

As Figure 1 shows, about 80% of the former patients reported positive changes regarding well-being, personal development and relationships to others, 70 to 80% regarding coping with life events, self-esteem, mood, life satisfaction and work ability. The proportion of patients with a stable partnership increased from beginning of treatment to follow-up from 67 to 76%. No consistent differences between psychoanalysis and psychotherapy patients regarding the retrospective assessment of their impairment before and after treatment were found.

Figure 1: Changes during treatment in the patients' view (n=247)

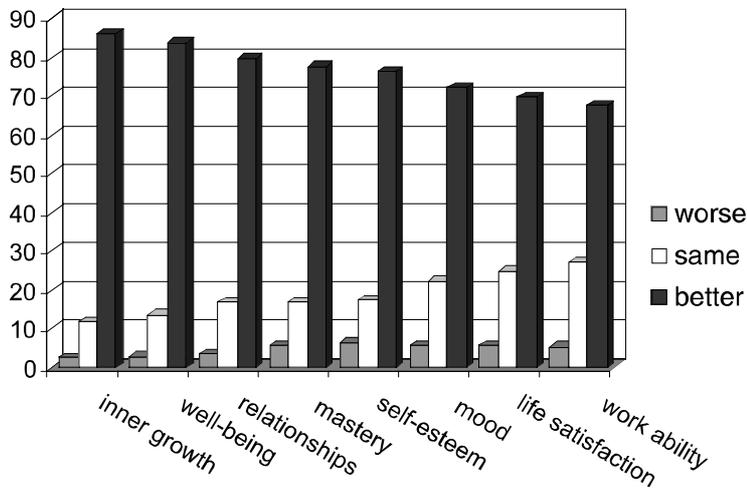
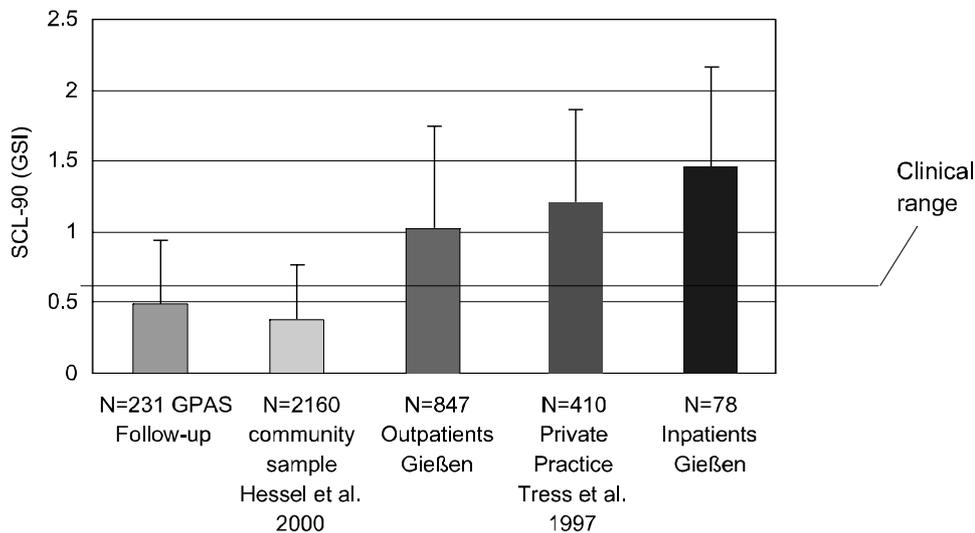


Figure 2 shows the current distress (SCL-90R) of the patients at follow-up compared to other samples. The study participants report lower distress than comparable patient samples (outpatients at Giessen psychosomatic ambulance, patients in private practice, inpatients at Giessen psychosomatic clinic). Patients of the GPAS achieved symptom scores comparable to the community sample. The results also illustrate the mainainance of the low level of distress even at about 6 years after termination of treatment.

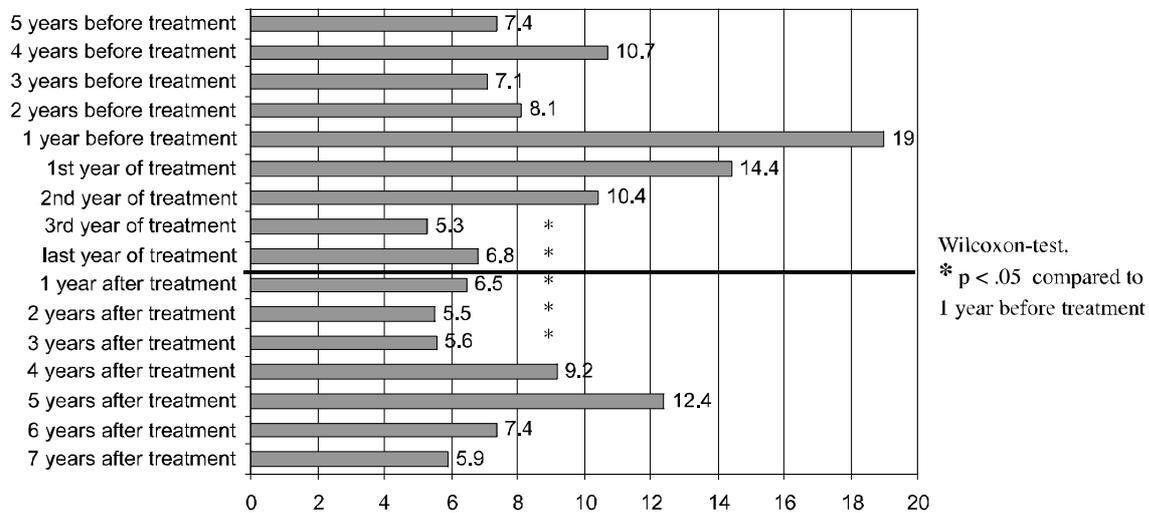
Figure 2: Current distress (SCL-90R-GSI): Participants of the GPAS compared to other samples



Results of the health care utilization subproject

With the written consent of the former patients the research team contacted the health insurance companies and asked for data of health care utilization before during and after treatment. Based on 47 complete cases figure 3 shows that there is an increase in days of sick leave in the year before treatment and a decrease in the course of treatment which is maintained after treatment. Even at follow up the level of days of sick leave was well under the mean of comparable insurants of the general population.

Figure 3: Days of sick leave before, during and after treatment based on health insurance data



Wilcoxon test, *p < .05 compared to 1 year before treatment

Interview subjects

Systematic evaluation of the follow-up interviews using the ‘bottom-up’ procedure mentioned above uncovered the following three dimensions, which describe central aspects of the patient’s change during psychoanalytic long-term psychotherapy:

- A) Self-reflection: limited or high self-reflection
- B) Object-relations: limited or high capacity to live in satisfying relationships
- C) Creativity and working ability: limited or high creativity and work ability

By combining these three dimensions systematically, eight prototypical treatment outcomes were logically defined (see Leuzinger-Bohleber et al. 2001 for the details of these prototypical outcomes).

In 89% of cases the former patients, their analysts, the psychoanalytic expert and the independent raters agreed with respect to the general outcome of therapy (good, medium, bad). If a more differentiated evaluation was requested (very good, good, medium, bad, very bad) 46% of the former patients were slightly more satisfied with therapy outcome than their treating analysts; 44% agreed with them and 10% evaluated the outcome slightly more critically than their analyst. The psychoanalytical experts were, in 50% of the follow-ups, slightly more critical than the former patients, and in 25% more critical than the treating analysts. In 40% of cases they agreed with the former patients and in 60% with the treating analysts. In 10% of cases they rated treatment outcome to be slightly more positive than the former patients, in 15% more positive than the treating analysts. According to their findings the psychoanalytical experts evaluate therapy outcome most strictly, and the former patients most mildly of all the different groups of raters in this study.

The raters found that successful analyses seem to depend on a good “matching process” between analyst and analysand. The idiosyncrasy of the different psychoanalytic processes and outcomes is amazing. It appears that these processes can lead to a satisfactory outcome if the analyst is capable of a skillful adaptation of his psychoanalytic technique to the individual characteristics, needs and conflicts of his specific patient, and can avoid following in a rigid and narrow way his

own “stereotyped” technique or his ideological view of how psychoanalysis should be. In particular, the treatment of severely disturbed patients seems to require much personal flexibility, creativity and sensitivity on the part of the analyst.

The fact that a statistically significant difference in the outcomes of psychoanalyses and psychoanalytic therapies was not found in the questionnaire sample cannot be interpreted as a “proof” that such a difference does not exist. Detailed analysis of the 129 follow-ups of the interview sample revealed clear differences between former psychoanalysis and former psychotherapy patients. The former psychoanalytic patients with “good enough” treatment outcome had internalised the analytic function in a more extensive and intensive way. Therefore their self-reflective functions were rated as “deeper”, “more elaborated” and “more differentiated” than those of the therapy patients. This finding may be useful for the interpretation of the findings of the Stockholm study on why former psychoanalytic patients increasingly improve more than the therapy patients over proportionately to the length of the follow-up period (cf Sandell, in this volume).

Most of the treatments had been terminated by the agreement of patient and analysts. 43 of the 118 former patients, whose data have been analysed in this respect, said that treatment had been too short for them; 11 said that treatment had been too long. Some psychoanalyses with medium or bad results were terminated after the insurance companies had stopped paying (after 240 or 300 sessions).

11% of the former patients in the interview sample were not satisfied with therapy outcome. In some cases obviously tragic life events (as loss of a partner, unemployment etc.) had influenced this negative view of therapy outcome. In 4% of the follow-ups either the former patient or his analyst were “very unsatisfied” with therapy outcome. In the group of the 11% unsatisfied patients were persons with all kinds of diagnoses. However, all the five patients with the extremely negative therapy outcome had been borderline patients, although seven borderline patients in the interview sample had good and stable therapy outcomes (even 6,5 years after the end of treatment)

Another unexpected finding is the number of severely traumatised patients (externally traumatic events in the context of World War II, long separations from primary objects, psychiatric illnesses of caregivers, sexual abuse, illness during childhood etc.). 81 of the 129 former patients belonged to this subgroup. Many of the analysts seem to have treated these patients with a modified psychoanalytic technique. There seemed to be two groups of severely traumatised patients with good therapeutic outcome. In the first group (76 patients), the trauma was reactivated and worked through in psychoanalysis itself. Another small group (five patients) seem to have protected the analytic relationship from the enactment of the severest traumas and, instead, used the analytic relationship as a “holding function”, reflecting with the analyst on the reactivation of the trauma in an external relationship. All these analysts said that they regretted that while analysis had proved to be quite successful, negative transference was not worked through thoroughly.

Evaluation

This is the most significant follow-up study of psychoanalysis performed thus far. Of particular importance is the careful attention paid to issues of sampling and the collection of the retrospective data with as little contamination from bias by current status. While no differences were found between the outcome of psychoanalysis and psychoanalytic psychotherapy on long term follow-up, qualitative analyses revealed some important differences. The way these researchers approached the opportunities presented by qualitative research are of great interest to all of us. The study results are actually presented as a highly original combination of qualitative and quantitative methods with great promise for replication in future follow-up or follow-along investigations or even in prospective studies.

Project TR-EAT: A multicenter study of inpatient psychodynamic treatment of eating disorders in Germany

- Kächele, H. (1999). A multicenter study of expenditure and success in psychodynamic therapy of eating disorders. Study design and initial results. *Psychother Psychosom Med Psychol*, 49(3-4), 100-108.
- Kächele, H., Kordy, H., Richard, M. (in press). Therapy amount and outcome of inpatient psychodynamic treatment of eating disorders in Germany: Data from a multicenter study. *Psychotherapy Research*, 11(3).

The Center for Psychotherapy Research in Stuttgart initiated a multicenter study on the effectiveness of inpatient psychodynamic treatment of eating disorders in the early 1990s. Project TR-EAT was a naturalistic, longitudinal, and observational study of outcome. Besides this overall objective, the study aimed to estimate the amount of therapeutic resources that were applied within the various treatment programs in everyday clinical practice and the impact on the short- and medium-term course of eating disorders. After the pilot phase, the main study began in 1993. It was completed at the end of 1998 with a 2.5-year follow-up assessment. Forty-three specialty hospitals and departments for psychosomatic medicine and psychotherapy in Germany participated in the data collection. Treatment duration and intensity were not standardized to observe the naturalistic clinical course of treatment. Patients included in this study were at least 18 years old and fulfilled diagnostic criteria for anorexia nervosa (AN) or bulimia nervosa (BN), or both, at screening. The study investigates (a) factors that determine length of treatment and (b) the effect of treatment duration and other factors on outcome for patients with eating disorders.

Sample

Treatment of 1,171 patients from 43 sites in Germany was examined; 355 patients fulfilled diagnostic criteria for AN, 647 patients fulfilled criteria for BN, and 169 patients fulfilled criteria for both disorders. The majority were female. Less than 4% of the sample were male (AN = 3.3%, BN = 2.3%). The mean age of the participants was 24.8 years for AN (SD = 5.6) and 25.9 years for BN (SD = 6.3). The mean duration of illness before admission was 8.2 years (SD = 6.1) for BN and 5.7 years (SD = 5.3) for AN. Anorexic patients had a body mass index (BMI) 72.1% of expected (SD = 8.4).

At the 2.5-year follow-up, 879 patients (75.1%) could be contacted. A comprehensive interview was conducted with 781 patients (66.7%). Limited information given by family or doctors was available for 98 patients (8.4%). Of the 292 patients who could not be reached, only 64 declined participation. It was not possible to establish contact with the other 207 patients despite repeated attempts to contact them via mail and telephone. For various other reasons, no data were available for 11 patients. In the course of this study, 10 patients died: 6 through suicide, 1 as a result of medical complications related to the illness, and 3 of unknown causes. Few differences were found between patients who participated in this 2.5-year study and those who did not.

Measures

All patients were assessed over a 2.5-year period. At therapy admission and discharge, as well as 1 year and 2.5 years after index admission, patients were questioned as to physical condition, mental state, and level of psychosocial functioning using a comprehensive battery of inventories. At the same time, the condition of each patient was clinically evaluated at admission and discharge by their primary therapist. The 2.5-year assessment was conducted by clinical experts. The 1-year assessment was conducted by mail and thus was limited to self-evaluation. The questionnaires covered sociodemographic and historical variables; the battery of psychological inventories included the Symptom Checklist-90-R (SCL-90-R), the Eating Disorder Inventory (EDI), the Freiburg Personality Inventory (Freiburger Persönlichkeitsinventar [FPI-R]), the Narcissistic Personality Inventory (Narzissmus Fragebogen), and the Parental Care Index (Familien-Klima-Skalen). Treatment exposure was measured using weekly documentation of

the frequency and duration of all psychotherapeutic contact. In addition, the occupation of the participant was considered (to estimate therapy cost), and the number of participants in group or family therapy was monitored. The 2.5-year follow-up assessment was completed using a semistructured interview, the Longitudinal Interval Follow-up Evaluation (LIFE; Keller, Lavori, Friedman, et al., 1987), adapted for use in the present study. Retrospective, longitudinal information on symptomatic disturbance (the “change points”) during the postdischarge course of the illness was obtained using LIFE. This information was used to track the course of recovery and relapse between the point of discharge and the 2.5-year follow-up interview (Kordy et al., in press).

Results

The following results are based on a sample of 1,112 patients (AN: $n = 338$, BN: $n = 605$, AN and BN: $n = 169$) from 43 hospitals, of which 733 (AN: $n = 225$, BN: $n = 399$, AN and BN: $n = 109$) participated in the 2.5-year follow-up assessment.

The mean treatment duration for all three subclasses of eating disorders was roughly 11 weeks (median weeks: AN = 11.1; BN = 11.4; AN and BN = 10.6). Twenty-five percent of patients were treated for 4 to 8 weeks; a further 50% were treated for 9 to 13 weeks. Fifteen-week treatments were rare, and those that continued for more than 6 months were exceptionally rare.

To investigate which variables defined treatment duration, a stepwise linear model was used. The construction of the model required three steps. The results are presented in Tables 1 and 2. Variances within and between hospitals were estimated using a first model without predictors 5 (Model 1 in Table 1), also known as an unconditional model (Bryk & Raudenbush, 1992). The effect of the patient-related variables on treatment duration is presented in the second column (Model 2). Finally, in the third step, data regarding the specialty status of the treatment offered were included (Model 3). As can be seen in Table 1, patient characteristics accounted for only a small percentage of variance within the hospitals. These patient variables did not explain variance between the hospitals.

Table 1 Proportion of variance explained of treatment duration within and between hospitals

| | Model 1^a $\sigma^2 \pm SE$ | Model 2^b $\sigma^2 \pm SE$ σ^2 explained | Model 3^c $\sigma^2 \pm SE$ σ^2 explained |
|---------|---|---|---|
| between | 19.19 \pm (4.69) | 19.95 \pm (4.91) | 14.75 \pm (3.69) 23.1% |
| within | 20.44 \pm (0.96) | 19.78 \pm (0.94) | 3.2% 19.33 \pm (0.91) 2.3% |

a Without predictors.

b Patient characteristics as predictors.

c Hospital characteristics.

Detailed results for Model 3 can be found in Table 2, which lists all variables with a statistically significant effect. The strongest effect was found in hospitals with a separate eating disorders ward. When compared with a specialty eating disorders hospital, their patients received 7 additional weeks of treatment on average. A few patient characteristics were moderate predictors of outcome. Patients with low treatment motivation at baseline received half a week less treatment on average than those with higher motivation.

Table 2 Selected Predictors of Treatment Duration

| Predictor | B | SE |
|--|--------|---------|
| Other vs. specialty hospital | 0.42 | 3.95 |
| Specialized program vs. specialty hospital | -0.33 | 3.98 |
| Specialized ward vs. specialty hospital | 7.29 | 4.36* |
| Motivation to change: no | -0.49 | 0.16*** |
| Psychological distress (GSI) | 0.50 | 0.18*** |
| Age | 0.013 | 0.016 |
| Weight (% of expected BMI) | -0.006 | 0.004 |
| BN diagnosis | 4.06 | 1.32*** |
| Weight x diagnosis (BN) | -0.05 | 0.01*** |
| Psychological distress x diagnosis (BN) | -0.74 | 0.23*** |
| Age x diagnosis (BN) | 0.05 | 0.03*** |

Note. GSI = Global Severity Index of the Symptoms Checklist-90-R; BMI = body mass index; BN = bulimia nervosa. * $p < .1$. ** $p < .05$. *** $p < .01$.

Although the effect of 4.06 for BN diagnosis appears significant, it does not indicate that BN was treated 4 weeks longer than AN on average. Three further significant interactions are involved in interpreting diagnosis effect. For AN patients a difference of 1 point on the SCL-90-R Global Severity Index (GSI) correlates with an extended treatment length of half a week, whereas for BN patients the same difference on the GSI leads to 0.24 weeks shorter treatment because of a GSI? BN interaction. A weight gain of 16% BMI, which equals an increase in weight from the upper diagnostic boundary of 17.5 BMI to the expected BMI of 20, results in a treatment shortened by 0.1 weeks for AN patients. This correlation is even stronger for BN patients; a weight gain of 16% BMI results in a treatment shortened by 0.75 weeks. Because BN patients have a higher weight at baseline, the effect is even more pronounced. The treatment duration of very overweight BN patients (greater than 130% BMI) is approximately 2 weeks shorter than that of BN patients with expected BMI. For AN and BN patients with 90% of expected body weight, a difference of only 0.56 weeks is found. These examples underscore once more the role of interaction effects.

Outcome rates at the end of treatment and at the 2.5-year follow-up assessment are presented in Table 3. Essentially, the present definition of treatment success implies an almost complete lack of symptoms or only symptoms for which immediate further treatment is not necessary. Positive outcome thus defined was found in a minority of AN patients and in patients who met both AN and BN criteria: 11% and 17%, respectively, at the end of treatment. Self-report evaluations and therapist's evaluation did not differ substantially. Positive outcome rates for BN were markedly higher. However, outcome success rates as assessed in therapist evaluations (45%) differed greatly from self-evaluations (31%). At the 2.5-year follow-up assessment, a significantly greater proportion of patients with AN (36% based on therapists reports and 33% based on patients reports) and with AN and BN (26% vs. 21%) were to a large extent symptom free. However, the rate of positive outcome for BN dropped slightly (36% based on therapists' reports vs. 22% based on patients' reports).

Table 3: Rate of success (in %) at discharge and at 2.5 years follow-up classified according to treatment duration

| Perspective | Discharge | | | | 2.5 years follow-up | | | |
|-------------|---------------|---------------|-------|------------------|---------------------|---------------|-------|-----|
| | ≤11 wks | ≥11 wks | Total | OR | ≤11 wks | ≥11 wks | Total | OR |
| AN | <i>n</i> =166 | <i>n</i> =170 | | | <i>n</i> =112 | <i>n</i> =113 | | |
| Patients | 7.8 | 13.4 | 10.6 | 1.1 | 34.8 | 31.0 | 32.9 | 0.7 |
| Therapists | 9.6 | 15.1 | 12.4 | 1.8 | 36.6 | 34.5 | 35.6 | 0.8 |
| BN | <i>n</i> =292 | <i>n</i> =303 | | | <i>n</i> =197 | <i>n</i> =202 | | |
| Patients | 33.0 | 29.0 | 31.0 | 0.7 ^a | 20.6 | 24.0 | 22.2 | 1.0 |
| Therapists | 48.0 | 43.0 | 45.4 | 0.6 | 35.5 | 37.1 | 36.3 | 0.9 |
| AN+BN | <i>n</i> =73 | <i>n</i> =95 | | | <i>n</i> =44 | <i>n</i> =65 | | |
| Patients | 13.7 | 15.8 | 14.9 | 1.2 | 27.3 | 16.9 | 21.1 | 0.5 |
| Therapists | 13.7 | 19.0 | 16.7 | 1.5 | 31.8 | 21.6 | 25.7 | 0.6 |

Note. Odds ratios after propensity score adjustment (with the exception of anorexia and bulimia nervosa).
^a 1 within the 95% confidence interval.

A patient-reported difference in outcome for shorter and longer treatments at the end of treatment was found only in BN patients. For patients with bulimia, the patient-reported positive outcome rate for shorter treatments was 33% higher than the rate for longer treatments with other correlated variables controlled for. The therapist-reported success rate for patients with anorexia was about 80% higher for longer term versus shorter term cases. However, this difference in success rates was not statistically reliable (despite the considerable sample sizes). Overall, there was no recognizable difference in outcome between shorter and longer treatment at the 2.5-year follow-up assessment. This analysis does not preclude the possibility that unconsidered variables may interact with treatment duration and intensity in predicting outcomes.

An analysis of possible predictors of treatment success at the 2.5-year follow-up was conducted, using a stepwise multivariate logistic regression method within AN and BN groups, separately. No substantial differences between outcome at the various hospitals could be found. The analysis of the predictive variables of treatment success used a simple logistic regression approach, excluding the hospital factor from the design. The resulting models for AN and BN differ with regard to the identified predictors as well as to the goodness of fit.

Overall, the goodness of fit was moderate for both models. The model for AN explained 31% of the variance. The model for BN showed 13% variance explained. Even after controlling for other covariates, treatment intensity had no effect on the outcome for patients with AN. However, treatment length (short vs. long) in interaction with the age variable was a significant predictor. Low body weight and low desired body weight (%BMI) at treatment admission and significant deviations as measured on the FPI-R were risk factors associated with a poor outcome. Examining the interaction between treatment duration and age revealed that high patient age indicates a poorer outcome. The predictive value of this variable was intensified in the outcome of younger patients: Those in the 18- to 20-year age range had two to four times higher rates of positive treatment outcome with shorter treatments than age-matched counterparts with longer treatments. This correlation is reversed for older patient outcomes: Those patients who received a longer treatment actually had an increased rate of good outcome. However, this rate as a whole was considerably lower than that of younger patients.

The results for BN are quite complex: Multi-impulsivity, additional anorectic symptoms, and high number of previous treatments were associated with lower success rates. Treatment success was only slightly lower for patients who scored high on the first three EDI subscales (i.e., those with a more severe eating disorder syndrome). The effect of treatment duration is complicated by interaction effects with age and with the Morgan-Russell E subscale, in which relationships to family and friends are presented. Patients with difficulty in establishing relationships (low Morgan-Russell scores) had a better prognosis when treated for a longer rather than a shorter period. If patients scored at least moderately on psychosocial functioning, the reverse effect resulted in the good outcome increasing with shorter treatment. The advantage of longer treatment for outcome was stronger for younger patients with poor social adjustment than for older patients, whereas for older patients with good psychosocial functioning the advantage of shorter treatment was stronger than for younger patients.

The results of this study suggest that inpatient psychodynamic treatment should have a duration of at least 8 to 12 weeks, whereas a longer treatment for older patients older than 40 years could be beneficial. Further treatment extensions should be based on individual cases as well as on the course of improvement. The decision for further inpatient or outpatient treatment should not be independent of patient status at point of discharge. Rather, new and specified treatment methods should be developed. The results of the medium-term course of eating disorders (Kordy et al., in press) suggest an increased risk of relapse in the period immediately after hospitalization. This could be counteracted by a maintenance treatment. Booster therapies could be such an approach to reduce the rate of relapse that occurs a few months after discharge. Stepwise care provision could serve as a guiding principle for the development of a comprehensive treatment strategy (Royal College of Psychiatrists, 1992). Experiences with such strategic approaches are positive in those countries that do not separate inpatient and outpatient treatment as strictly as is the custom in Germany.

Treatment duration in interaction with psychosocial functioning seems to be an indicator of outcome: The probability of a good outcome increased for those patients with good social adjustment. This effect was intensified in older patients and suggests that long treatment (i.e., long absence) has a reduced effect for patients with good social functioning, especially when those patients are married. However, this effect reverses for young patients with difficulties establishing relationships: They do not have these problems in a longer treatment.

Evaluation

This is an ambitious, high quality study which is the best attempt so far to demonstrate the value of intensive long-term treatments using naturalistic methods. Unfortunately, the study yielded little evidence that suggests that intensive psychotherapy for AN or BN might be of special value. The participation of such a large sample of hospitals in Germany, whilst an advantage in terms of statistical power, also limits possible conclusions. For example, the differences in patient mix between the hospitals limit the interpretation of the observed effect of the specialty level of the treatment. The possible bias for this factor alone or in association with the various clinical settings could not be adjusted with the propensity score method used because that would have required that all hospitals apply longer as well as shorter treatments.

Of note for the findings regarding treatment length is the range that was used in this study: The treatments investigated run from 5 to approximately 16 weeks. Treatments shorter than 5 weeks were excluded from the analyses because it was uncertain to what extent the duration was intended and what proportion could be attributed to dropouts. Treatments longer than 16 weeks were not found frequently enough to justify inclusion. Furthermore, the possible effect of

many variables not included in the model remained unobserved (e.g., parameters for the course of illness not included in this study, further characteristics of the hospitals, and parameters for the treatment program). Other possible factors within the follow-up period, such as the effect of further outpatient treatment or critically decisive life events, were not included in this study and thus limit generalization.

The significance of childhood neurosis for adult mental health: A follow-up study

- Waldron, S., Shrier, D. K., Stone, B., & al. (1975). School phobia and other neuroses: a systematic study of the children and their families. *American Journal of Psychiatry*, 132, 802-808.

This long-term follow-up study of neurotic children in general focused on children with school phobia because of the evidence that impairment continues into adolescence, while the symptom itself tends to remit during childhood with most short-term therapies. Therefore, extensive psychotherapy for this condition would ordinarily be indicated only if the long-term prognosis were unfavourable.

Sample

The mental health of 42 young adults who had suffered from a neurosis in childhood was compared with that of 20 control subjects. A child psychiatrist screened the charts of all patients under 13 who were first evaluated at the researchers' clinic between 1955 and 1962 (N=627). Using the classification of psychopathological disorders in childhood of the Group for the Advancement of Psychiatry (Group for the Advancement of Psychiatry, 1966), it was possible to differentiate between those children who suffered from neurotic disorders or other milder conditions (e.g., reactive disorders or developmental disturbances) and the sicker children. Those who had experienced a school phobia were identified from among the neurotic group. Criteria of classification were first refined in a pilot series of charts, resulting in excellent interrater reliability.

Two-thirds of the over 600 children were considered sicker than neurotic and excluded from further study. Forty-five of the 203 neurotic children were identified as having had school phobia. A panel of 35 subjects was drawn up from the group with school phobia; this was the maximum number that could be studied. One other neurotic child was then matched to each of these children with school phobia on the basis of sex, age at referral, and year of referral to the clinic from the class that each child with school phobia was attending. The researchers were able to locate 91% of the study's 105 subjects, of whom two-thirds agreed to be interviewed. 24 phobic subjects, 18 subjects with other neuroses, and 20 controls were seen. Fifty-eight percent of the follow-up group were men. Most subjects were of middle- to lower- class origin. The subjects averaged 22 years old at follow-up; fewer than 5% were younger than 18.

Measures

The Menninger Clinic's Health-Sickness Rating (HSR) Scale (Luborsky, 1962; Luborsky & Bachrach, 1974), in which ratings are anchored to case descriptions, and the Current and Past Psychopathology Scales (CAPPS), a semi-structured clinical interview with rating scales developed by Endicott and Spitzer at Columbia University (Endicott & Spitzer, 1972) were used. Each time an individual was rated for severity of illness on the CAPPS, the case descriptions provided with the HSR scale were used, a rating on the 100-point HSR scale was given, then converted to the corresponding score for the severity of illness expressed in the 6-point scale. 4 subscales of this overall health-sickness rating were developed, reflecting different aspects of mental health and based upon the 7 subscales originally developed at the Menninger Clinic.

Reliability of the two psychiatrists conducting the follow-up interviews was monitored by independent ratings of an unselected sample of the tape recordings of interviews. Reliability was excellent for the various scales; for example, the most important judgment, the HSR score, showed an interclass correlation coefficient of .87 between the two raters. Neither interviewer had any knowledge of the old records or of the classification of the subject at the time of the interview, except as the subject revealed it himself in the course of the interview.

Results

Because there were so few differences between the 2 groups of former patients, the former patient group as a whole was compared with the control group for the remainder of the analysis.

There were striking differences in distribution of diagnosis and degree of illness at follow-up between the former patients as a whole and the control group.

Table 1. Health sickness ratings and diagnosis at follow-up of 42 former patients (FP) and 20 Control Subjects (C)

| Health-sickness rating* | No specific diagnosis | | Neurosis** | | P.D. | | Psychosis | | Total | | Percent | |
|-------------------------|-----------------------|----|------------|---|------|---|-----------|---|-------|----|---------|----|
| | FP | C | FP | C | FP | C | FP | C | FP | C | FP | C |
| 1: None | 1 | 10 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 10 | 2 | 50 |
| 2: Minimal | 9 | 7 | 0 | 0 | 0 | 0 | 0 | 0 | 9 | 7 | 21 | 35 |
| 3: Mild | 11 | 2 | 1 | 0 | 1 | 0 | 0 | 0 | 13 | 2 | 31 | 10 |
| 4: Moderate | 4 | 1 | 7 | 0 | 3 | 0 | 0 | 0 | 14 | 1 | 33 | 5 |
| 5: Severe | 0 | 0 | 1 | 0 | 2 | 0 | 2 | 0 | 5 | 0 | 12 | 0 |
| 6: Extreme | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total no.% | 25 | 20 | 9 | 0 | 6 | 0 | 2 | 0 | 42 | 20 | - | - |

* HSR scores on the 6-point scale correspond to the original 100-point scale as follows: 1=86-100, 2=76-85, 3=66-75, 4=51-65, 5=26-50, 6=0-25.

** The numbers for the neurosis have been corrected for computer overdiagnosis of phobic neurosis when the clinical picture did not warrant this specific diagnosis.

40% of the former patients, but none of the controls, received specific diagnoses from the computer program ($p < .01$, chi square analysis). Twenty-one percent of the former patients were diagnosed as having specific neurosis, (Four suffered from depressive neurosis; 2 from hysterical neurosis, conversion type; 1 from phobic neurosis; 1 from anxiety neurosis; and 1 from obsessive-compulsion neurosis.) 14% as having a personality disorder including drug dependence, and 5% as being psychotic, although neither of these 2 patients had ever been hospitalized. Thus a wide range of psychopathology was found in the former patients. The HSR scales showed an even more striking difference between the former patients and the controls: more than 75% of the former patients were at least mildly ill, compared to only 15% of the controls ($p = .001$).

The relationship between the nature and degree of illness of the 2 groups can be summarized as follows: 64% of the former patients were mildly to moderately ill, predominantly with a neurosis or character disorder, while another 12% were severely ill, predominantly with a personality disorder or psychosis. In contrast, only 15% of the control subjects were mildly to moderately ill, all with character disorders. None of the controls was more severely ill.

We were also interested in which of the different aspects of mental health was impaired. The data in table 2 demonstrate that the former patients were quite impaired in severity of their symptoms and in their interpersonal relationships and less impaired occupationally and in breadth of their interests. In all aspects they were substantially less healthy than the control subjects.

Table 2. Percent of former patients and control subjects with more than minimal impairment on the HSR Scale and Subscales

| Item | Former patients (n=42) | Control subjects (n=20) | Significance* |
|------------------------------|---------------------------|----------------------------|---------------|
| Overall HSR | 76 | 15 | p<.001 |
| Occupational role | 48 | 5 | p<.001 |
| Interpersonal relationships | 79 | 25 | p<.001 |
| Severity of symptoms | 74 | 20 | p<.001 |
| Breadth & depth of interests | 52 | 10 | p<.01 |

* Significance was determined by analysis of variance over entire 6-point range (Student's t test).

Evaluation

No patient received adequate treatment by psychoanalytic standards. If the treatment received resulted in some improvement for some of these children, then without intervention the former patients would have been, if anything, sicker. Thus this study's findings make necessary the conclusion that these children need effective treatment. This study is consistent with other less thoroughly psychoanalytically informed investigations that reported enduring psychological problems in adulthood for children diagnosed as anxiety disordered (Champion, Goodall, & Rutter, 1995; Cohen, Cohen, & Brook, 1993; Cohen, Cohen, Kasen et al., 1993). Thus, while ordinary psychiatric treatment cannot prevent the relatively poor adult outcomes of severe phobic disorder, whether child psychoanalysis can achieve this remains an unanswered question.

Anna Freud Centre studies 3: The long-term follow-up of child analytic treatments (AFC3)

- Fonagy, P. & Target, M. (1998). The outcome of psychodynamic therapy: the work of the Anna Freud Centre. Invited public lecture, London, England, September 1998.
- Target, M. & Fonagy, P. (1998). The long-term follow-up of child psychoanalysis. Paper presented at the Vulnerable Child Symposium at the American Psychoanalytic Association, Toronto, Canada, May 1998.

This is an ongoing follow-up study asking the simple question of whether psychoanalytic treatment in childhood enhances adult functioning. The epidemiological background for this study is provided by the growing recognition that children do not grow out of either emotional or behavioural disorder. The adult outcome may not be overt pathology alone but may manifest as poor planning, inadequate sexual relationships, absence of social support, low self-esteem, the persistence of trauma, insecure attachments and adverse life events. From a psychoanalytic point of view, this may be explained as indicating continuities in the representational system. The question is whether psychoanalytic intervention in childhood functions as a protector?

A fascinating recent study from Professor Sir Michael Rutter and his colleagues reported a 20 year follow-up of over 200 individuals half of whom had childhood disturbance aged 10-11. Measures of psychosocial functioning included a life events schedule, a measure of the quality of planning, particularly during life transitions, adult personality functioning and adult psychiatric diagnoses. The key finding of the project was that childhood psychiatric disturbance was associated with an increasing frequency of severe negative life events during adulthood. These could not be seen as the consequences of adult psychiatric disorder, or continued contact with the family of origin, nor could they be simply discounted as brought on himself by the individual (e.g. divorce may be considered self-induced but loss of employment consequent upon the closing of a factory is hard to conceive of in this way). It is more likely that the psychological sequelae of childhood psychiatric disturbance (such as poor planning or a handicap in understanding minds) leads these individuals into more than usually risky life situations. This, in turn, increases the probability of encountering negative life events. The question the present study addresses was if therapy in childhood has the capacity to reduce such risks. Clearly, such protective effects would only be expected from interventions which had been relatively successful in childhood.

Sample

Four groups are being recruited for this study: (a) those who received intensive psychoanalytic treatment; (b) those who received once (or twice) weekly psychotherapy; (c) the siblings of the treated groups (in order to control for the effect of shared family environment) and (d) a matched group whose disorder was untreated in childhood. Subjects are mostly young adults between 24 and 35 and individuals whose diagnosis was too severe to permit evaluation using the instruments were excluded.

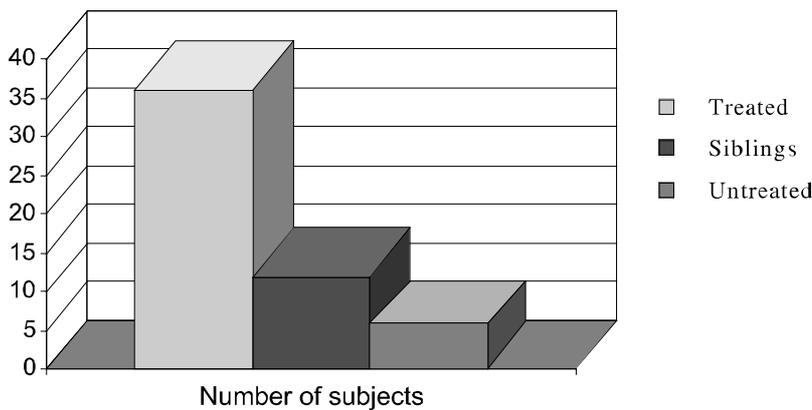
Measures

Three types of measures are used. First, and perhaps most central, in-depth interview based objective measures of life-events, transitions and plans, current personality functioning, psychiatric and personality disorder diagnosis. Second, self report measures of symptomatology (SCL-90), physical health (SF-36), IQ (NART), personality (EPQ) etc. And third, psychodynamic measures of attachment and internal representations of object relationships which provide relatively reliable data concerning the quality of object relationships, the coherence of object representations, expectations concerning other's behaviour, morality, perspective taking, hostility and mentalizing capacity.

Preliminary results

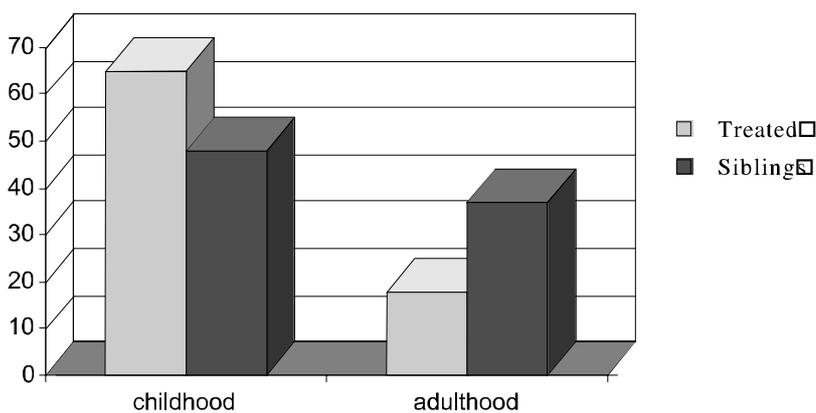
We are still in the middle of the study and results reported here are subject to modification as the sample accumulates. In particular, the difficulties in recruiting untreated subjects makes comparisons premature for this group. The researchers feel somewhat more confident of the comparisons between treated and untreated siblings and between treated subjects who achieved a clinically significant change and those whose therapeutic outcome in childhood was poor. Figure 1 displays the numbers of subjects traced thus far and on whom these preliminary results are based.

Figure 1: Subjects so far traced, interviewed and coded



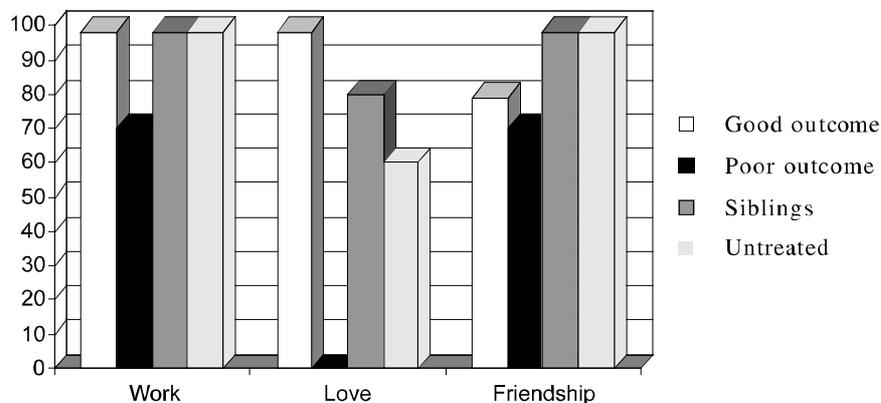
There is evidence to support the researchers' hypothesis that whilst in childhood the vast majority of treated subjects suffered significantly more adversity relative to their siblings, in adulthood the siblings were more likely to experience significant life events than the treated subjects (see Figure 2).

Figure 2: Severe adversity in childhood and adulthood for treated subjects and siblings



In terms of personality functioning, in the work domain all groups in the current sample with the exception of those whose childhood outcome was poor are doing well. In the love relationship domain, individuals with successfully treated psychiatric disorders in childhood appeared to be doing somewhat better than their siblings or the untreated controls. However, none of those unsuccessfully treated in childhood appears to have an adequate love relationship. In terms of friendships, even those successfully treated appear to be somewhat disadvantaged relative to their siblings (see Figure 3).

Figure 3: Good personality functioning in three domains across treated patients with both good and poor outcome, siblings and untreated controls



In terms of attachment security, those children whose outcome was relatively good appear to do as well as their siblings in terms of the likelihood of secure attachment. Those unsuccessfully treated appear to be predominantly preoccupied and entangled, whereas those untreated appear to be predominantly dismissing (see Figures 4, 5 & 6 which display 3-way and 5-way attachment classifications and examine the 3-way classification by therapeutic result respectively).

Figure 4: 3-way attachment classification for treated group, siblings and untreated group

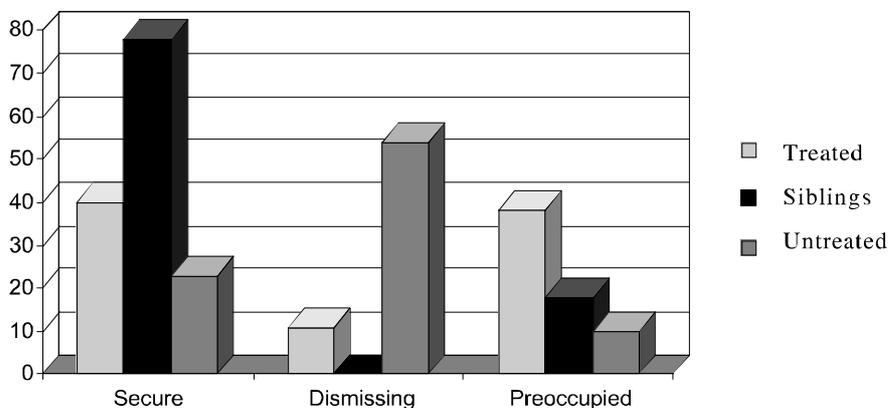


Figure 5: 5-way attachment classification for treated group, siblings and untreated group

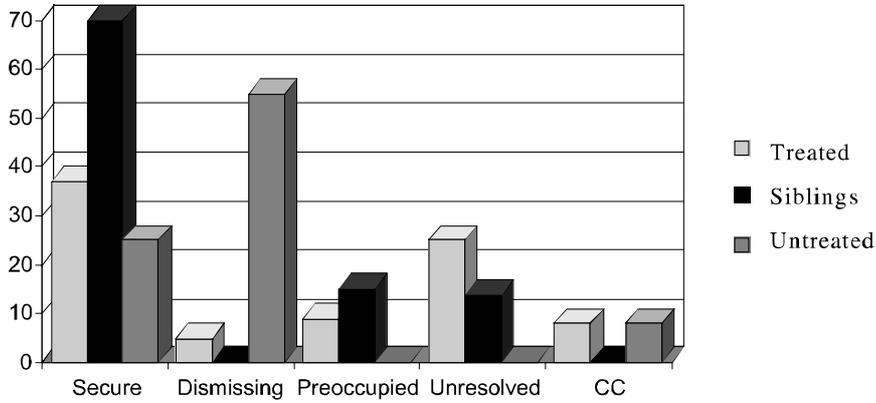
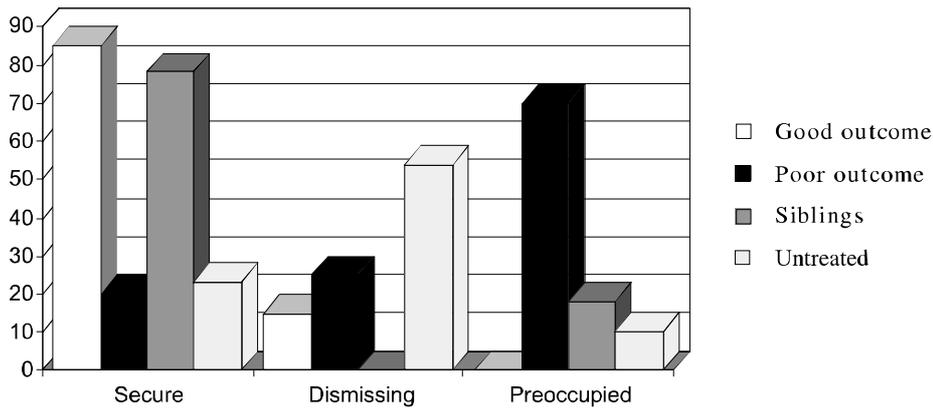
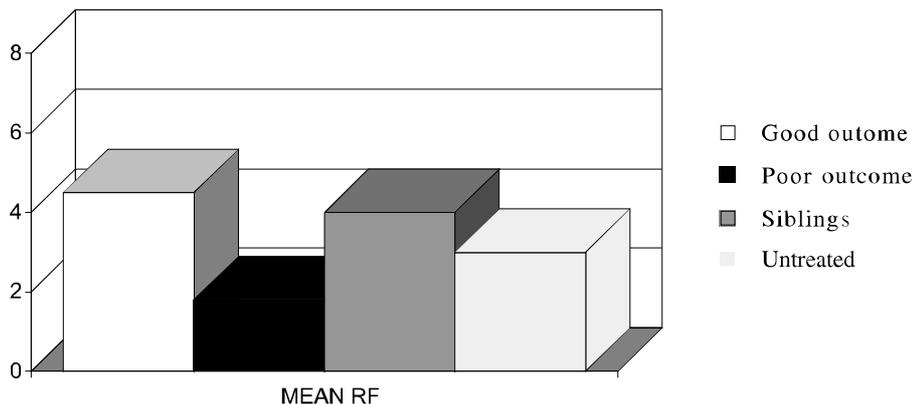


Figure 6: 3-way attachment classification for good outcome and poor outcome: treated groups, siblings and untreated group



In terms of the capacity to mentalise, to reflect on mental states, as predicted, the successfully treated group does somewhat better than all the others, whereas those whose outcome was poor in childhood appear to remain unable to conceive of mental states accurately (see Figure 7).

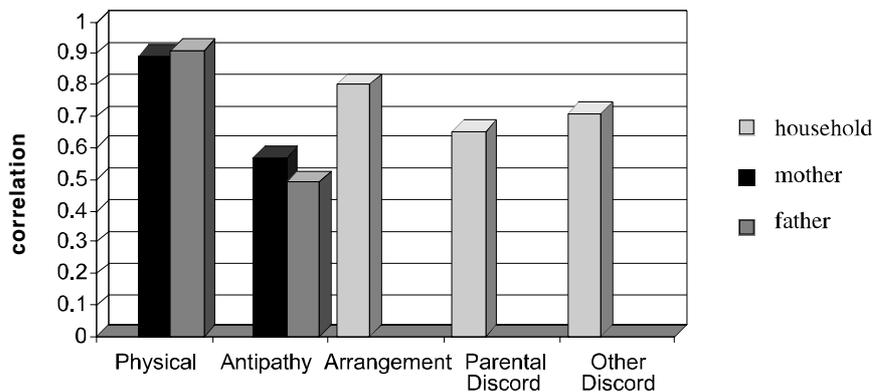
Figure 7: Mean reflective function in good and poor outcome treated groups, siblings and untreated controls



In brief, successful childhood treatment does appear to be somewhat of a protective factor, although perhaps less dramatically so than it might have been hoped. However, where treatment was unsuccessful, this seems to represent a risk factor, with unsuccessfully treated individuals perhaps even worse off than those whose disorders were untreated. It should be borne in mind that the samples are as yet small and further interviews may yield quite different observations.

As part of this study the researchers were able to make a number of other preliminary observations of some interest. For example, they were able to compare the information about childhood gained from these retrospective interviews with the original observations carefully recorded by clinicians under Anna Freud's supervision. It seems that the agreement in recall between case-files and adult recollection was relatively high, particularly for physical abuse and discord in the parental relationship (see Figure 8).

Figure 8: Agreement between ratings of case files and childhood experience of care and abuse interview (CECA)



Ratings also matched case-files in terms of the extent to which childhood experiences were regarded as loving, rejecting, pressuring or involving. Thus it may be concluded, with respect to the current controversy concerning the accuracy of childhood memories, that these are at least factually broadly reliable.

Is there evidence that the forgetting (repression) of adverse experience is associated with psychopathology or poor personality functioning? It seems that individuals who are better functioning remember somewhat less well: their recollections are coherent but slightly idealising. They appear to smooth over or forget reporting adverse experiences noted at the time of their assessment. It seems their memory problems arise less from simple forgetting than the reinterpretation of negative experiences as positive. The question arises, if it is sensible to approach psychological therapy by helping people to remember, when relatively good functioning seems to be associated with the capacity to forget.

A further interesting unanticipated observation was that actual trauma remembered clearly in adulthood and claimed never to have been forgotten was nonetheless often not recognised by clinicians working 10-20 years ago. Some of the poor long-term outcome may be associated with therapists interpreting these children's reports as fantasy and these individuals repeating such traumata in later development. Perhaps it is not surprising that such individuals remained preoccupied, entangled in their childhood experiences, with their traumatic experiences unresolved, their psychiatric functioning is less than optimal and they are unable to adapt to either work or social situations.

A further observation related long-term outcome to technique. Which therapeutic techniques proved to be effective in the long term? Again speaking broadly, it seems that traumatised borderline children are not substantially helped by interpretations of conflict, Oedipal or pre-Oedipal. More simple therapeutic interventions, focussing on the elaboration of the child's current mental state, either with regard to the therapeutic situation or the child's current life appeared to be far more effective for these childhood problems. Focussing on the child's emotional life, his unformulated but perhaps frightening thoughts and fantasies, appeared to bear the richest therapeutic fruit.

Evaluation

This is an interesting study with an unusually thorough assessments of adult functioning. The small current samples makes the findings reported here highly preliminary and subject to change. The findings, if they are confirmed by a fuller review of untreated patients, indicate that children who receive psychotherapy are better off in the long-term than those who are not able to have access to this intervention. As these groups could only be matched retrospectively, these results remain suggestive rather than conclusive.

Saarland Study of Psychotherapy Effectiveness and Patient Satisfaction

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Background

The study presented here is a replication study of the US survey on the satisfaction of patients with their treatment that was conducted by Martin Seligman in 1994 on instruction of *Consumer Reports*. Just like the study of Seligman, this investigation aims to prove the effectiveness of psychotherapeutic treatments *in the field*, whereby the researchers are particularly interested in its dependence on specific psychotherapeutic orientations (above all psychoanalysis, psychodynamic psychotherapy, behavior therapy, client-centered therapy) and on treatment duration. Additionally, the effectiveness of psychotherapeutic treatment is to be compared to other ways of treating mental disorders (family doctor's treatment, pharmacological treatment, self-treatment in self-help groups). Thereby, the question of effectiveness is to be answered solely from the subjective perspective of the patients. In order to determine effectiveness, the researchers took the dimensions of effectiveness of the CR-study (Seligman, 1995) as a basis: 1. specific improvement of the problem that led the patient to therapy, 2. satisfaction with treatment, 3. global improvement of the overall emotional state.

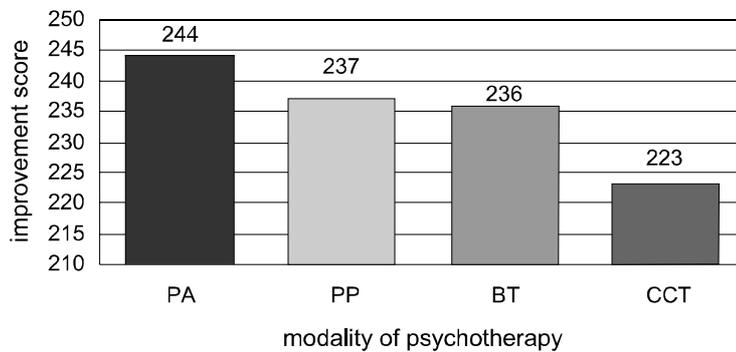
Sample and measures

To collect the data, the original *Consumer Reports* questionnaire was used. After having received the right of user, the questionnaire was translated by a native speaker and was adapted to German standards if required. The nationwide distribution of the questionnaire was carried out by the *Stiftung Warentest*, by different psychotherapeutic associations and via the internet. From June 1st, 2000 to February 28th, 2001, a total of 1621 questionnaires were received, of which 1506 have been included in the study; 115 questionnaires had to be left out for different reasons. Since the socio-demographic characteristics of the subjects of the sample correspond to the characteristics of psychotherapeutic patients in Germany as described in literature (see also Franz, 1997; Scheidt et al., 1998; Ruger & Leibing, 1999), the researchers were able to proceed from a relatively representative selection of their sample.

Results

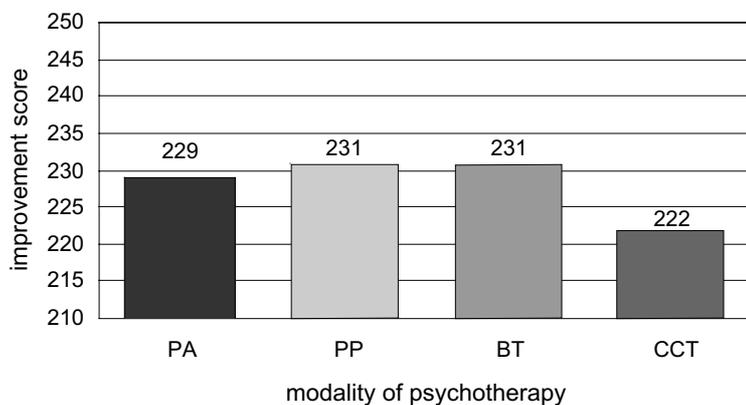
Taking the dimensions of effectiveness mentioned above, the researchers used the same method as in the *Consumer Reports*-study to determine a global scale for effectiveness. This scale ranges from 0 to 300; 300 meaning a maximum of therapeutic effectiveness, 150 meaning no effectiveness at all, and values below 150 indicating a negative effectiveness in the sense of an increase of psychic complaints in the course of the treatment.

The first analysis of the data refers only to psychotherapeutic treatments and does not consider treatments by family doctors and self-help groups. The results are as follows:

Figure 1: Effectiveness of psychotherapy

Preliminary calculations detect a statistically significant difference between psychoanalysis (PA) and the other forms of treatment. Also, there is a significant difference between psychodynamic psychotherapy (PP) respectively behavior therapy (BT) and client-centered psychotherapy (CCT). The effectiveness of behavior therapy and psychodynamic psychotherapy is on the same level.

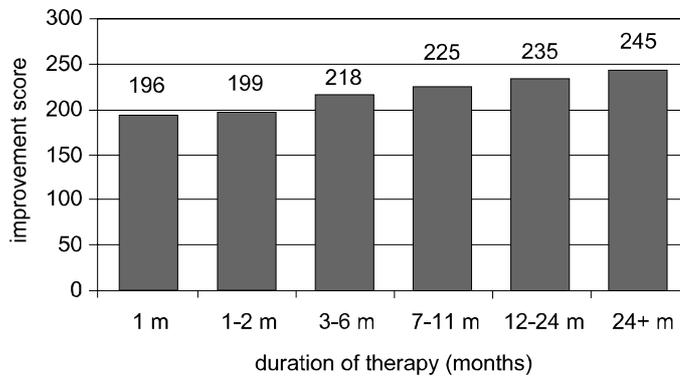
However, there is good reason to suppose that the differences in effectiveness essentially cannot be attributed to the therapeutic orientation, but to the duration of the treatment. The majority of psychoanalytic patients have been treated for more than 2 years, whereas an equally high share of the treatments in behavior therapy lasted less than 2 years. A comparison of the patients whose treatment lasted less than 2 years, testifies to this assumption:

Figure 2: Effectiveness of treatments with a duration of less than 2 years

At the same time, the marginal differences in effectiveness did not reach a level of significance.

The distinct influence of treatment duration onto treatment outcome can be seen when taking a look at the effectiveness (considering all therapeutic orientations) as a function of length of treatment:

Figure 3: Effectiveness in relation to treatment duration



The first statistically significant improvement of effectiveness shows from 7 months on, a second one from 1 year on, and another highly significant improvement shows from 2 years of therapeutic treatment on.

The preliminary results seem to correspond to the ones of the *Consumer Report*-study. Considering the present state of statistical analysis, though, differentiated statements cannot yet be made.

Evaluation

This replication in Germany identified a significant number of psychoanalytic treatments. The US consumer report included no psychoanalytic treatment. Like the original Consumer Reports study, which this project faithfully replicates, the study's strengths are also its greatest weaknesses. The methodology of the Consumer Report is controversial and the sample in this study is relatively small compared to the original survey. Using a retrospective self-report patient satisfaction questionnaire the authors were able to sample a large number of patients. However, without collecting data on those who did not return the questionnaire, it is impossible to know how representative this sample is. The sampling parameters are somewhat unclear. Simply comparing the socio-demographic characteristics with those of the general psychotherapy population is not sufficient. Furthermore, the validity of the retrospective report of treatment satisfaction needs to be confirmed using measures collected before, during, and immediately after the therapy, possibly collected on a representative subset of the whole sample. The results appear to be promising and favourable to long term intensive treatment.

Steißlingen survey of individual and group psychotherapy

- Heinzl, R., & Breyer, F. (1995). Stabile Besserung. *Deutsches Ärzteblatt*, 11, 752.
- Heinzl, R., Breyer, F., Klein, T. (1996). Ambulante Psychoanalyse in Deutschland. Eine katamnestiche Evaluationsstudie, Diskussionsbeiträge der Univ. Konstanz, März 1996.
- Heinzl, R., & Breyer, F. (1996). Katamnesenstudie belegt Wirksamkeit der analytischen Therapie. *Deutsches Ärzteblatt*, 11, 658.
- Heinzl, R., Breyer, F., Klein, T. (1998). Ambulante analytische Einzel- und Gruppenpsycho- therapie in einer bundesweiten katamnestiche Evaluationsstudie. *Z. Gruppenpsychotherapie und Gruppendynamik*, 34, 135-152.
- Breyer, F., Heinzl, R., Klein, T. (1997). Kosten und Nutzen ambulanter Psychoanalyse in Deutschland. (Cost and benefits of outpatient psychoanalytic therapy in Germany) *Gesundheitsökonomie und Qualitätsmanagement*, 2, 59-73.
- Dossmann, R., Kutter, P., Heinzl, R., & Wurmser, L. (1996). The Long-Term Benefits of .Intensive Psychotherapy. *Psychoanalytic Inquiry, Supplement*, 74-86.

Aim

Unlike many (clinical) outcome projects, this study was designed to measure and evaluate the effects of individual and group analytical psychotherapy performed in its most prevalent setting: outpatient treatment in the therapist's office. One specific goal of the inquiry was to determine the effectiveness of analytical psychotherapy in such a manner that its costs and benefits become more transparent for the general population of insured persons. The researchers were concerned with both the direct benefits in terms of an amelioration of the patient's health situation as well as with the indirect benefits in terms of an increase in gross national product due to savings on lost working time due to sick-leave. They did not propose to investigate how or by which means the effects of psychotherapy are achieved and for which symptoms and diagnoses it achieves the best results. Dührssen and Jorswieck (1965) have pointed out that for the verification of the effects of psychotherapy a distinction according to illness symptoms is hardly useful. Consequently, distinctions were only made between three basic psychoanalytic schools (Freud -Jung -Adler)

Design

A purely catamnestic and anonymous procedure was employed. Only after completing therapy (up to 5 years later) were patient and therapist asked to participate in a measurement of therapy success. Neither patient nor therapist can be identified by means of the data collected. Moreover, neither therapist nor researcher determined what indicated success in therapy; The indicators are oriented on the subjective assessments of the patients themselves: Finally, the general background of the inquiry is not an artificial experiment but a representative sampling of all long term psychoanalytic outpatient treatments conducted during the time frame 1990-1994.

Sample

From the membership lists of the DGPT (German Society for Psychoanalysis, Psychotherapy, Psychosomatics and Depth Psychology-comprises both Freudian and Jungian psychotherapists) and the DGIP (German Society for Individual Psychology-Adlerians) a 20% random sample was taken. The questionnaire was then sent to the selected (medical, psychological and lay) psychotherapists asking them to send it on to all of their former patients who had completed their therapy between January 1990 and December 1994. In order to differentiate the respondents according to (1) the analytical method employed in their therapy, (2) individual or group setting and (3) the basic analytical schools of their therapists (Freud, Jung, Adler), the therapists were asked to supply this supplemental information on a coded sheet (to insure anonymity) correlating

with a code number marked on the Individual patient's questionnaire. No actual names of patients or therapists appeared on the material returned to us. Out of 979 questionnaires sent to former patients, 666 were returned (68%); 633 of these were suitable for evaluation.

Instruments

Subjects were asked for self-assessment of their physical, mental, social and overall health status at three points in time: at the beginning and end of their therapy and at the time of assessment (up to five years after completing therapy). In order to assess the effects of therapies that took place in a natural setting patients were asked to rate on a 5-point scale their overall health condition, their physical and mental condition and their personal relationships. The patients themselves were allowed to decide, what they understood these categories to mean. In addition they were asked for their work-loss days and their utilisation of other health care services—(Schlesinger, Mumford, & Glass, 1980). In March 95 a report was given at the Deutsche Ärzteblatt (Heinzel & Breyer, 1995). Then a social scientist joined the project and tightened up the questionnaire on one A4 page. The structure of the questionnaire was as follows:

In addition to the particular data such as therapist code, duration of therapy, total number of sessions, method of therapy (individual or group), year of birth and sex; this questionnaire comprised the following questions pertaining to all three above-mentioned points in time. The first 4 questions contained a 5-point rating scale from 1 (very good) to 5 (very 'bad'). Intermediate values were not specified, so that evaluation on an interval level was impossible.

How was / how is your over-all health condition?
 How was / how is your physical health status?
 How was / how is your mental health status?
 How were / how are your relationships?

A further question about job activity was interpreted only descriptively.

Did you / do you take ... (1 = nothing, 5 = very much)
 a) medication for acute illness?
 b) long term medication for chronic illness?
 c) psychotropic medication? .

How often did you consult a physician (not including preventive check-ups) in the year prior to begin / end of therapy, time of assessment?
 a) general practitioner?
 b) a specialist?

Patients were asked to indicate the specific frequency (number of times).

How many days per year did (do) you take sick leave?
 How many days per year did (do) you stay in hospital?
 Did (do) you have any other therapy? (method... from... until...)

Results

On the basis of t-tests comparing responses to the questionnaire for before, during, and after therapy, it can be concluded that the patients consider their over-all condition, physical and mental health situation and their subjectively experienced relationships to be better at the completion of the therapy than at the beginning, and that this effect continued to improve in a

stable manner up to the time of the completion of the questionnaire. Improvements proved to be comparable irrespective of basic professions (medical, psychological, lay psychoanalyst) or the basic analytical schools (Freud, Jung, Adler). Among the aforementioned subgroups there were no significant differences in assessment of the effects of therapy. This finding corresponds with most of the therapy research studies referred to above. Like Mackenzie (1994), no difference in the effectiveness of individual and group therapies was found, though on average in the German health care system – as was the case in this data as well – group psychotherapy is allotted only half the number of treatment sessions available to individual psychotherapy (maximum 150:300).

When survey data for prescription drug consumption were analysed, a noticeable reduction was found especially in the case of psychotropic medication. However, the reduction is almost as strong with medication for acute illness, which shows the strongest long term effect. A possible interpretation of these results is that through therapy patients become less prone to getting sick and learn in their therapy to manage acute illness and disturbances of their overall physical and mental health more efficiently than in the past. A significant savings in other health care services can be seen with respect to visits to physicians as well as days in hospital. Especially interesting is a two-thirds decline in lost work days.

In general, hardly any difference between individual and group therapy is ascertainable apart from the somewhat better results of group therapy with respect to days in hospital and consultation of general practitioners. However, due to the small amount of explained variance, these differences do not seem significant. Due to the lower costs of group therapy compared to individual therapy (individual to group fee relationship 1:3, number of sessions allotted 2.4:1) and the calculated relationship of the cost savings (1:1.7) within an average time of two years after the end of the therapy, a calculation of the rentability leads to a total ratio of 1:13. This means that whereas individual therapy saves only one-quarter of its costs in this time-frame, group therapy save 3.3 times its costs.

Evaluation

This study addresses the interesting question of the satisfaction level and health care utilization of patients treated with individual and group psychotherapy. Despite its large sample size, the study is severely limited by the sampling bias inherent in a anonymous questionnaire (return rate of 65%) and a retrospective self-report measure. More work needs to be done to verify that those patients who returned the questionnaire are not significantly different from those who did not, as well to compare self-report measures of psychological health and health care utilization against more objective measures. Finally, better statistical procedures are needed for studying pre-, during, and post- measures without the confounds of regression to the mean and initial value bias.

IPTAR study of the effectiveness of psychoanalytic psychotherapy

- Freedman, N., Hoffenberg, J. D., Vorus, N., & Frosch, A. (1999). The effectiveness of psychoanalytic psychotherapy: The role of treatment duration, frequency of sessions, and the therapeutic relationship. *Journal of the American Psychoanalytic Association*, 47, 741-772.
- Freedman, N. (1999). Report from Mid-Manhattan: The research program of the institute for Psychoanalytic Training and Research (IPTAR). Paper presented at the Psychoanalyses and Psychoanalytic Long-term Therapies International Conference, University of Hamburg, October 21-24, 1999.

Background

This study was built in the image of the Consumer Reports study (Seligman, 1995) as a way to use self-report to measure treatment outcome in the IPTAR Clinical Center (ICC). The roles of treatment duration, frequency of session, and the therapeutic relationship were studied in determining treatment effectiveness. The questionnaire and scoring methodology of the Consumer Reports study were used for this purpose. This study aims to go beyond a mere replication by applying the measures exclusively to patients in psychoanalytic psychotherapy and by treating the data in a manner specifically responsive to issues of concern to psychoanalysts and psychoanalytic patients.

Aims

This study was guided by a series of questions:

- What is the impact of treatment exposure (i.e., duration) on treatment outcome?
- What is the impact of session frequency on treatment outcome?
- What is the role of both duration and frequency on the evolving treatment relationship?
- Is there an interaction among clinical syndrome, duration, frequency, and outcome?

Method

The study was a survey of patient satisfaction and treatment in psychoanalytic psychotherapy. All patients of the ICC, past and current, were contacted by letter and asked to participate in a study of the effectiveness of the psychotherapy they had received at the ICC. Patients who agreed were sent the Consumer Reports Effectiveness Questionnaire (EQ). Two hundred forty questionnaires were sent and 99 returned (41%). Therapists were in no way involved in this process.

Sample

The sample for the study consisted of 99 patients drawn from the total patient population of the ICC. Comparisons reveal that these patients were indistinguishable from the overall clinic patient census for 1996 (n=97). Patients were predominantly female, under 35 years old, single, college-educated, and English speaking. Initial diagnostic impressions included dysthymic reactions, anxiety reactions, adjustment and personality disorders, as well as substance abuse problems, and in small numbers, more severe pathology. Twenty-eight percent of patients in the study were on psychopharmacological medication, largely antidepressants.

Treatment

The research was conducted under the auspices of the IPTAR Clinical Center (ICC) established in 1993 to serve a population in need by unable to afford ongoing psychological services. It is a community-oriented mental health center whose goal is to maintain the treatment of every patient accepted to its natural completion without regard to financial considerations. The ICC is a low-cost facility and most treatment is paid for out of pocket, without third-party payments. Duration

of treatment in the study sample ranged from one month to over two years with 38% in treatment from one to two years, and 21% over two years. Fifty-five percent of the sample was seen once a week, 32% twice a week, and 8% three times a week.

Measures

The Effectiveness Questionnaire (EQ) consists of twenty-eight items asking patients to identify the problems that brought them into treatment, quality of the treatment setting (frequency and duration), attitudes toward their therapist, and perceptions of the outcome of their treatment. The EQ is a shortened version of the questionnaire developed by *Consumer Reports* and is used with their permission and their scoring system.

The major outcome variable of the EQ is the effectiveness score, which is subdivided into three 0-100 scales: specific improvement (how much the therapy helped the respondent with “the problems that led me to therapy”), satisfaction with one’s therapist, and global improvement (how respondents felt at the time of the survey, compared with how they felt when they began treatment). A second outcome variable, index of adaptive life gains, was calculated from the EQ to assess gains in concrete aspects of living. Data from symptoms described on the questionnaire were factor analysed to reveal five orthogonal factors: (1) eating disorders, (2) anxiety, (3) depression, (4) family disorganization, and (5) stress. Finally, items on the EQ descriptive of patients’ perception of and experience with their therapist were used to calculate a positive relationship index (PRI), negative relationship index (NRI), and together an optimal relationship index (ORI).

Results

Duration

Treatment duration was significantly correlated with self-report of effectiveness ($r=.28$, $p<.005$). When treatment length was subdivided into four groups, ANOVA revealed an incremental relationship between treatment length and effectiveness (see Figure 1).

Figure 1

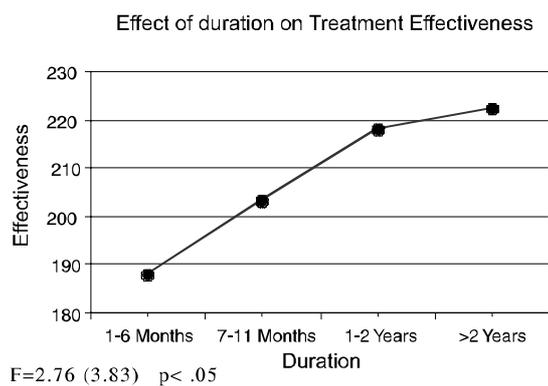
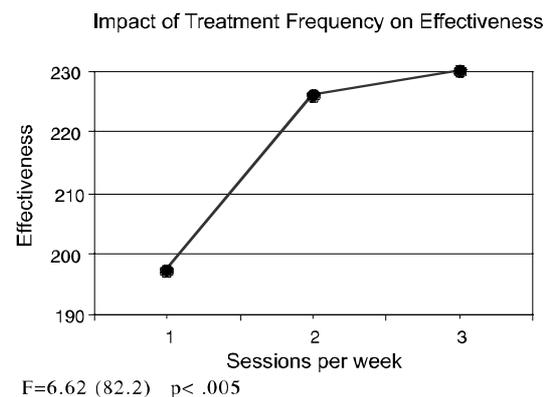


Figure 2



Session frequency

ANOVA also revealed a significant relationship between frequency of treatment and self-report of effectiveness. Post-hoc tests showed that this difference was significant between once a week and greater than once a week groups, but not between twice and three times a week (see Figure 2). Multiple linear regression analyses suggested that the effects of duration and frequency were independently significant.

Treatment relationship

Significant correlations were found between all three relationship measures and overall effectiveness: PRI ($r=.56$, $p<.001$), NRI ($r=.26$, $p<.01$), ORI ($r=.47$, $p<.001$). Since the PRI correlation is largest, the authors interpret these results to mean that a patient experience of a positive relationship with the therapist is related to effectiveness. A regression model designed to predict effectiveness based on duration, frequency, and quality of relationship found frequency and quality of relationship to be significant predictors accounting for over a third of the variance ($F=23.1$, $p<.0001$, $R^2=.36$).

Interplay between clinical syndrome and treatment conditions

When subjects were subdivided into five groups by clinical syndrome (eating disorders, anxiety, depression, family disorganization, and stress), differential relationships were found between frequency, duration, and effectiveness in each of these groups. Frequency was significantly related to effectiveness only in eating disordered and anxiety patients, while duration was related to effectiveness in patients most troubled by family disorganization and stress (see Table 1).

Table 1. Relationship between frequency, duration and effectiveness by clinical syndrome

| Effect by factor | Frequency | Duration |
|--------------------------|----------------|----------------|
| Overall | $r= .29^{***}$ | $r= .28^{***}$ |
| 1 Eating disorders | $r= .51^*$ | $r= .09$ |
| 2 Anxiety | $r= .57^{**}$ | $r= .14$ |
| 3 Depression | $r= .25$ | $r= .22$ |
| 4 Family disorganization | $r= .17$ | $r= .44$ |
| 5 Stress | $r= .07$ | $r= .49^{**}$ |

*= $p<.05$; **= $p<.01$; ***= $p<.005$

Evaluation

This study makes impressive use of a modified version of the *Consumer Reports* questionnaire, showing that treatment duration, frequency, and patient retrospective report of therapeutic relationship are related to self-report of treatment effectiveness. The study also attempts to distinguish these trends among patients with different clinical syndromes. Like all such retrospective studies, though, the findings are limited by self-selection of the sample population, and the self-report and retrospective nature of the ratings. The authors should be commended for their use of a “recall validation” procedure, comparing patient recall of a session with the actual audiotape of that session.

The Boston Psychotherapy Study of Schizophrenia (BPSS)

- Stanton, A. H., Gunderson, J. G., Knapp, P. H., Vancelli, M. L., Schnitzer, R., & Rosenthal, R. (1984). Effects of psychotherapy in schizophrenia: I. Design and implementation of a controlled study. *Schizophrenia Bulletin*, 10, 520-563.

This was a random allocation controlled study of schizophrenic patients who were offered either supportive psychodynamic psychotherapy or expressive psychodynamic psychotherapy.

Sample

The patient group was a recently hospitalised non-chronic group with diagnoses of schizophrenia.

Treatment

Therapists were all psychoanalytically oriented. Those patients in supportive therapy were offered help oriented towards coping with problems of daily living. Those receiving expressive therapy were oriented towards an integration and understanding of the meaning of their psychosis. Therapies were carried out over two years and patients were maintained on medication.

Results

Supportive therapy appeared to be significantly more helpful on measures such as relapse and the number of days in employment. The expressive group achieved better results in terms of ego functioning and cognitive improvement. Skill at dynamic exploration as assessed in independent ratings, was associated with greater reduction in global psychopathology, less denial of illness and less apathy. The 31% of patients who remained in their assigned therapy were observed to have the best outcomes at two years. It is, however, unclear if this result is not simply a reflection of the superior adaptive and interpersonal capacities required to maintain therapeutic contacts in the long term.

Evaluation

This is an important well-conducted study although it suffers from a lack of manualization of treatments and this type of therapy places exceptionally high demands on therapeutic skill. It is one of the studies to draw attention to the inadequacy of the supportive-expressive dimension in psychotherapy research.

Anna Freud Centre studies 1: The work on juvenile-onset insulin dependent diabetes (AFC1)

- Fonagy, P., Moran, G.S. (1990). Studies of the efficacy of child psychoanalysis. *Journal of Consulting and Clinical Psychology, 58*, 684-695
- Moran, G.S., Fonagy, P. (1987). Psychoanalysis and diabetic control: A single-case study. *British Journal of Medical Psychology, 60*, 357-372
- Moran, G., Fonagy, P., Kurtz, A., Bolton, A., & Brook, C. (1991). A controlled study of the psychoanalytic treatment of brittle diabetes. *Journal of the American Academy of Child and Adolescent Psychiatry, 30*, 926-935.

This series of studies aimed to establish the relevance of psychoanalytic psychotherapy for children and adolescents with insulin dependent diabetes mellitus who had chronic and pervasive difficulties in maintaining diabetic control.

Sample

Twenty two children and adolescents hospitalised for poorly controlled diabetes, mostly with episodes of hyperglycaemia, were allocated to one of two clinical units on the basis of their home address. The patients were offered comparable medical interventions and were well-matched on demographic and clinical variables.

Treatment

Patients assigned to one of the two units were offered psychoanalytic psychotherapy three to four times per week for relatively brief periods, initially on an inpatient basis. The therapy was carried out by experienced qualified clinicians working with an Anna Freudian orientation. The focus of the therapy was explicitly the patient's developmental emotional conflicts rather than specific conflicts over the diabetes and its management.

Measures

Therapeutic outcome was assessed in terms of hospitalisations, levels of diabetic control (HbA1c) and growth.

Results

There were clinically significant improvements in diabetic control in the psycho-analytically treated group. HbA1c levels were significantly lower at termination in the experimental group and these improvements were maintained on follow-up. By contrast, improvements observed in the group who benefited only from medical intervention, tended to dissipate by 3 months after discharge (see Fig 1).

Figure 1: HbA_{1c} Levels at admission and at 3 and 12 month follow-up for psychotherapy and comparison groups

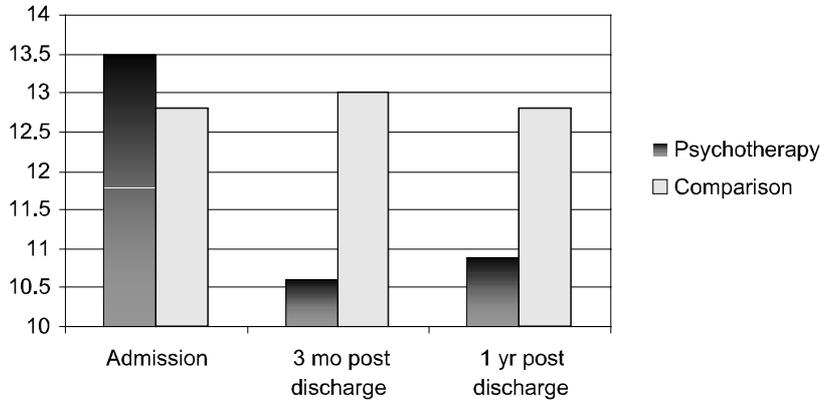


Figure 2: Changes in HbA_{1c} for psychotherapy and comparison groups

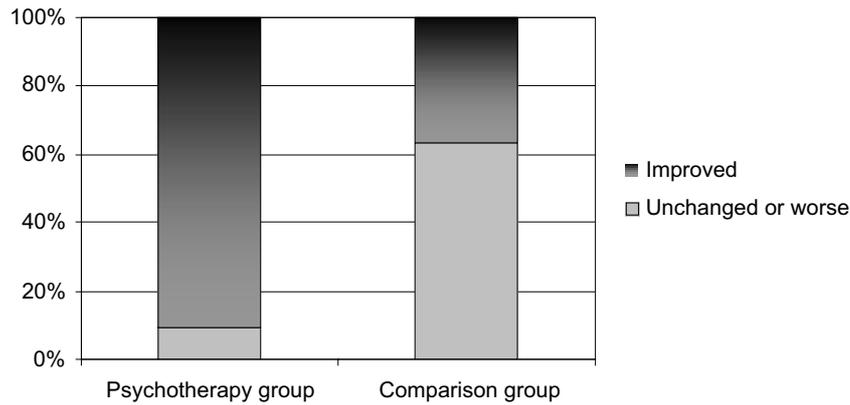
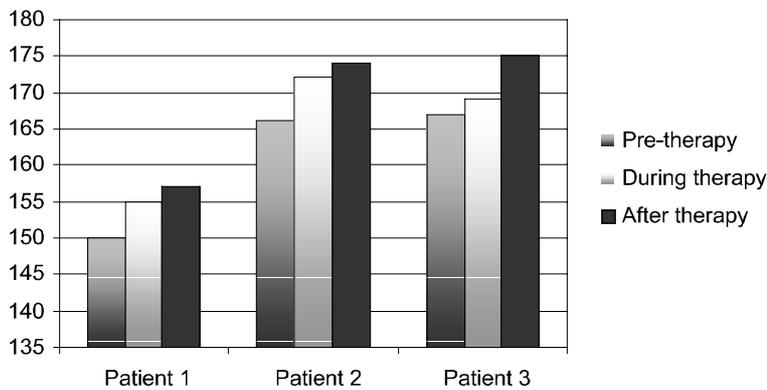


Figure 3: Predicted adult height of patients based on height and bone age



All but one of the psychotherapeutically treated patients showed clinically significant changes but only three of the 11 in the comparison group (see Fig 2). There was also a reduction in hospitalisation during the follow-up period in the psychoanalytically treated group.

Two spin-off studies were also reported. Moran and Fonagy (1987) reported that changes in metabolic control were closely associated in time with the analytic material as reported by the therapist. In general the emergence of manifest anxiety in the session associated with psychic conflict preceded improvements in diabetic control by about two weeks.

The second study reported (in Fonagy and Moran 1990) was a small series of three experimental single case studies. The original sample included three children (one girl and two boys) with significant growth retardation (height below the 5th percentile for age). Growth rate was carefully monitored for all these children. After a randomly determined time period the children entered psychoanalytic psychotherapy. Improvements in growth rate were observed in all three cases associated with the commencement of therapy, although these were more marked in children who were younger at the time of undertaking psychotherapeutic treatment (see Fig 3). In the case of one boy an increase of over 10cm was observed in the predicted adult height.

Evaluation

This promising series of studies suffers from an absence of replication, absence of placebo control, small sample size, unmatched length of hospitalisation and the absence of psychological measures of treatment outcome (although measures used were non-reactive). The importance of the studies is enhanced by the known long-term complications associated with this condition and the relatively poor outcome associated with other treatment methods.

The Los Angeles study of developmental reading disorders (LAS)

- Heinicke, C. M. (1965). Frequency of psychotherapeutic session as a factor affecting the child's developmental status. *The Psychoanalytic Study of the Child*, 20, 2-98
- Heinicke, C. M., Ramsey-Klee, D. M. (1986). Outcome of child psychotherapy as a function of frequency of sessions. *Journal of the American Academy of Child Psychiatry* 25, 247-253

This is an unusual study in focusing on children with a specific developmental disability in reading. Psychodynamic measures were used to establish a dose-response relationship between the intensity of the psychoanalytic treatment and outcome.

Sample

Children aged 7-10 with developmental reading disorders were randomly assigned to one of three groups. All the children had been threatened with being held back at school.

Treatment

Treatment was one session per week or four sessions per week for two years or once a week for the first year and four times per week for the second. The therapy was strongly influenced by the ideas of Anna Freud.

Measures

Outcome was measured in terms of the referral problem (the child's reading level) and general academic performance together with a standardised psychoanalytic diagnostic profile, based on the work of Anna Freud.

Results

Children receiving more frequent therapy had better results. Children seen once a week showed a greater rate of improvement than their counterparts in the first year of treatment although they were about even by the second year. Children seen more frequently, however, showed a greater rate of improvement in reading in the year after the end of treatment and were characterised by being more flexible in their adaptation and having a greater capacity for relationships at both the end of treatment and in the year after the end of treatment. The more intensive treatment in the second year had a clear beneficial effect.

Evaluation

Although this study focuses on reading disorder, it is relevant to other groups given the close intertwining of behavioural and learning disturbances (Rutter, 1989). It uses objective measures and random assignment and the measures are both objective and service relevant. Diagnostic characteristics of the sample, however, are not well described and the therapy offered is not well specified.

Anna Freud Centre studies 5: Prospective study of the outcome of child psychoanalysis and psychotherapy (AFC5)

■ Target, M., March, J., Ensink, K., Fabricius, J., & Fonagy, P.

This study has completed its pilot phase, is expected to be the first random assignment, clinical trial comparing the effectiveness of psychoanalysis and other, more widely-practised forms of therapy for children. The investigation is focussed on children who have severe and complex emotional disorders, between 6 and 12 years of age. All of these children, like most of the more difficult cases seen in any child mental health service, will have concurrent disorders in addition to their anxiety or depressive symptoms, which are causing impairment across the different contexts of the child's life.

Method

Sample

The study aims to recruit 160 children, over a 2-3 year period, to a clinical trial of three manualised forms of therapy; psychoanalysis in comparison with once weekly psychotherapy, cognitive-behaviour therapy and 'treatment as usual' (whatever intervention would normally be arranged by the participating clinics). Child psychiatric status and social and emotional functioning will be comprehensively evaluated before, during and after treatment, and for two years following termination, using a range of validated measures. Special attention will be paid to possible differences between the treatments in specific, clinically important domains of child and family functioning, and to evidence of cost effectiveness.

Design

The selection of the most appropriate treatment and control conditions was complex. There are serious problems with establishing an untreated control group of referred children: the children would need to remain untreated for years, to provide a comparison with the long-term outcome of psychoanalysis. This is neither practically likely to be achieved, nor ethically acceptable, for a very disturbed group of children who have actually been referred for treatment. The inclusion of a non-referred control group (for comparison with the untreated outcome of these disorders) was considered. However, these children would not in fact be comparable to those with similar disorders who had been referred (it is very likely that severely disturbed, anxious children who have not been brought for treatment come from different families from those with similar symptoms whose parents are seeking help). A second problem is similar to that for a referred, untreated group: they might very well seek or be offered treatment during the period of the study, or the researchers might well feel ethically bound to encourage the parents to initiate a referral. The use of a treatment-as-usual control group is becoming popular in both adult and child studies of psychotherapy outcome (Roth & Fonagy, 1996). The disadvantage is that comparison is provided by a set of treatments which may vary a great deal. However, the advantage to the study is that because of limited resources, this group is likely to receive considerably less treatment, on average, than do children in the first three groups, allowing the normal outcome of clinic treatment to be monitored, or - in the case of families who receive minimal treatment for whatever reason - the course of these disorders with assessment but no extensive treatment.

Outcome measures

Some measures developed for the evaluation of each form of therapy, CBT and psychodynamic treatment, will be used to assess progress across all conditions. In addition, for some time the research team has been working to develop a set of appropriate outcome measures to get over a difficulty which faces all clinicians and researchers studying psychological treatments for

children: the fact that many of the existing measures fail to capture key aspects of children's problems and of the changes clinicians hope to see. There are standardised ways of describing psychiatric symptoms, such as checklists or structured interviews, but there are no detailed measures of social and developmental changes in normal and referred children of a kind which tap other aspects of child functioning, which may be a primary focus in psychoanalytic treatment. A vital part of the preparatory work for this child therapy outcome study has, therefore, been to put together a group of measures of child development and adjustment, and to validate them, first with non-referred children and currently with those presenting in clinical settings.

Having laid this groundwork, this outcome study will therefore use a group of assessments which look at global adjustment, aspects of attachment, social reasoning and understanding, and quality of relationships. These can be used alongside symptom measures, to give a broad and developmentally relevant picture of the child and of changes over the course of therapy. The measures are divided into five levels, all important in the assessment of child psychotherapy outcome: symptomatic or diagnostic; psychosocial adaptation; cognitive and emotional capacities which appear to underpin symptomatology and adaptation; relationships within the family and with peers; service use. The study will carefully monitor the costs of the treatment provided as well as any cost offset in the use of other services, concurrently or following therapy. A measure of child and parent satisfaction to assess the acceptability of each therapy to children and their carers will also be used.

Monitoring of treatment

Different therapists will administer the psychodynamic and CBT conditions, in order to ensure that all participating therapists have extensive training in, experience of and commitment to the psychotherapeutic approach which they are to practise. All psychodynamic therapists will treat at least one child in intensive and one in non-intensive therapy. Each therapist will, in addition, be trained on following the manual relevant to their therapeutic orientation, and on the use of the measure used for monitoring treatment process (the same measure will assess adherence to each of the manuals). These procedures are essential to ensure that the intended therapies have in fact been delivered, to look at dose-response effects and more generally to relate aspects of process and outcome. All treatments are manualised and a measure of treatment fidelity is under development.

Evaluation

This is the first randomised study of psychoanalytic child psychotherapy and child psychoanalysis. While such a study is much needed, there are major obstacles still to be surmounted before full implementation is realistic. The challenges faced by the team include major funding problems (the study has been twice turned down by the British Medical Research Council and once by NIMH) as well as practical ones (such as recruiting a sample who gives informed consent to randomisation of such different treatment models) and financial issues. The pilot phase helped the researchers to identify key problems in the manualisation of treatment and the importance of recording is evident. It is unlikely that important results will be available in the next five years.

The Munich psychotherapy of depression study (MPDS) – Comparing the effects of psychoanalysis and psychotherapy (MPDS)

- Huber, D., Klug, G., & von Rad, M. (1997). Münchner Psychotherapie-Studie (MPS). In M. Leuzinger-Bohleber & U. Stuhr (Eds.), *Psychoanalysen im Rückblick*. Gießen: Psychosozial.
- Huber, D., Klug, G., & von Rad, M. (2001). Die Münchner Prozess-Outcome Studie - Ein Vergleich zwischen Psychoanalysen und psychodynamischen Psychotherapien unter besonderer Berücksichtigung therapiespezifischer Ergebnisse. In U. Stuhr & M. Leuzinger-Bohleber & M. Beutel (Eds.), *Psychoanalytische Langzeittherapien*. Stuttgart: Kohlhammer.

The Munich Psychotherapy of Depression Study aims to answer two questions:

- 1 Are there any differences in the effectiveness between psychoanalysis and psychodynamic psychotherapy for depression? And if so: are those changes psychoanalysis brings about based on “structural changes” and, because of this, are they more profound and more stable than those psychodynamic psychotherapy brings about?
- 2 Are there any links between therapeutic process and outcome? And if so: what are they?

Design

To answer the first research question, a randomized control design was chosen to compare the two experimental groups: (1) a group of patients treated with psychoanalysis (PA) taking place three times a week in a recumbent position with an average duration of 240 hours and (2) a group of patients treated with psychodynamic psychotherapy (PT) taking place once a week sitting up with an average duration of 80 – 120 hours.

Because of the relatively small number of patients in each group (N= 30) a strictly random allocation could lead to an uneven distribution of important patient variables. Therefore the patients were stratified with regard to severity of symptoms and age. Therapies rather than therapists were assigned at random so as not to interfere with the important, individual patient-therapist match.

Randomisation

Each patient of the outpatient department of the Institute for Psychosomatic Medicine, Psychotherapy and Medical Psychology of the Technical University of Munich who met the inclusion criteria received an extensive audiorecorded clinical intake interview. Based on this recorded interview a board of three experienced psychoanalysts (the so called “indication board”) decided whether the patient could be randomly assigned to the two experimental groups.

The inclusion criteria are as follows: between 25 and 45 years of age, ICD-10 diagnosis: depressive episode or recurrent depressive disorder/DSM IV diagnosis: MDD; BDI >16; previous psychotherapy finished at least 2 years before entering the study; not taking antidepressive medication; adequate German language skills.

The 10 participating therapists were experienced psychoanalysts and psychotherapists in private practice and have been working with patients for at least five years. They were trained at an approved institute and graduated there. They applied only those therapies they were used to, and nobody was forced to apply a therapeutic modality he did not consider as suitable for a specific patient who has been referred to him.

Treatments

Psychoanalysis is defined as a treatment modality that establishes a full transference neurosis, accompanied by regressive processes which are resolved by interpretation leading to insight and mastery. It is a re-constructive therapy with thorough and long-range goals (see Wallerstein, 1986). It has a frequency of at least three sessions a week, takes place using the couch with a minimum duration of 240 hours (a time limitation imposed by the German health insurance system).

Psychodynamic psychotherapy is defined as a treatment modality similar in mechanisms but without aiming at a full transference neurosis, limiting itself to agreed-upon sectors of psychic distress and personality malfunctioning leading to less extensive and stable results but similar in direction and kind (see Wallerstein, 1986). It takes place one session a week, face-to-face with an average duration of 80 to 120 sessions (according to the German health insurance system).

Measures

Data are gathered from patient, therapist and researcher (“external investigator”). The test battery of outcome measures is adapted from the core battery suggested by the Society of Psychotherapy Research (SPR; see Grawe, Donati & Bernauer, 1994), to be comparable with other ongoing studies. A main goal of the study is to measure not only symptoms and behaviour, but especially mode-specific effects; therefore special instruments to measure structural change and individual therapeutic goals were administered. Structural change was measured with the Scales of Psychological Capacities (SPC), developed by Wallerstein and the PRP II group because there is some evidence from the reliability-studies of the PRP II group and other validity studies as well, that it is a reliable and valid, and, on the whole, a very promising instrument (DeWitt et al., 1999; Huber et al., 2001a; Wallerstein, 1991). Individual goals are assessed by means of the Goal Attainment Scaling (Kiresuk & Sherman, 1968; Kiresuk, Smith, & Cardillo, 1994) which in the Heidelberg Study (von Rad, Senf, & Bräutigam, 1998) showed an interesting discrimination between PA and PT.

Measurement points for the outcome measures are at pretreatment, at post-treatment and at follow-up each year after end of treatment. Table 1 summarises the procedure for administering the battery of measures:

Table 1. Procedural Plan of the MPS study

| | |
|---|--|
| Pre-treatment Measurement | <ul style="list-style-type: none"> • External investigator 1 and patient: intake-interview, ICD-10 and DSM-IV diagnosis, GAF, BADO, BDI, BSS, HAMD • Board of three experienced psychoanalysts/psychotherapists: decision on patient's inclusion in the study and on randomised allotment • External investigator 1 and patient: SPC- interview; informed consent • Patient: self-report questionnaires: BDI, SCL-90-R, IIP, FKBS, INTREX, SOZU, BADO, FLZ, FPI-R • External investigator 1 and patient: assessment of individual goals (goal attainment scaling GAS) • Referral to therapist • Therapist: documentation of diagnosis, psychodynamic hypothesis, level of personality organisation, treatment goals, prognosis, HAQ-T Process Measurement |
| Process Measurement | <ul style="list-style-type: none"> • Audio-recording of every session • Patient: self-report questionnaires: BDI, SCL-90-R, IIP, GAS and HAQ-P every 6 months • Therapist: therapy accompanying card to be filled out after every session; periodical process rating scale with HAQ-T every 6 months Post-treatment |
| Post-treatment Measurement | <ul style="list-style-type: none"> • External investigator 2 ("blind" for applied therapy) and patient: post-treatment interview, SPC-interview, life-events checklist, ICD-10 and DSM-IV diagnosis, GAF, BSS, HAMD, BADO • Patient: self-report questionnaires: BDI, SCL-90-R, IIP, FKBS, INTREX, SOZU, BADO, FLZ, FPI-R, GAS, HAQ-P, VEV • Therapist: periodical process rating scale and HAQ-T, assessment of termination of treatment |
| Follow-up Measurement (every year) | <ul style="list-style-type: none"> • External investigator 2 and patient: follow-up interview, SPC-interview, life-events checklist, ICD-10 and DSM-IV diagnosis, GAF, BSS, HAMD, BADO • Patient: self-report questionnaires: BDI, SCL-90-R, IIP, FKBS, INTREX, SOZU, BADO, FLZ, FPI-R, GAS, VEV |

At the end of the intake-interview with ICD-10 and DSM-IV diagnosis the external investigator fills out the Global Assessment of Functioning Scale (GAF, DSM-IV axis 5; American Psychiatric Association, 1994), the Symptom Severity Score (BSS; Schepank, 1995), the Hamilton Rating Scale for Depression (HRSD, Hamilton, 1960) and the Basic Documentation of the German College of Psychosomatic Medicine (BADO, this version described by Huber, Henrich, & von Rad, 2000), including the rating of the psychic structure of the patient (axis 4: Structure of the Operationalized Psychodynamic Diagnostics, OPD; Arbeitskreis OPD, 1996). After a positive decision by the "indication board" and the "informed consent" of the patient the external investigator interviews the patient with a semi-structured SPC-interview to get the appropriate information to score the SPC-scales. In the third pre-treatment session the external investigator and the patient assess together the individual goals the patient wants to achieve during the therapy. The patient is assigned to one of the experimental groups after this intake procedure, so that the external investigator is "blind" for therapeutic modality during the pre-treatment measurement.

Before the treatment starts the patient fills out the following self-report questionnaires: Symptom Check-List (SCL-90-R, Derogatis, 1977; German version G. Franke, 1995). Beck Depression Inventory (BDI, Beck, 1961; German version Hautzinger, Bailer, Worall & Kenner, 1995). Inventory of Interpersonal Problems, short version (IIP, Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988; German version Horowitz, Strauß, & Kordy, 1994). Introject questionnaire (INTREX, Benjamin, 1974; German version Tress, 1993). Questionnaire for Coping Strategies

(FKBS, Hentschel, 1998). Freiburg Personality Inventory, revised version (FPI-R, Fahrenberg, Hampel, & Selg, 1985). Questionnaire of Life Satisfaction (FLZ, Huber, Henrich, & Herschbach, 1988). Basic documentation of the German College of Psychosomatic Medicine (BADO, this version described by Huber et al., 2000). Questionnaire of Social Support, short version (F-SOZU-K-22, Sommer & Fydrich, 1991).

The therapist fills out the Helping Alliance Questionnaire (HAQ-T; Alexander & Luborsky, 1986; German version: Bassler, Potratz, & Krauthauser, 1995) and a documentation form with psychodynamic diagnoses, main defences, level of personality organisation, motivation, main psychodynamic hypotheses, treatment goals and prognosis.

During the ongoing therapeutic process neither the patient nor the therapist is contacted personally, so as to minimise interference with the process, although research itself as an observation inevitably influences the process. The process measures are sent to patient and psychotherapist by mail.

The therapist records each session on an audiorecorder and fills out a therapy accompanying card immediately after each session. Every six months the therapist receives the following two measures: Periodical Process Rating Scales with questions about transference, resistance, analytic work, technique, setting, sessions relevant for patient's change, counter-transference, dealing with current life events and with treatment parameters and main unconscious themes; HAQ-T.

Every 6 months the patient receives the SCL-90-R, BDI, IIP-C, GAS, and HAQ-P.

The external investigator 2 at post-treatment and follow-up will not be the same as at pre-treatment and will be "blind" about the therapeutic modality that was applied.

At post-treatment and follow-up the patient and external investigator 2 meet, and the pre-treatment instruments, including clinical and SPC interview, will be used again. In addition, a retrospective life-event checklist and a self-report questionnaire of Change in Experiencing and Behaviour (VEV, Zielke & Kopf-Mehnert, 1978b) are added.

The therapist gives an assessment of the termination of treatment.

Preliminary results

At this stage, the results from the first process measurement, half a year after beginning of treatment can be set out – with all the necessary qualifications regarding an ongoing study with an incomplete recruitment of patients.

The research question to be answered is the following: Are there any differences between psychoanalysis and psychodynamic psychotherapy during the first half year of treatment regarding: the attainment of the individual patient's goals; the therapists' assessment of the therapeutic process; and the patients' assessment of the therapeutic alliance?

42 patients passed the first six-month measurement; 21 of them in the psychoanalysis group, and 21 of them in the psychotherapy group. According to the inclusion criteria they have an ICD-10 diagnosis of depressive episode or recurrent depressive disorder; mean age is 34 years, mean BDI is 24; there are 13 men and 29 women in the sample. There is no significant difference in age, BDI-score or sex distribution between the groups.

Patient and external investigator together defined individual therapy goals in three different domains, and formulated five steps to reach this goal (any deterioration, no change, first step towards reaching the goal, reaching realistic goal and one more step than expected in reaching

the realistic goal). The external investigator's task was to operationalize the goals together with the patient and to formulate a series of steps of similar difficulty to reach the goals; it was the patient's task to define the goals as precisely as possible.

There was no significant difference between the two experimental groups at that measurement point in any of the three domains of their individual goals (1st domain: $\chi^2=2.65$; $df=3$; n.s.; 2nd domain: $\chi^2=2.97$; $df=4$; n.s.; 3rd domain: $\chi^2=3.41$; $df=2$; n.s.). Out of 42 patients 29 have reached the first step, 10 patients had reached the realistic therapy goal and 3 patients were beyond the realistic therapy goal as conceived of at beginning of treatment.

The Periodical Process Rating Scales, filled out by the therapists every half year, were selected to evaluate the therapeutic process from the therapists' view. Eighteen out of 218 variables in the Periodical Process Rating Scales, which could be expected to give an idea of the therapist's technique, and of the intensity of the patient's reactions to it, were chosen and compared for the two experimental groups. The HAQ-P with its two factors: satisfaction with relationship and satisfaction with success of treatment, (Bassler, Potratz, & Krauthauser, 1995) was chosen to give another window into the ongoing therapeutic process.

The variables of the two experimental groups were compared on an ordinal scale level by a non-parametric test, the Wilcoxon test. There were no significant differences between the 18 variables of the Periodical Process Rating Scale for a two-way test and a 5% significance level, except for the variable "affective tone of transference" ($W=291.5$, $Z=-2.03$, $p=0.042$). It is clearly more negative in the psychoanalysis group, showing more variance (mean=3.0; $SD=1.48$) than in the psychotherapy group (mean=2.11; $SD=.83$). No significant differences could be found in the two factors of the HAQ-P between the two experimental groups.

The more negative tone of transference in the psychoanalysis group can be interpreted as an indication of the growing tension in the therapeutic dyad. It has to be attributed to the analytic attitude of the therapist, because the data do not indicate a generally increased disposition towards negative transference on the patients' side in the psychoanalysis group. Interesting enough the tension seems not to be recognized by the patients themselves who do not score a more negative experience in the helping alliance measured with the HAQ-P. There seems to be some evidence that in the opening phase of a psychoanalysis the positive affects of the therapeutic "honeymoon" prevail in the patient's consciousness whereas the negative affects in this group are still unconscious and only recognized by the therapist.

On the whole, these findings are to be regarded as a trend, and not as a definite result, because not all patients of the two experimental groups could be analysed statistically to this point. Therefore, more sophisticated research questions will be investigated only when data from all patients are available.

Evaluation

This is an extremely promising and potentially most important study. Particularly important and unusual is the focus on a single diagnostic group – depression. Most psychoanalytic studies take relatively heterogeneous groups of neurotic patients which even if successful, contain too few individuals with any specific diagnosis to conclude that psychoanalysis is an effective treatment for specific conditions. The researchers have selected a very wide array of instruments to test the hypothesis that greater intensity of treatment generates more powerful treatment effects. The process of randomisation, a major hurdle in these investigations, is progressing well and the recruitment phase is almost complete. Further information from this study is urgently anticipated by all those interested in the future of psychoanalysis and psychoanalytic therapy.

The Munich – New York collaborative study: The psychodynamic treatment of BPO (MNYS)

■ Buchheim, P., Dammann, G., Lohmer, M., Martius, Ph. (Munich) & Kernberg, O., Clarkin, J. (New York)

The Department of Psychosomatic Medicine and Psychotherapy at the Technical University of Munich and the Personality Disorders Institute of the Cornell Medical Center in New York have collaborated since 1997 in conducting an empirically supported training of psychoanalytic therapists (in Munich). They have also collaborated in designing a controlled, comparative psychodynamic treatment study of German outpatients with Borderline Personality Disorders.

Treatment

The first aim of the feasibility study is to empirically evaluate the training of a group of 30 experienced psychoanalytic therapists in the Munich centre in a particular type of object-relations treatment - "Transference focused Psychotherapy (TFP)". TFP was conceptualised and elaborated by Kernberg, Clarkin and co-workers as a manualised psychodynamic psychotherapy for patients with the diagnosis of Borderline Personality Disorder. The manual was written by the research team of the Cornell Psychotherapy Program based upon the treatment of 55 cases. Data available for this project included that from the treatment development study funded by NIMH, in which the sessions were recorded and carefully examined. This is a distillation of both the theoretical writings about the treatment and the actual experience in doing the treatment in a project explicitly designed to manualise it.

Training to adherence

The principles of the training program have been largely developed by the research team of the Cornell Psychotherapy Program over the last 17 years, with additional work over the past year in the German research group focusing on:

- the written manual describing the principles of the theory and the treatment with accompanying clinical illustrations.
- a video-tape library of actual sessions with BPD patients, illustrating various stages of the treatment process both in terms of good adherence and relative levels of competence.
- an intensive seminar that is taught by the senior therapists to instruct new therapists in the treatment.
- the supervision of an initial case of each of the therapists in training with ratings of adherence and competence.

In Munich to date, 30 psychoanalytic therapists have applied for and were selected for the training based on their experience and reputation as excellent clinicians. Since April 1997, the German psychotherapists have been taught by Otto Kernberg, John Clarkin and Michael Stone in three intensive seminars about the principles of the theoretical and clinical concepts of the TFP-Treatment with accompanying clinical illustrations. Additionally, two very experienced German supervisors were selected by the Munich research team to receive direct training from their colleagues in the Personality Disorders Institute.

The second important aim of the feasibility study, the description and evaluation of Therapy as Usual (TAU) of inpatients and outpatients with the Borderline Personality Disorders, will be conducted in collaboration with the Departments of Psychiatry of the two Medical Faculties at Munich Universities.

Evaluation

This is a major study with potentially important implications. The Munich clinic carries a particularly high caseload of patients with borderline diagnosis and therapists have considerable experience of this group of clinicians with the methodology of psychotherapy research. Additional strength is offered to the project by the international collaboration with the Cornell Group.

The London partial hospital study (LPHS)

- Bateman, A., & Fonagy, P. (1999). The effectiveness of partial hospitalization in the treatment of borderline personality disorder - a randomised controlled trial. *American Journal of Psychiatry*.
- Bateman, A., & Fonagy, P. (2001). Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalization: an 18-month follow-up. *American Journal of Psychiatry*, 158, 36-42.

This study is an experimental trial of the psychoanalytic approach to the treatment of borderline patients. The treatment takes place in a day-hospital setting and the psychoanalytic psychotherapy is administered by supervised nurse therapists rather than psychoanalysts. The study is of interest however because it tests the importance and therapeutic value of a psychoanalytically informed environment in the management and treatment of these patients.

Sample

This is a unique randomised controlled study of the psychoanalytic psychotherapeutic treatment of borderline personality disorder patients in partial hospital setting although psychotherapy was not the only active component of the treatment, the psychoanalytic orientation was the critical organising principle of this day hospital. Forty-four patients were randomised to treatment as usual or the day hospital. All patients in the sample met both DSM-III-R and Gunderson criteria for borderline personality disorder. The patient group showed severe psychiatric disorders including mood disorders, eating disorders, dysthymia and borderline, narcissistic or paranoid personality disorder. There was a high prevalence of physical abuse, sexual abuse, early loss, rape etc.

Treatment

The control treatment was variable. Almost three-quarters received day hospital care in non-psychotherapeutic settings. In addition they benefited from day centres, polypharmacy, community support, outpatients services and occasional inpatient services. The experimental group had individual psychotherapy under close supervision, group psychoanalytic psychotherapy, expressive therapy and the staff received consistent support. The theoretical framework included a focus on disorganised attachment manifesting as an intolerance of closeness, addressing gross limitations of mentalising capacity, assistance in developing a transitional state of mind, and a close focus on the counter-transference.

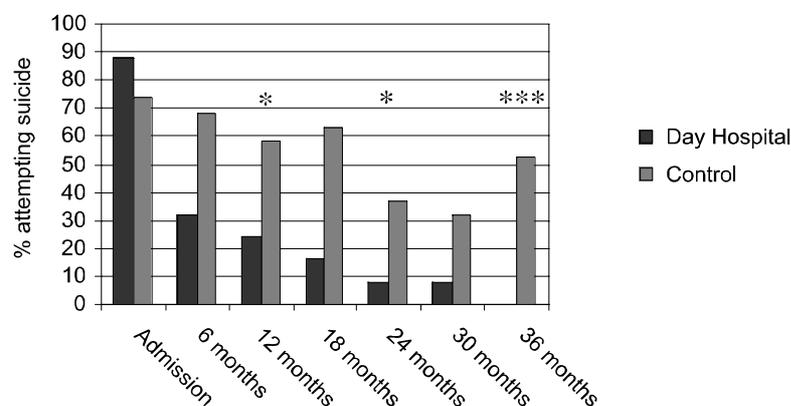
Measures

The most important measures were suicidal and self-mutilatory acts, hospitalisation, length of inpatient episodes and self-report measures of symptom distress (SCL-90) and mood (BDI and Spielberger State and Trait Anxiety Scale).

Results

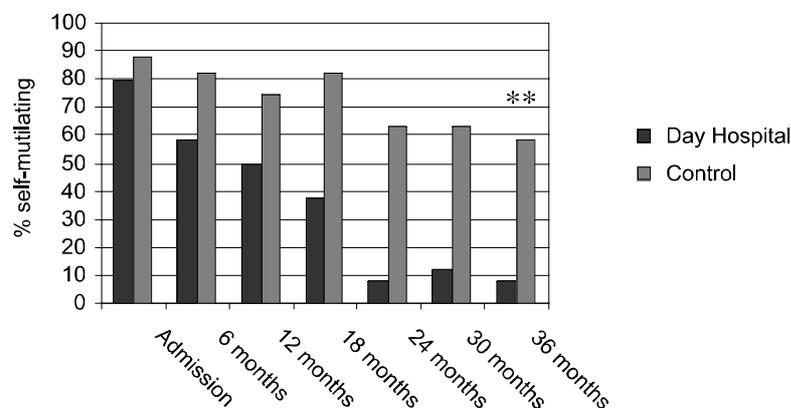
There was a dramatic drop in the number of suicide attempts after six months of treatment, maintained over the 18 months of day hospital treatment (see Figure 1). During the 18 months follow-up period the rate started to increase in the control group but continued to decrease in the experimental group.

Figure 1: Rates of attempted suicide in experimental (day hospital) and control samples over the 18 month study (significant differences: * .05; * .001).**



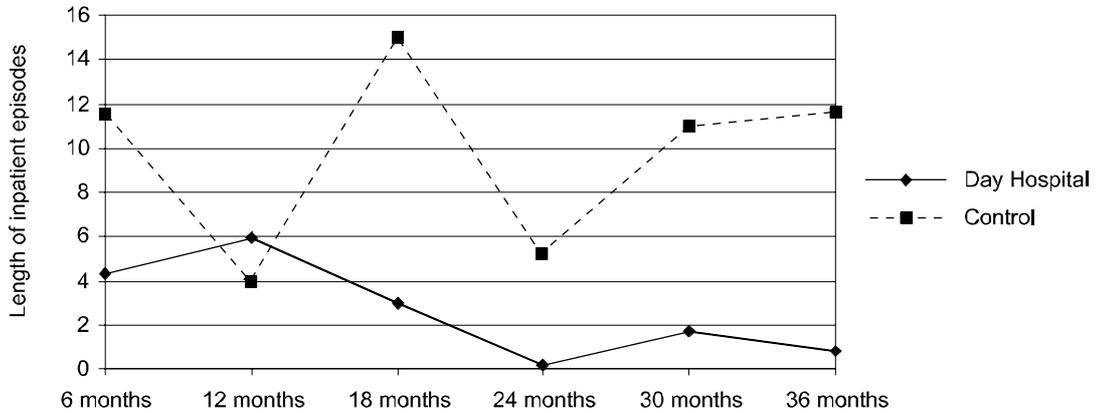
There was a significantly slower reduction in the rate of self-mutilating behaviour which decreased to under 40% in the final 6 months of the trial (see Figure 2). During the follow-up period the patients continuing to self mutilate were almost reduced to non in the treatment group but remained at about 60% in the control group.

Figure 2: Rates of self-mutilation in experimental (day hospital) and control groups over the 18 months of the study (significant difference ** .01).



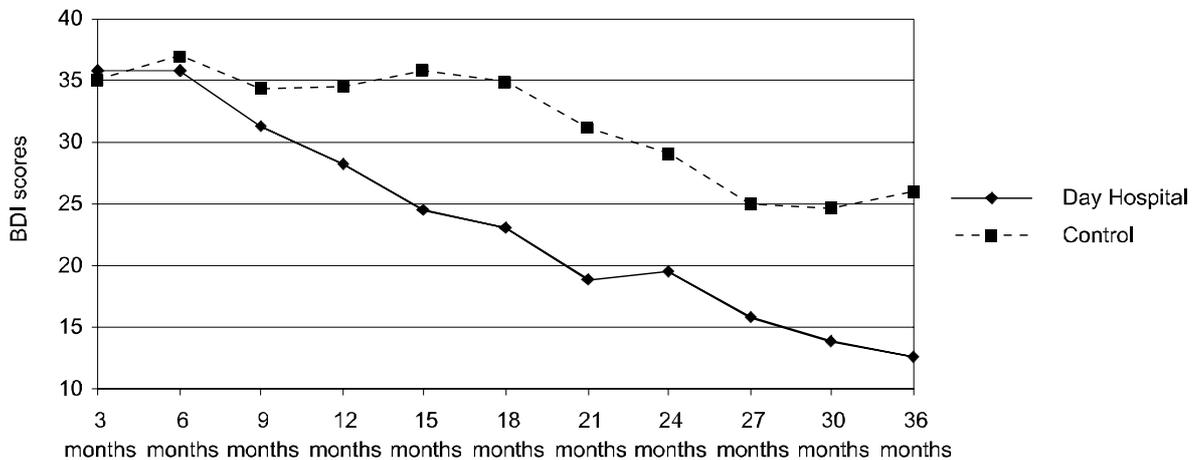
The number and length of hospital admissions during the 18 months of the trial remained low for the day hospital group but was on the increase again for the control group at 18 months (the time of discharge for the day hospital group) and remained around ten days for the average control patient (Figure 3).

Figure 3: Length (in days) of inpatient episodes per six month period for experimental (day hospital) and control groups.



Impressively, depression continued to decline for the day hospital group but was unchanged for the treatment as usual control group during the first 18 months of the treatment period for the experimental group and declined only slowly thereafter (Figure 4).

Figure 4: Depression ratings (on the BDI) for experimental (day hospital) and control groups at three monthly intervals up to 18 months.



Manifest anxiety was measured by the Spielberger manifest anxiety scale (State version). As with depression, meant level of anxiety decreased sharply during the 18 months of treatment in the experimental group and continued do do so over the follow-up period. While in the control group, anxiety decreased only marginally and remained at high levels until the end of the observation period (see Figure 5). Overall self report symptomatology across a number of symptom clusters was assessed by the SCL-90 GSI score also at 3 monthly intervals. Symptom distress as measured by this instrument also decreased consistently across measurement points during the follow-up period but did so at a far slower rate for the experimental group (see Figure 6).

Figure 5: Self ratings of state and trait anxiety (Spielberger) for experimental (day hospital) and control groups at three monthly intervals.

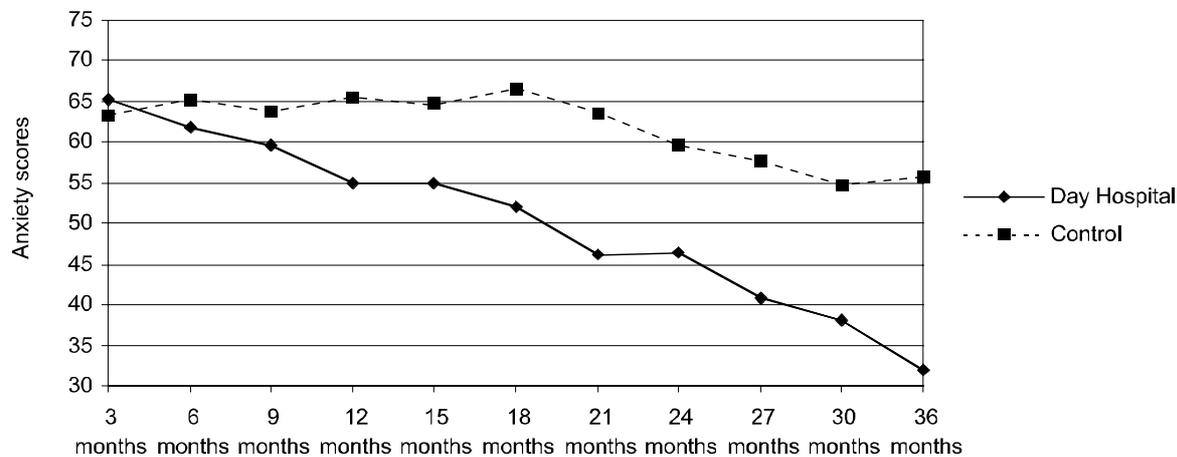
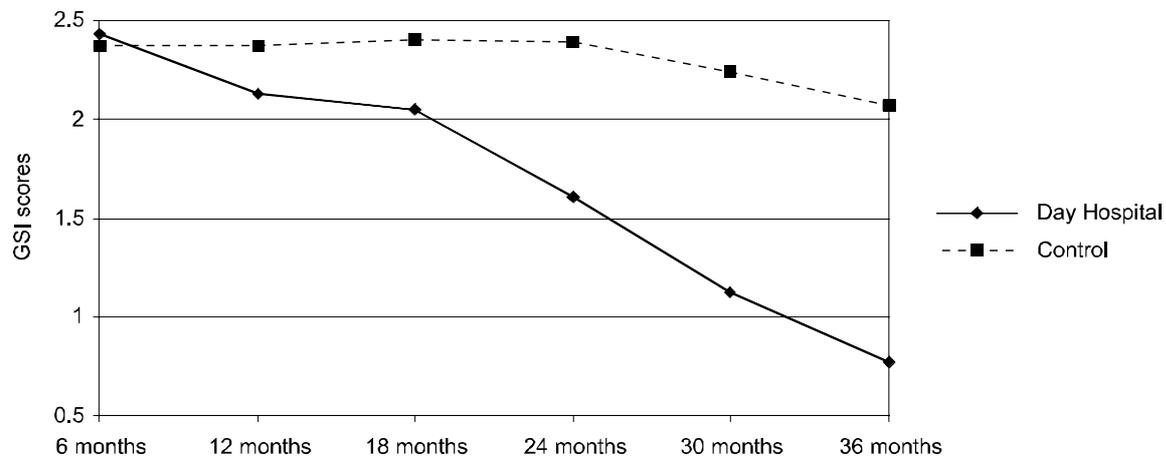


Figure 6: General symptom ratings on the SCL-90 at three monthly intervals for experimental (day hospital) and control groups.



Evaluation

This is the first randomised controlled trial of a psychodynamic treatment for borderline personality disorder. It should be added that a programme such as this has many features besides therapy that may have beneficial effects. The authors suggest that certain key psychoanalytic features of the programme account for its powerful effects, which appear to be well maintained over an 18 months follow-up period. The features of the program suggested by the authors as related to its effectiveness might include a consistent and reliable focus on the mental states (beliefs, wishes and desires) of the patients, its highly structured character, its intensity, its coherence coupled with a flexible treatment approach, its relationship focus and the individualisation of care plans. Other important areas may include a focus on acts of suicide and self-mutilation, and the selective use of medication. While the study was clearly not a test of the effectiveness of psychoanalysis, it was a test of some of the psychoanalytic principles of understanding borderline pathology advanced by these and other authors (Bateman, 1997; Fonagy & Target, 2000; Kernberg, 1975, 1987).

The Helsinki psychotherapy study (THPS)

■ Aalberg, V.,¹ Hannula, J.,¹ Julkunen, J.,² Järvikoski, A.,³ Kaipainen, M.,¹ Knekt, P.,^{4, 5} Lindfors, O.,¹ Marttunen, M.,⁵ Mäkelä, P.,¹ Renlund, C.,¹

In Finland about 20% of the population suffers from different mental disorders and about 40% of all work disability pensions are due to them. Depressive and anxiety disorders form the most important and growing group of disorders causing work disability. One of the most widely used forms of psychotherapy rehabilitation in Finland is long-term psychodynamic psychotherapy, which commonly lasts at least 2-3 years, thus causing considerable costs. No study has so far been published comparing the effectiveness of this form of psychotherapy with that of other forms of psychotherapy. Accordingly the information on cost-utility of this form of long-term therapy is scarce.

Objectives

The primary objective of this randomized clinical trial is to evaluate the effects of four forms of psychotherapy in the treatment of depressive or anxiety disorders. More specifically, the objective is to compare the effects of the different forms of psychotherapy on psychiatric morbidity and symptoms, on social functioning and ability to work, and on psychological functioning as well as to compare the cost-utility of the different forms of psychotherapy. A secondary objective is to evaluate the effect of patient-related characteristics on the outcome of the different forms of psychotherapy.

Forms of psychotherapy

The following four forms of psychotherapy are included in this study:

- problem solving therapy (the frequency of sessions is one every second or third week, up to a maximum 12 sessions and a duration of therapy of up to 8 months).
- short-term psychodynamic therapy (the therapy consists of 20 sessions, one session a week, lasting 5-6 months)
- long-term psychodynamic therapy (the frequency of sessions is 2-3 times a week and the duration of therapy is 2-3 years)
- psychoanalysis (the frequency of sessions is 4 times a week, and the duration is about 5 years)

The therapists participating have practised at least for two years after their training in the special form of psychotherapy and most of them have over ten years of experience. The therapies are conducted as is usual in clinical practice. No therapy manuals are used. The therapy process is monitored by questionnaires and by interviewing the patients and the therapists after the end of the therapy. No video or audio taping are carried out during the sessions.

Study design

Altogether, 390 patients from the Helsinki region mainly referred by psychiatrists working in private practice, community mental health care system, student health care system and occupational health services are recruited to the study. 330 of the participants are randomly assigned to one of three treatment groups: problem solving therapy (120 patients), short-term psychodynamic therapy (120 patients), and long-term psychodynamic therapy (90 patients). The participants of the psychoanalysis group (60 patients) are self selected.

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The status of the patients (symptoms, psychiatric diagnosis, psychological functioning, and social functioning) is assessed at the beginning of the study and repeated assessments are carried out according to a fixed schedule; 3 months, 7 months, 9 months, 1 year, 1.5 years, 2 years, 3 years, 4 years and 5 years after the baseline examination.

Eligibility criteria, recruitment and exclusions

The patients come from psychiatric services representing individuals usually treated by psychotherapy in Finland. To be eligible, the trial participants have to be 20-45 years of age and to have a disorder causing social dysfunctioning (work functioning). The participants also have to simultaneously suffer from an anxiety or mood disorder (according to DSM-IV) and from neurosis or high-level borderline disorder (on a psychodynamic scale).

Potential participants are excluded from the study for the following reasons: psychotic disorder or severe personality disorder; adjustment disorder; substance abuse; organic brain disease or other severe organic disease; and mental retardation. Also individuals treated with psychotherapy within the previous two years, psychiatric health employees and persons known to the research team members are excluded.

Methods at baseline

Internationally approved methods are used for description of symptoms, psychiatric diagnosis, psychological functioning and social functioning at the baseline examination. The measurements directed to the participants are carried out as ratings based on interviews, self-reported questionnaires, and as psychological tests. The following main instruments are used:

Symptoms: Hamilton Depression Rating Scale (HDS) and Hamilton Anxiety Rating Scale (HARS-G) based on interview rating scales and Symptom Check list (SCL-90), Beck Depression Inventory (BDI) and Scale for Suicidal Ideation (SSI) based on questionnaires;

- Psychiatric diagnosis: DSM-IV (based on structured interview);
- Psychological functioning: Quality of Object Relations Rating Scale (QRS) based on interview assessment, Defence Style Questionnaire (DSQ), and Structural Aspects of Social Behaviour (SASB introject) based on questionnaires and Rorschach Inkblot Technique (Comprehensive System) and Wechsler Adult Intelligence Scale-Revised (WAIS-R) psychological tests;
- Social functioning: Global Assessment Functioning Scale (GAF) based on interview rating scale and Social Adjustment Scale (SAS), Inventory of Interpersonal Problems (IIP), Life Situation Survey, Perceived Competence, Sense of Coherence Scale and assessment of working capacity based on questionnaires.

Laboratory determinations (serum cholesterol, serum thyroid hormones, serum glucose metabolism) are carried out based on serum samples taken from the participants, and a tissue sample bank at -70C has been founded. Individual information on use of psychiatric medication, hospitalization, mortality, disability pensions and sick-leave periods is obtained by linking the data to nationwide public registers. The therapists and therapy process are assessed by Common Core Questionnaire (CCQ) and Working Alliance Inventory (WAI). Health economic data is also collected from patients and from official registers.

Follow-up examinations

During the follow-up period, the questionnaires are carried out at every occasion of repeated measurements, i.e., after 3 months, 7 months, 9 months, 1 year, 1.5 years, 2 years, 3 years, 4 years and 5 years. Those questionnaires carried out after 3 months, 9 months, 1.5 years, 2 years and 4 years are brief. The interviews are repeated four times, i.e. after 7 months, 1 year, 3 years and 5 years. The psychological tests (WAIS-R and Rorschach) and the laboratory determinations are repeated after 3 years and 5 years.

Quality control

The reliability of the questionnaires is evaluated by estimating the agreement between answers on similar questions. The consistency of the interviewer's ratings is evaluated by repeated control ratings of 40 selected interviews. Based on these ratings both the agreement between raters and long time stability of the ratings are evaluated. Reliability is also estimated on the basis of 20 Rorschach protocols according to Comprehensive System guidelines.

Data monitoring

General adherence to the study protocol is continuously evaluated by monitoring recruitment success, rates of dropout, timeliness and completeness of form handling and accuracy of the data base. Treatment group balance for confounding factors, including disorder factors and information about the therapy process, is continuously evaluated. Other comparisons include dropout rates and missing data. Use of other treatments during the five-year follow-up period is evaluated by questionnaires and based on information from public registers.

Statistical analyses

The data is longitudinal with repeated measurements. The primary analysis, based on intention to treat, is designed to evaluate differences between the intervention groups over time in the different indicators using random regression models. Because of the complications caused by the fact that the therapies compared are of different duration and by confounding caused by medical treatment (psychotropic medication), a variety of other approaches will also be used.

Organization and present state of the study

Organization

The study is conducted jointly by the Department of Psychiatry, Helsinki University Central Hospital, the Social Insurance Institution and the Rehabilitation Foundation in collaboration with the National Public Health Institute and other Finnish organisations. The executive organisation consists of a steering committee, a scientific committee and several expert groups (data management, psychiatric, psychological, social and health economic). About fifteen researchers are working within the project. A safety committee follows the progression of the study scrutinizing possible side effects.

Pilot study

A pilot study to determine the feasibility of a large-scale trial was successfully conducted with 36 participants in 1993-1994.

Schedule

The baseline examination was started in 1995 and all patients will be recruited by the end of 1999. The follow-up will be completed at the end of 2004. Currently (August 1998) 397 patients have applied to the study, 254 have been accepted, 182 have started their therapy and 93 have ended it. Of the patients about 30% are men and about 70% of all patients suffer from mood disorders.

Reporting of results

The first main evaluation will compare the effects of problem solving therapy and short-term psychodynamic therapy in 2000 when both therapies have been completed. The second main evaluation comparing short-term and long term psychodynamic therapies will be carried out in 2002 when the long-term therapies have ended. Further evaluations will be performed based on data collected up to 2004 after a five year period from the baseline.

Evaluation

During the last five decades a large number of studies on the effectiveness of different types of short-term psychotherapy have been published. Although long-term psychotherapy is a widely used treatment which consumes a large amount of resources, no studies have been published comparing the benefits of long-term psychotherapy with those of short-term therapies. Therefore it is to be expected that the present study will give unique information on the relative efficacy of long-term psychotherapies. The study's state-of-the-art design and broad support should ensure that this is the case.

FRAMES (FRMS)

- Dahl, H. & Stengel, B. (1978). A classification of emotion words: A modification and partial test of de Rivera's decision theory of emotions. *Psychoanalysis and Contemporary Thought*, 1, 252-274
- Dahl, H. (1979). The appetite hypothesis of emotions: A new psychoanalytic model of motivation. In C. Izard (Ed.) *Emotions in Personality and Psychopathology*, 201-225. New York: Plenum.
- Dahl, H. & Teller, V. (1994). The characteristics, identification and application of FRAMES. *Psychotherapy Research*, 4, 252-274.
- Hölzer, M. & Dahl, H. (1996). How to find FRAMES. *Psychotherapy Research*, 6, 177-197.
- Dahl, H. (1998). The voyage of el Rubaiyat and the discovery of FRAMES. In R. Bornstein & J. Masling (Eds.), *Empirical Studies of the Therapeutic Hour*, 179-227. Washington, DC: American Psychological Association.

Brief summary of approach

FRAMES (Fundamental Repetitive and Maladaptive Emotion Structures) are a research tool for assessing psychopathology, the therapeutic process, and treatment outcome (Dahl, 1998; Dahl & Teller, 1994). 'The principle of free association as the "basic rule" in psychoanalysis is to sample stories that are characteristic or typical of the patient's emotional experiences' (Hölzer & Dahl, 1996). The plots of these stories with their events expressed as emotions, permit reliable and systematic descriptions of each patient's central conflicts using the FRAMES method. The underlying emotion theory (Dahl, 1979) and empirical classification (Dahl & Stengel, 1978) include several basic propositions:

- a emotions share basic attributes of familiar somatic appetites such as hunger and sex;
- b one of two major functional classes of emotions, termed IT emotions, have objects and function as appetitive wishes about those objects;
- c a second major class, ME emotions, function as beliefs about the state of fulfilment or nonfulfillment of wishes, including appetitive ones;
- d together, the IT and ME emotions constitute a basic information feedback system that provides knowledge about our fundamental and significant motives and their outcomes. IT emotions (e.g. love, surprise, anger, fear) function as appetitive wishes about objects. If the wish can be consummated, the result is a Positive ME emotion (e.g. contentment, joy). If the wish cannot be consummated the result is a Negative ME emotion (e.g. anxiety, depression).

The goals of this research program are to demonstrate the use of FRAMES: (a) to provide a detailed description of each patient's recurrent maladaptive structures, i.e. character pathology; (b) to identify the nature of the therapist's interventions that help alter the structures; and (c) to assess the outcome by determining the fate of the FRAMES at the end of treatment. The specific structure and content of Prototype (first demonstrated) FRAMES constitute hypotheses which predict that the same sequence of events (plot) will recur again. These hypotheses can be empirically tested and confirmed or disconfirmed, e.g., as Dahl (1998) demonstrated at the microprocess level in a crucial change in a FRAME structure that followed a critical intervention.

Major results

The methods and procedures for reliably identifying FRAMES have evolved over the past two decades and include results from doctoral dissertations. The basic steps are: (1) applying some criteria for selecting the session(s) to be studied; (2) classifying the patient's expressions of emotion (typically very numerous) in verbatim transcripts of the session tape recordings; (3) constructing an "object map," which is simply a table in which the successive columns

represent the object being talked about and the row entries are the paragraph and sentence numbers of the talk, which then allow selecting segments that contain definable story plots; (4) describing the plots; and (5) constructing a prototype FRAME Structure and looking for Instantiations (repetitions).

These steps have been applied to transcripts of treatment hours, structured interviews, reported behaviour, and the observed behaviour of children. Instantiations of prototype FRAMES can be found with different persons in different settings and particularly in interactions with the analyst. For example, in the analysis of Mrs. C, one repeatedly identified FRAME structure (*Support*) was: (1) patient has conflicts, (2) wants support, (3) does not get support, and (4) expresses hostility. Another FRAME structure (*Provocation*), highlighted at the end of the fourth year of analysis (hours 726-728), was: (1) patient picks a fight with someone, (2) the person fights back or the patient attacks herself, and (3) the patient feels “satisfied.” In these three sessions it was possible to show the point of change in this FRAME structure. In 726 she enacted the plot twice with her husband. In 727 she repeated the same plot three times with the analyst and in an association to a novel. In this session, when the patient omitted the third event, the analyst made an interpretation to remind her of how satisfying these provocations and retaliations were to her. In 728 she picked a fight with her husband, got him to fight back, but this time she felt “very unpleasant,” and the persistence of this change was supported by the fact that the original FRAME structure did not appear again in later hours of the analysis, illustrating how FRAMES can capture and specify how and which conflicts change.

Brief evaluation of the approach

One of the four major strengths of the method is that the structure and content of the Prototype constitutes a testable hypothesis that predicts that the same sequence of events will occur again. New instances of the FRAME structure then confirm the prediction and failure to find them disconfirm them. A second strength is that FRAMES, in contrast to some other research strategies, e.g. CCRT, do not involve pre-set or predefined categories; they are ideographic representations of maladaptive behaviour. The categories of events and their sequential order are determined by and are specific to each patient’s own narratives. A third strength is that the method can also be applied to both reported behaviour and observed behaviour. And fourth is the fact that the central importance of emotional expression, which all analysts give lip service to, is based on a clear theory and classification system.

A first limitation is that, although considerable research has been conducted using the FRAMES method, the work needs to be applied to a much wider range of analytic, and perhaps psychotherapeutic patients to discover the method’s limitations and possibilities. The most detailed studies thus far have only been conducted on Mrs. C. Secondly, although FRAMES share with other measures involving judgements of similarity, there is a need for more reliability studies such as those reported by Siegel (2001). He found very encouraging reliabilities for the emotion classifications, and both the segmenting and the plot sequencing agreements among two independent raters. The issue of what are sometimes perceived as problems associated with specifying the relationship between conscious and presumed unconscious mental representations is not addressed.

¹The Reliability, Identification, and Evolution of FRAMES in the case of Mrs. C. A dissertation of the Gordon F. Derner Institute of Advanced Studies, Adelphi University (2001).

There is no attempt to establish causal relations between particular classes of interventions and patient change, but there is a strong implication that the focus of most interventions should be on the events in FRAMES which the patient, for defensive reasons, is avoiding. And efforts to discover definitive interventions, as illustrated in the Provocation example, are best directed at these. No other general rules are implied. Finally, although the appetite hypothesis of emotions, which is fundamental to representing and understanding FRAMES, is often misunderstood as “tied to drive/structural” conceptualizations of mental functioning, this is incorrect. It is in fact a clear substitute for traditional drive formulations. Moreover, rather than precluding “the interactive, relational or intersubjective aspects of the change process” the appetite hypothesis emphasizes the centrality of the relationship between objects, in particular that between the patient and the analyst.

Core conflictual relationship theme method (CCRT)

- Luborsky, L. (1976). Helping alliances in psychotherapy: The groundwork for a study of their relationship to its outcome. In J.L. Claghorn (Ed.), *Successful psychotherapy* (pp. 92-116). New York: Brunner/Mazel.
- Luborsky, L., Barber, J., & Diguier, J. (1993). The meanings of the narratives told during psychotherapy: The fruits of a new operational unit. *Psychotherapy Research*, 2, 277-290.
- Luborsky, L., Popp, C., Luborsky, E., & Mark, D. (1994). The core conflictual relationship theme. *Psychotherapy Research*, 4, 172-183.
- Luborsky, L. & Luborsky, E. (1995). The era of measures of the transference – the CCRT and other measures. In T. Shapiro & R. Emde (Eds.), *Research in psychoanalysis: Process, development, outcome* (pp. 329-351). Madison, CT: International Universities Press.
- Luborsky, L., & Crits-Christoph, P. (1998). *Understanding transference: The core conflictual relationship theme method*. (2nd ed.). Washington, DC: American Psychological Association Press.

Brief summary of approach

The CCRT is the longest established empirical method for deriving patients' central relationship pattern from clinical material including the patient's transference pattern (Luborsky, 1976), usually inferred from material in treatment sessions. In recent years, there has been the growing realization that unguided systems for formulating the transference are unreliable – even very experienced analysts often fail to agree with one another. In addition, the usual method of formulating transference is difficult to evaluate for its reliability because each therapist's formulations can differ both in its language and in its components. In contrast, the CCRT method facilitates the use of the same language and same components. While the CCRT relies on the basic principles that experienced psychodynamic clinicians typically use in formulating transference patterns, it allows clinical judges to rely on shared guidelines for making inferences.

First, Relationship Episodes (REs), or self-other narratives, are located in accounts of the patient's [narratives of] interactions with others, usually in verbatim transcripts, though more structured intake interviews have also been used. A relationship episode is defined as part of a session in which there is a clear narrative about relationships with others, or at times, with the self. These episodes are located and marked off on the transcript of the session by an experienced judge. Once recurrent aspects of relationship episodes are identified, they are reviewed with the following questions in mind: (a) what are the patient's wishes? (b) what are the responses from others? (c) what are the responses from the self? Another major dimension of scoring is the distinction between positive and negative responses. Negative responses are those that the patient experiences as involving expected or actual frustration of satisfaction or wishes. Positive responses involve expected or actual satisfaction of wishes.

The method initially relied on "tailor-made" idiosyncratic categories, or types of components inferred by each clinical judge in the judge's own language for describing internal qualities of each patient's central relationship pattern. Later, standard categories were added to the method, i.e. a limited set of categories that are used in common by all judges for all patients. The judge first infers a tailor-made category from some aspect of the narrative, and then translates it into one or two of the standard categories. Several different category lists have been compiled over the years. The first consisted of 15 categories for each type of component, the second comprised 30 for each type of component; data reduction procedures (cluster analysis) finally yielded 8 standard categories for wishes, 8 for responses from others, and 8 for responses of self. Reliabilities for standard categories range from .61 to .70 (Luborsky & Diguier, 1998).

Major results

The state of the art of research on the CCRT has been summarized in a relatively recent review (Luborsky, Diguier, H, & al., 2000). Over the last two decades, numerous research articles and two books have been published that describe the CCRT and its development and application. Significant effort has been invested in the construction and refinement of the CCRT method, the standard categories of Wishes and Responses, and in establishing its reliability and validity (Luborsky & Crits-Christoph, 1998). The CCRT operationalises transference in a clinical meaningful way, and as a consequence researchers from literally around the world have adopted the method, and it has been translated into several languages. Luborsky and his colleagues have also tested an extensive series of hypotheses concerning the origin, the functions and the stimuli that activate the transference. They include the observations that it involves a central relationship pattern, that it originates with early parental figures, that it comes to involve the therapist, and that it is partly an awareness (Luborsky & Luborsky, 1995; Luborsky, Popp, & Barber, 1994). In another example of the kind of study done with the CCRT, Popp and colleagues (Popp, Luborsky, & Crits-Christoph, 1990), in order to test the observation that the core conflictual relationship pattern appears in multiple modes, were able to demonstrate a significant similarity of the CCRT from dreams with the CCRT from waking narratives.

Brief evaluation of the approach

The CCRT has provided powerful research support for key psychoanalytic theories about transference, and as such is one of the best demonstrations of the possibilities of operationalising psychoanalytic constructs in a form suitable for empirical research. It remains close to the clinical material, and provides guidelines for inference that clinicians find suitable. It can be scored reliably even by judges who have had little or no clinical training (Luborsky, Andrusyna, Friedman et al.). It is not, however, a measure of the therapeutic process, and the implications for how patients (and their CCRTs) change is unclear. As the method comes to be widely applied in countries that are culturally and linguistically varied, there is some concern about the adequacy of the hierarchical system of standard categories that were mainly developed in the US. Research is currently underway in several countries to establish the cross-cultural utility of the W, RO, RS category system, and to offer additional scoring options, where necessary.

Ulm-Leipzig-Göttingen studies of transference patterns using the CCRT method

- Albani, C., Pokorny, D., Dahlbender, R., & Kächele, H. (1994). Vom Zentralen Beziehungs-Konflikt-Thema (ZBKT) zu Zentralen Beziehungsmustern (ZBM). Eine methodenkritische Weiterentwicklung der Methode des "Zentralen Beziehungs-Konflikt-Themas". *Psychother Psychosom med Psychol*, 44, 89-98.
- Albani, C., Blaser, G., Thomä, H., & Kächele, H. (2000). La fine dell'analisi di Amalie. Una ricerca con il metodo del tema relazionale conflittuale centrale (CCRT). *Psichiatria e Psicoterapia Analitica*, 19, 27-37.
- Albani, C., Brauer, V., Blaser, G., Geyer, M., & Kächele, H. (2000). Sind Beziehungsmuster in stationärer, integrativer Psychotherapie veränderbar? *Gruppenpsychotherapie und Gruppendynamik*, 36, 156-173.
- Dahlbender, R., Erena, C., Reichenauer, G., & Kächele, H. (2001). Meisterung konflikthafter Beziehungsmuster im Verlaufe einer psychodynamischen Fokaltherapie. *Psychoth Psychom med Psychol*, 51, 176-185.

Brief summary of the approach

The Ulm-Leipzig-Göttingen study group after having developed the German version of the CCRT method by Luborsky & Crits-Christoph (Luborsky & Crits-Christoph, 1990) has been investigating transference patterns in two single cases. In the first case, a short term focal psychoanalytic therapy, they identified six transference patterns, elaborating a structural version of the CCRT concept which they called the Connected Central Relationship Patterns (CCRP) (Albani et al., 1994; Dahlbender, Albani, Pokorny, & Kächele, 1998); adding the concept of mastery (Grenyer & Luborsky, 1996) they demonstrated that focal work on one of the six CCRT-defined transference patterns is related to systematic change in terms of mastery (Dahlbender et al., 2001).

In the second case, a long term high frequency psychoanalytic therapy, they illustrated the possible use of CCRT as an in-treatment change measure (Albani, Blaser et al., 2000), illustrated the functional utility of the Ulm process model of psychoanalytic therapy (Albani et al., submitted) and analysed object-specific CCRT-patterns (C. Albani et al., in press). They have also studied changes of relationship patterns in in-patient psychodynamic group therapy (Albani, Brauer et al., 2000).

As a contribution to basic research this group analyzed the connection between affective evaluation of recollected relationship experiences and the severity of the psychic impairment by this method (Albani et al., 1999; Cierpka et al., 1998). This study, carried out at three different university centers, contributes to validating the valence dimension of the CCRT-method. Working on the state of the CCRT-research on affective evaluation of relationship narratives, the connection between the valence dimension of the responses from others (RO), responses of the self (RS) and the severity of the psychic disorder has been analyzed investigating a large sample of relationship episodes (N = 8686) taken from 266 female patients. Therapists and patients evaluate the severity of the impairment similarly. The more the patients are impaired, the more negatively they describe both their own reactions and those of their interaction partners as shown in the relationship episodes.

In an exploratory study they explored the relationship between attachment related variables, assessed by the adult attachment prototype rating (AAPR by Pilkonis, 1988) and relationship patterns in a sample of adult psychotherapy patients (C Albani et al., in press). Sub-samples formed according to three attachment prototypes (excessively dependent, relationally instable, and compulsive self-reliant) were found to differ mainly in CCRT-variables with respect to object- and subject-related wishes and responses of the self.

Brief evaluation of the approach

The German CCRT group have been active over a number of years not just demonstrating the transportability of the approach across cultures but expending the constructs beyond the ideas originally entailed in the measure. The linking between different fields of process research (e.g. the exploration of attachment classification – CCRT relationship) will help in understanding both sets of approaches. It should be remembered that these are studies of the nature of therapeutic effect and moderators of these effects; in and of themselves they do not help us answer the vexed questions concerning the reasons and mechanisms of improvement (only in a principally descriptive manner).

Control-mastery theory and the plan formulation method (CMT)

- Weiss, J., Sampson, H., & and the Mount Zion Psychotherapy Research Group. (1986). *The psychoanalytic process: theory, clinical observation, and empirical research*. New York: Guilford Press.
- Weiss, J. (1993). *How Psychotherapy Works*. New York: Guilford Press.

Brief summary of approach

Control-Mastery Theory (Weiss, 1993; Weiss, Sampson, & and the Mount Zion Psychotherapy Research Group, 1986) is a cognitively oriented approach derived from ego psychology, which has recently become described as cognitive-relational. The theory holds that psychopathology stems largely from pathogenic beliefs acquired during childhood that prevent patients from pursuing appropriate life goals. These beliefs are frightening and constricting. The person suffering from them assumes that the pursuit of certain goals will endanger herself or another. Irrational beliefs in one's power to hurt others, excessive fears of retaliation, and exaggerated expectations of being overwhelmed by feelings such as anger and fear are all examples of beliefs that can act as obstructions to the pursuit or attainment of goals.

The theory assumes that the patient comes to therapy with an unconscious plan to disprove these debilitating "pathogenic beliefs." One of the primary means by which a patient attempts to disconfirm pathogenic beliefs is to test them in her relationship with the therapist. Therapeutic action lies in disproving patients' pathogenic beliefs. The patient plans how she will work in therapy to disprove her pathogenic beliefs (Weiss, 1993), overcome her problems and achieve her goals. The therapist may help the patient to disconfirm her pathogenic beliefs through a variety of means; by her overall attitude toward the patient, by passing patients' attempts to test the pathogenic beliefs, and by interpretation. The model has important implications for technique. Weiss (1993) argues that there can be no technical approach that applies to all patients. Technique must be case specific, and the therapist must adapt her approach to each patient's particular beliefs and goals.

Interpretations may be used for a variety of purposes: to pass the patient's tests, to help the patient feel more secure in therapy, as well as to help the patient become conscious of pathogenic beliefs and goals, and thereby to work more effectively at disproving these beliefs and pursuing these goals. An interpretation is helpful to the extent that the patient can use it in her efforts to overcome her pathogenic beliefs. The therapist may also be helpful by noninterpretive means by providing the patient with a sense of safety. The patient then begins to develop insights on her own.

In this model, the therapist should, in general, not be neutral; rather, he or she should serve as the patient's ally in the effort to disprove the patient's pathogenic beliefs and pursue goals. Weiss emphasizes that even if the therapist tries to be neutral, the patient does not experience the therapist as neutral, since the patient's tendency is to relate everything the therapist says to her efforts to disprove pathogenic beliefs. The patient's successful use of interpretation depends on the patient's reliance on the therapist's authority to help her to pursue her unconscious goals.

Formulations developed according to this theory have four component parts: the patient's *goals* for therapy; the *obstructions* (pathogenic beliefs) that inhibit the patient from pursuing or achieving these goals; the *insights* that will help the patient achieve therapy goals; and the manner in which the patient will work in therapy to overcome these obstacles and achieve these goals (*tests*) (Curtis, Silberschatz, Sampson, & Weiss, 1994).

The procedure for generating a formulation, The Plan Formulation Method, has five steps.

- Three or four clinical judges independently review verbatim transcripts of early therapy hours. Each judge then creates a list of ‘real’ and ‘alternative’ goals, obstructions, tests, and insights for the case.
- The judges’ lists are combined into master lists of goals, obstructions, tests, and insights.
- The master lists are returned to the clinical judges who independently rate the items on a 5-point Likert scale for their relevance to the case.
- Reliability is measured for each of the four plan components by calculating alphas for the pooled judges’ ratings.
- A final formulation is developed by a group of judges who decide by consensus which items should be included. The Plan formulation includes a description of the patient and the patient’s current life circumstance, followed by a narrative of the patient’s presenting complaints. Then the goals, obstructions, tests, and insights are listed. Reliabilities have ranged from .84 to .90.

Major results

The validity of the Plan Formulation Method has been tested in studies in which formulations have been used to measure the impact of therapist interventions on patient progress in therapy. Several studies have demonstrated that the accuracy of therapist interventions (defined as degree of adherence of the interpretation to the individual’s Plan Formulation) predicts subsequent patient progress in therapy. A few studies have also shown that a case-specific outcome measure, Plan Attainment, that rates the degree to which a patient has achieved the goals and insights and has overcome the obstacles identified in his or her Plan Formulation correlates with other standardized outcome measures and is a predictor of patient functioning at post-therapy follow-up. These findings appear to support the hypothesis that the Plan Formulation identifies important factors that influence the nature and maintenance of a patient’s psychopathology. When the therapist responds in accord with the patient’s plans, the patient improves.

The ability to develop reliable case formulations using the Plan Formulation Method has enabled this group to systematically compare theories of psychotherapy empirically and in a clinically meaningful way. Weiss (1993), for example, tested two theories about the emergence of previously repressed mental contents. The ‘Higher Mental Functioning Hypothesis’ (HMFH), which is derived from Control-Mastery Theory, assumes that such contents may emerge because the patient unconsciously decides that he may safely experience them. The ‘Automatic Functioning Hypothesis’ (AFH), derived from classical drive structural theory, assumes they may come forward if they push through to the patient’s consciousness or if they are disguised or isolated so that they evade the forces of repression. The successful testing of this hypothesis rested on the assumption that the patient would feel differently while previously repressed mental contents were emerging. According to the HMFH, the patient will overcome his anxiety about the contents before they come forth, and so will not feel especially anxious while they are emerging. The AFH assumes that if previously repressed mental contents emerge, the patients feel increased anxiety, unless they are disguised or isolated. This hypothesis was tested using the transcribed analysis of Mrs. C, with judges determining what contents were warded off and applying ratings of anxiety. The Higher Mental Functioning Hypothesis was confirmed. A series of studies, many of which have been published (some of which are unpublished doctoral dissertations) have systematically tested various predictions derived from control-mastery theory (see Weiss, 1993; Weiss et al., 1986).

Brief evaluation of the approach

One of the real strengths of this research program is that it attempts to systematically test theory; at the same time, it is clinically relevant, promising to offer new insights about how psychotherapy promotes patient change. Unlike much psychotherapy research, which tends not to bear directly on how clinical intervention should be conducted, this work has clear and immediate implications for how therapists might work effectively. This group has a long record of productive research, and their work is gaining international stature.

The Control-Mastery theory has been tested against traditional psychoanalytic theory (Weiss et al., 1986). These tests have been done by research organized by investigators adhering to the traditional theory and by investigators adhering to Control-Mastery Theory. The results supported the Control-Mastery Theory. Research has demonstrated that interpretations designed to help the patient to overcome her pathogenic beliefs have an immediate effect. The patient becomes more insightful, bolder, and less defensive.

The investigators who carry out research on the Control-Mastery Theory must be familiar enough with the theory to rate its central constructs - including pathogenic beliefs, unconscious goals, and patients' tests.

The research carried out by Control-Mastery investigators has tended to support the Control-Mastery Theory against the traditional psychoanalytic theory. It has not been tested against Luborsky's CCRT approach, or against other current perspectives.

Configurational analysis and role-relationship models (CARR)

- Horowitz, M. J., (1987-2nd edition) *States of Mind: Configurational Analysis of Individual Personality*. New York: Plenum.
- Horowitz, M. J. (1995). Defensive control states and person schemas. In T. Shapiro & R. N. Emde (Eds.), *Research in psychoanalysis: Process, development, outcome* (pp. 67-89). Madison, Connecticut: International Universities Press.
- Horowitz, M. J., Eells, T., Singer, J., & Salovey, P. (1995). Role-relationship models for case formulation. *Archives of General Psychiatry*, 52, 625-632.
- Horowitz, M. J., & Stinson, C. H. (1995). Consciousness and the processes of control. *Journal of Psychotherapy Practice and Research*, 4, 123-139.
- Horowitz, M. J. (1992). *Person Schemas and Maladaptive Interpersonal Patterns*. Chicago: University of Chicago Press.
- Horowitz, M. J. (1997). *Formulation as a Basis for Planning Psychotherapy Treatment*. Washington, D.C.: American Psychiatric Press.

Brief summary of approach

Until recently clinical theories, psychological formulations of patients, and inferences about their mental processes could be evaluated only informally. Such assessments necessarily relied largely on clinical understanding and judgement. Important strides are now being made in the formidable task of testing, in scientifically acceptable ways, inferences and assumptions made routinely in clinical practice about patients' mental processes. Mardi Horowitz and his colleagues' method for generating psychological formulations that are reliable and replicable is one of several important exemplars of this development. All of these approaches apply an organizing framework for specific constructs and capture repetitive structures of motivation, cognition, emotion or interpersonal transactions.

The Role Relationship Model Configurational method derives from an extensive research program and during the last ten years a series of publications has appeared presenting the model and its theoretical underpinnings. Significant effort has clearly been invested in the development of this approach to diagnosis and formulation, and it represents a step forward in the ongoing attempt to operationalise complex and subtle clinical constructs. Underlying this new approach to case formulation is an ambitious attempt at creating a new theory of mind that borrows constructs, terminology and metaphors from psychoanalytic theory, cognitive science and information processing models.

The central construct in this approach to case formulation is that of schemas. Person schemas are defined as 'structures of meaning' that affect thinking, planning and action concerning the self and others. Schemas are: unconscious and part of preconscious processing; they organize processes of control of emotions over time; help form conscious experience; their derivatives become (conscious) belief structures; as person schemas they are 'self' and 'other' relational structures that exist in multiple combinations; they include scripts for action sequences; and they are forms of knowledge that co-ordinate features of perception, thought, emotion and action.

Role Relationship Models (RRMs) are a method for identifying person schemas, giving them an organizing framework, and presenting them diagrammatically. The RRM captures attributes of the self (as seen by the self) and attributes of other persons. They also include a script for the expected emotional interactions between oneself and the other. In short, how we behave or act toward others depends on how we view ourselves in relation to the other person. How we experience an event that occurs in reality depends on what latent person schema is activated by the event. Various desired, dreaded, and defensive RRM are postulated as part of a configuration. The configuration thus presents the dynamic of wish-fear dilemmas and defensive and characterological compromise positions.

Major results

Horowitz (1995) correctly argues that diagnosis of personality disorders represents only a first step towards treatment and that proper individual case formulation is essential for effective therapy. Configurational analysis and RRM is a method for systematic formulation. Configurational analysis adds steps for inference of states, conflicted topics, and defense tactics to inference of RRM and their configurations. The method requires a videotape or transcript of an evaluation interview or therapy session if it is to have research validity. The first step in creating an RRM requires identifying systematic consistencies and inconsistencies in the words that a patient uses to describe him- or herself. This task can apparently be accomplished reliably using a systematic format for the configuration of RRM. In one example (Horowitz et al., 1995) two independent teams freely created their own RRM configurations. One team arrived at an RRM ‘shy sick patient’; the other team generated ‘socially uncomfortable’ for that same configurational location. These formulations were then deemed ‘acceptably close’. Formulations are represented by several figures, diagrams and cycle charts illustrating the RRMC of the patient, and the systematic “blank” format that guides inferences.

An important assumption seems to be that identity and relationship conflicts are common in personality disorders. A central premise of the RRM method is that identity conflicts can be assessed as multiple roles; these roles can be inferred from state-variant statements about oneself. The RRM method requires judgements about self concepts and roles of self and significant others. Cycles of states, with their variable emotions, rules, and defenses are seen in most personality disorders, so this method seems appropriate to the actual clinical complexities. That is why Horowitz and his colleagues evolved it as a necessary increase of complexity from where they started, which was using Luborsky’s CCRT as the self-other aspect of the formulation system called configurational analysis.

Brief evaluation of the approach

The RRM method attempts to address an important problem for clinical science. It is creative, complex, and intriguing. The effort to integrate psychoanalytic theory with models from cognitive science and information processing can yield terminology that is used across disciplines, and that can carry psychoanalytic thinking beyond its own tight disciplinary circle. This common cognitive science language—states of mind, person schemas, defensive control of emotional information processing—may strike some who read and hear only psychoanalytic writings as “difficult” but it does offer the possibility of articulation to other psychological and neurobiological sciences.

The description of the symptomatology of personality disorders in Horowitz’s work on histrionic, compulsive dependent, and narcissistic categories, and their underlying motivation of behavior, utilizes the full system of configurational analysis (phenomena, states of mind, conflicted topics, defenses, self-other belief structure, RRM configurations). Looking at the RRM configurations alone does not capture the whole formulaic picture. That is why Horowitz has added a method for typologizing developmental level of self-other schematizations to configurational analysis. Some empirical studies have shown an important interaction of this dispositional variable with process-outcome interactions. Horowitz asserts that maladaptive state cycles and contradictions and conflicts in conflicted themes, defensive styles, and person schemas are the hallmarks of personality disorders. Most researchers who have studied the traits comprising, or at least descriptive of, the various personality disorders now acknowledge state variation and even bipolarity (excessive voyeurism and excessive exhibitionism) in character related problems.

The treatment implications of RRMC include predictions of transference and countertransference dilemmas. An RRMC can inform a therapist's approach, it is a way to clarify conflicts and it helps her to organize developmental information. It can lead to a systematic way of judging when to make what specific interventions and how she can clearly frame an interpretation. However, it is configurational analysis as a whole rather than the RRM as one component that is likely to be most helpful to clinicians in direct practice with individuals. Researchers may wish to formulate the RRM configurations that underlie and lead to maladaptive interpersonal patterns both before and after treatment, in order to specify qualitative changes. It is not, however, a quantitative method.

Multiple code theory (MCT) and the referential process: applications to process research²

- Bucci, W. (1995) The power of the narrative; A multiple code account. In Pennebaker, J. (Ed.) *Emotion, Disclosure and Health*, Washington, D.C.: American Psychological Association .
- Bucci, W. (1997) *Psychoanalysis and Cognitive Science: A multiple code theory*. New York: Guilford Press.
- Bucci, W. (1998) Transformation of meanings in the analytic discourse; A strategy for research. *Canadian Journal of Psychoanalysis*, 6, 233-260.
- Bucci, W. (1999) The multiple code theory and the "third ear"; The role of theory and research in clinical practice. *Psichiatria e Psicoterapia Analitica*, 18, 299-310.
- Bucci, W. (2000) The need for a "psychoanalytic psychology" in the cognitive science field. *Psychoanalytic Psychology*, 17, 203-224.
- Bucci, W. (2001) Pathways of emotional communication. *Psychoanalytic Inquiry*, 20, 40-70.

Brief summary of approach

This research program is based on a new general psychological theory – the theory of multiple coding and the referential process, which describes the interactions of biological, emotional and cognitive systems (Bucci, 1997). The psychotherapy research is conducted within a broad research context that involves examining the concepts of the multiple code theory, and developing measures of these concepts, in nonclinical as well as clinical studies. In this theoretical framework, with the assistance of computerized procedures, the interaction between patient and analyst can be examined, and features of the interaction associated with different treatment effects can be identified. Application of the measures feeds back to further examination and elaboration of the theory.

Basic concepts of the multiple code theory: All information, including emotional information, is represented and processed in three major forms: the *subsymbolic nonverbal* processing that dominates in somatic and sensory systems, the *symbolic nonverbal* system of imagery, and the *symbolic verbal* system of language. The three systems are connected by the *referential process*, which links all types of nonverbal representations to one another and to words. *Emotion schemas* – the psychic structures on which treatment focuses – are made up of components of all three systems. The goal of treatment may be understood as change in the emotion schemas, in particular as integration of systems that have been dissociated.

Phases of the referential process: Change occurs through the bidirectional effects of the referential process, in the context of the therapeutic relationship. The referential process begins with arousal of a dissociated emotion schema, often expressed first in subsymbolic, bodily form. The schema may then be symbolized in narrative form, as, for example, a report of a recent event, a memory, a fantasy or a dream. The schema may also be symbolized in a different way in enactments or here and now events in the relationship. The narratives or enactments may be seen as metaphors of the emotion schemas – instantiations of the prototypic stories of one's life. The new material can then be reflected upon in the therapeutic discourse. The analyst is likely to take an active role in this reflection phase. If the process is effective, the words that are spoken will ultimately connect back to the somatic and sensory components of the dissociated schema so that the person actually feels different, sees things differently. The phases of the referential process occur repeatedly, within a session and across a treatment.

² Support for this research has been provided by the 45 Foundation, the Leslie Glass Foundation, and the Fund for Psychoanalytic Research of the American Psychoanalytic Association.

Each phase of the referential process is associated with a set of operational indicators in language and behavior. These include measures of Referential Activity (RA), which reflect the linking of nonverbal experience to language, and other language style and content measures. The RA measures include scales rated by judges following procedures outlined in the RA manual (Bucci, Kabasakalian, & al., 1992), and a computer assisted version, the CRA, developed by Mergenthaler and Bucci (Mergenthaler & Bucci, 1999). (For more detailed descriptions of the RA and CRA measures and their psychometric properties, including references, and for information concerning versions in languages other than English, see the section on measures) The language style measures are not intended to stand alone, but to be used in a network of other measures assessing clinical content, including measures of central themes and measures of defense, as discussed by Bucci (1997; 1998; 1999). The linguistic procedures point to *where* in the session particular aspects of the process are occurring; content measures are then applied to specify *what* is happening.

For a more detailed account of the RA scales and computer procedures, see the Appendix to this report.

Major results

The psychotherapy research agenda focuses on features of therapeutic work in the phases of the referential process. Interventions are evaluated on the basis of facilitating movement through these phases, and on the basis of changes in emotion schemas, assessed through thematic measures. Treatment effects may be examined within a session or over the treatment course. The research relies largely on verbatim transcripts of therapy sessions; the methods have also been applied to videotaped and audiotaped materials and process notes.

Features of the symbolizing phase: This phase is characterized primarily by high levels of RA or CRA, and by narratives about persons other than the analyst. CRA peaks are consistently associated with the Relationship Episodes (REs) on which the CCRT is based, and with Dahl and Teller's measure of FRAMES where objects are persons other than the analyst, as shown in a recent paper by Sammons & Siegel (Sammons & Siegel, 1998). CRA fluctuation provides a reliable, automatized method of locating REs that may, in some cases, be used in place of judges' ratings. The relation of RA to narrative speech has also been validated in several studies summarized by Mergenthaler and Bucci (Mergenthaler & Bucci, 1999).

During the narrative of the CRA peak, the analyst is typically silent; an intervention during a CRA peak marks a noteworthy technical moment in a session, for further investigation. Analysts are most likely to intervene verbally at the close of a narrative, when RA declines. Interventions at such times are likely to be focal probes and interpretations of the meaning of the narrative material. These features of content and timing have been observed with striking consistency across a wide range of analysts and patients (Bucci, 1998; 1999).

Transference or enactment phases have been identified in which central emotion themes are symbolized in "protosymbolic" form. CRA is likely to be relatively low, with REs and FRAMES scored with the analyst as object, as shown in a recent paper by Pessier and Stuart (Pessier & Stuart, 2000). Subsymbolic language style is dominant as indicated by stylistic components of language, and paralinguistic indicators such as pausing, discussed below.

Features of the subsymbolic phase. Subsymbolic processing is now being studied in a wide range of naturalistic and experimental as well as psychotherapy and other clinical research studies, as discussed by Bucci (2001). The patient's language is characterized by low levels of RA and CRA. REs as usually defined (with human objects) are unlikely. Themes focus on inanimate objects, particularly bodily states, pain, illness, body parts and actions (Bucci, 1998; 1999). Subsymbolic processing is not viewed as a phase of resistance, as in classical

psychoanalytic theory, but may be a phase of disorganization *and/or* a phase of moving toward the symbolic mode, *without leaving emotions and bodily experience behind*. While this phase is likely to be characterized by facial, somatic and motoric expression, at times without accompanying speech, a number of linguistic and paralinguistic indicators of subsymbolic expression have also been identified using audiotapes and transcripts, as shown in ongoing work by Dubé, Roussos and Bucci (Dubé, Roussos, & Bucci, 2001). The analyst will be relatively silent while the patient is in this mode; verbal interventions that occur will tend to be neutral or supportive; with the goal of moving the patient toward a symbolizing mode (Bucci, 1998; 1999).

Reflection phase. CRA is generally low; REs may not be identified; emotional insight is likely to be present as indicated by concomitant high levels of the computerized Emotion Tone (ET) and Abstractness (AB) measures developed by Mergenthaler. The analyst is likely to be active in this phase.

Indicators of change or impasse in the treatment process.

The effectiveness of therapeutic work is indicated by the playing out of the referential process leading to changes in emotion schemas. Effects may be noted in the short term response within a session, or over time in the treatment (Bucci, 1997; 1998; 1999). The patient may move on to a new narrative indicated by high CRA, or may enter a phase of reflection leading to emotional insight. Change in an emotion schema is reflected in change in CCRTs or FRAMES, as expressed in narratives told in symbolizing or enactment phases. Possible indicators of impasse would include increase in abstract language (as shown, for example, by high levels of Mergenthaler's AB without concomitant ET); negative feelings toward the analyst expressed in narratives or enactments; or an increase in subsymbolic indicators coupled with a decrease in CRA. The indicators of impasse may also be indicators that a new cycle is beginning, with the patient moving again into an arousal phase. In addition to the "mini-outcome" studies, several studies (summarized in Bucci, 1995; 1998) have provided evidence supporting the relation of RA patterning to treatment outcome, defined in symptomatic and behavioral terms.

Brief evaluation of the approach

The strength of this approach, and its primary focus, is the new vision of the therapeutic process, developed in the theoretical context of multiple coding, and implemented using reliable and valid process measures, including computerized measures. Using this approach, consistent patterns of interaction, factors affecting these interactions, and effects on patient responses have been identified across diverse patient-analyst pairs. These observations also highlight noteworthy events in a session, such as deviations from expected interaction patterns, or indicators of impasse. These observations raise new research questions and provide a focus for interaction with clinicians, as in collaborative work with López Moreno and her colleagues at the Racker Institute study in Buenos Aires. (It should be noted that the direct application of these process research measures in clinical work or as a basis for supervision requires a particular epistemological stance, in which the measures are used to mark noteworthy moments as a basis for discussion with clinicians, rather than as indicators of the effectiveness or lack of effectiveness of an intervention.)

The relationship of the process findings to measures of treatment outcome has been addressed thus far in a preliminary manner, and remains to be examined systematically. Additional measures of the referential process, in particular, measures of the subsymbolic and reflection phases; and additional indicators of change in the emotion schemas, including changes in behavioral indicators as well as in thematic contents, are in development. Other ongoing and future projects include development and assessment of a second generation computer assisted RA measure,

the ARA, with clearer relationship to RA as scored by judges; development of a second generation computerized text analysis program for PCs, the Discourse Attributes Analysis Program (DAAP), that will use weighted dictionary scoring, and will eliminate the need for arbitrary word block segmentation; and development of additional versions of the rating scales and computer assisted procedures in languages other than English, working with colleagues in Europe and South America. The theory, like all living theories, as well as the research methods developed in this context, are in a constant process of revision and elaboration. As the work proceeds, the researchers expect that some answers will be found, and even more new questions will emerge.

The Montevideo study of attachment and narratives³

- Altmann de Litvan, M., & Gril, S. (1998). *Estudio exploratorio basado en el Modelo de los Ciclos y los Indicadores de apego*. Paper presented at the First Latin-American IPA Research Conference, Buenos Aires.
- Altmann de Litvan, M., & Gril, S. (1999). *Preliminary results of an exploratory study based on Process Measures and Attachment Indicators*. Paper presented at the 2nd Latin American IPA Research Conference, Santiago de Chile.
- Altmann de Litvan, M., & Gril, S. (2000). Relaciones entre duelo y apego en el Vínculo Madre- bebé: Desde la clínica a la Investigación empírica, in *Los duelos y sus destinos. Depresiones, Hoy*. Asociación Psicoanalítica del Uruguay: Publicación del Congreso de Psicoanálisis.
- Gril, S., & Mergenthaler, E. (1998). Psicoterapia e Investigación, in *Revista de Investigación de la Facultad de Psicología* (Vol. 1). Uruguay.
- Mergenthaler, E., & Gril, S. (1996). Descripción de las reglas para la transcripción de sesiones de psicoterapia. *Revista Argentina de Clínica Psicológica*, 5(2), 163-176.

Brief summary of approach

This is a process study of psychoanalytic infant – mother consultations. It attempts to bring the advances of psychoanalytic process research in the traditional consulting room encounter to the applied context of mother – infant interaction. This is a therapeutic setting that shares some features with the psychoanalytic but, in addition has a developmental focus.

Sample

Ten mother baby dyads were selected at random from the regular treatment program at the Pediatric University Hospital in Montevideo. The babies were aged from 3 to 18 months and showed psychofunctional disorders. The dyads received 3 to 4 therapeutic interviews.

Treatment

The goal of these psychoanalytically oriented consultations with mothers and their babies is to help the mother to better understand her emotions, especially when interacting with her child in the therapeutic situation itself. A psychotherapeutic objective is to enable the mother to (re)adjust to her baby in direct response to its non-verbal interventions by connecting the baby's gestures and behaviour with emotions and by verbal expressing of emotions.

Measures

The verbal exchange of therapist and mother is being empirically assessed using computer assisted language measures. Narrative Style is measured using a computer-based measure of Referential Activity developed by Mergenthaler & Bucci (Mergenthaler & Bucci, 1999). The analysis of the text material utilizes the Cycles Model Program (CM, available from the Ulm Textbank website, Mergenthaler, 1996).

³ This project is developed in the Department of Medical Psychology headed by Prof. Dr. Ricardo Bernardi (Faculty of Medicine, University of La República). It has the collaboration of the Early Relationship Research Group. (Psychologists: Beatriz Angulo, Eulalia Broveto, Gabriela Nogueira, Alicia Perkal, Soledad Próspero, Emilia Sasson, Elena Gonzalez, Manuel Viera. Sociologist: Analía Corti.) and the statistical advice from the mathematician Mario Luzardo (Faculty of Psychology, Universidad de la República). It is a collaborative study with the University of Ulm and Prof. Erhard Mergenthaler has been a consultant to the project throughout. The project has been supported by the Research Advisory Board of the IPA since 1998. One of the main researchers (Marina Altmann de Litvan) has developed previous work in the field of early relationship, psychofunctional disorders and attachment. The other main researcher (Sylvia Gril) has been working on the validation of the Therapeutic Cycles Model into Spanish language and its application to various clinical settings.

The non-verbal interactions between mother and baby during the interview will be empirically assessed using Massie and Campbell's attachment indicators (gazing, vocalizing, touching, affect, proximity, holding), both from mother to baby and the baby to mother (Massie & Campbell, 1983), following the word block segmentation.

Subprojects

- Study of risk in attachment
- Study of productivity in the session according to clinical and empirical criteria.
- Validation of the Therapeutic Cycles Model into Spanish language
- Study of the impact of interventions in the developmental process
- Implementation of training programs for health care groups and mothers in the topic of attachment

Major findings

The psychotherapeutic interviews had an effect on the attachment indicators: the subjects changed from the extreme points (insecure, avoidance and over-anxious) towards the middle range (secure attachment). In the last sessions both mother and baby are closer to the middle range (3: secure attachment), and all the attachment indicators are closer to the middle range in the last sessions both in the mother and the baby.

All linguistic and non verbal variables were correlated in a block by block basis and no significant correlations were found between the verbal measures in the mother and therapist's speech and the attachment indicators in the mother-baby dyad (Pearson correlation).

Moments of productive speech between mother and therapist were not always moments of activation of the non-verbal indicators between mother and baby. These results showed the independence of the 2 levels: therapeutic discourse, and the non-verbal exchanges between mother and baby.

Brief evaluation of the approach

In interpreting the present results, several limitations to this study should be considered. One of the problems of this study is the limited number of cases. Nevertheless, for many of the sub-studies performed the sampling frame was the number of blocks of 150 words. This design enabled the study the relationship between verbal and non-verbal measures but didn't permit the study of the reasons for the changes that take place during the psychotherapeutic process. A new phase of the project is now being developed in order to study the process in each case at a microanalytic level.

Overall, the study has several strengths. First, the data showed that this model of psychotherapeutic intervention had a positive impact on the attachment indicators as measured by Massie and Campbell. Second, moments of productivity in the verbal exchange between the mother and the therapist are not necessarily moments of activation of non-verbal attachment indicators between the mother and the baby. These results may have practical implications for therapeutic interventions. In order to improve the mother's attachment to the baby these interventions should stimulate her to gaze, to vocalise and to touch the baby and also to avoid using abstract words as a means of communicating with the baby.

The Menninger treatment interventions project (TRIP)

- Gabbard, G. O., Horwitz, L., Allen, J. G., Frieswyk, S., Newsom, G., Colson, D. B., & Coyne, L. (1994). Transference interpretation in the psychotherapy of borderline patients: A high-risk, high-gain phenomenon. *Harvard Review of Psychiatry*, 2, 59-69.
- Horwitz, L., Gabbard, G. O., Allen, J. G., Frieswyk, S. H., Colson, D. B., Newsom, G. E., & Coyne, L. (1996). *Borderline personality disorder: Tailoring the psychotherapy to the patient*. Washington, DC: American Psychiatric Press.

This was a small-scale but intensive study of three patients with a diagnosis of borderline personality disorder treated in psychoanalytic psychotherapy at the Menninger Clinic. The investigators explored the relationship of interpretations and therapeutic alliance. Independent groups of raters studied transcripts of audio-taped therapy sessions. One group studied changes in therapeutic alliance in response to specific interventions, while the other group rated the interventions themselves on the supportive-expressive dimension.

Results

Transference interpretations tended to be more helpful from the point of view of strengthening the therapeutic alliance if used after the groundwork had been laid by supportive interventions. The findings argue against the appropriateness of the supportive-expressive dichotomy as characterising any therapy. The findings suggest that a dynamic combination of supportive and expressive interventions may be most useful in psychoanalytic psychotherapy with borderline patients.

Evaluation

This was not a study of outcome, yet it is helpful in identifying process dimensions relevant to measuring the effects of psychoanalysis. Some methodological innovations, for example those concerning the use of time series techniques, also represent potentially significant advances. The report is valuable for its integration of qualitative and quantitative research methodology.

The Buenos Aires study – empirical study of a six year successful psychoanalytic therapy of a patient with anorexia nervosa (BAS)

■ Hagelin, A., Acosta Güemes, S., Tebaldi, E., Tebaldi, R., Hodari, M.E., Weissman, J.C.

Brief summary

This research involves study of tape recorded psychoanalytic sessions according to three basic variables (originally five): object relations, anxieties, and defences (the remaining two variables – structural change and psychosexual development – will be examined at a later date). After due consideration, Luborsky's CCRT Method for "Understanding Transference" (Luborsky & Crits-Christoph, 1990) was chosen as a measure of object relations. In order to rate anxieties, a special tool was designed, combining Freud's theories of anxieties, findings from the ULM research and local studies. In order to systematically study defences, Freud's conceptions on defences along with Perry's systematic studies (Perry, Cooper, & Michels, 1987; Perry, Luborsky, Silberschatz, & Popp, 1989; Perry & Cooper, 1986) and recent, not yet published, studies were considered. The association between these three measures represents the research question of central interest.

The outcome of psychoanalytic therapy after almost six years of treatment has been found to be positive in three specific domains (Kordy, Rad, & Senf, 1988): symptomatic, personality and family and social. The Buenos Aires Study was adapted and some special tools designed to study these aspects of the individual case.

Evaluation

This process study may make an important contribution by considering a unique combination of a number of measures of therapeutic action. The measures combine newly crafted measures with better established ones. The lack of explicitly stated hypotheses represent a major challenge to the study.

The Amsterdam study of process records (ASPR)

- Stoker, J. & Beenen, F. and the Dutch Psychoanalytic Institute (1996): *Outline of a quality monitoring and checking system for longterm (4 or 5 times a week) psychoanalytic treatment*. Presentation at the Stuttgart Kolleg, February 8-10, 1996

The study's focus is on process and outcome research, i.e. the systematic evaluation of the psychoanalytic enterprise before, during and after the treatment. Process-measures will be at the centre of attention with the ultimate goal of adding scientific-empirical arguments to analysts' clinical knowledge of the curative factors in psychoanalytic treatment. The aim of the multicentre project, of which the current study is a part, lies in the introduction of multicentre cooperation to establish a systematic structural evaluation system of daily psychoanalytic practice, combined with an empirical research effort that underscores the claim of psychoanalysis to a place among the sciences. A concrete future output of the whole enterprise could be the construction of one (flexible) quality monitoring and checking system for psychoanalytic treatment.

Sample

Patients will be recruited by and from the local centres for pilot-studies using AAI-interviews and CHAP-interviews. Interview material will be translated and scored and otherwise systematically processed by the group.

Measures

In the approach described, first priority will be to implement quality monitoring and checking instruments in the different local centres. First choice in this regard is the Periodical Rating Scale. This list will be filled out by the analysts several times during the treatment period and the data will be entered into the computer of the Dutch Psychoanalytic Institute for central data processing. The scale covers:

- General characteristics of the treatment (time keeping, missed sessions, quality of the sessions, resistance) and content of the material (concerning the body, romantic/sexual relationships, relationships with significant others, object relations relating to unconscious content, sexuality, aggression relating to unconscious, current life events, employment, gender/age issues, discussion of treatment parameters)
- Predominant aspects of analyst's feelings towards/about the patient in this week's sessions.
- Analyst's predominant styles of intervention in this week's sessions.

Results

By developing and implementing the described instruments, it seems possible to evaluate more systematically, and therefore more reliably, the changes of the mind, especially the effect of treatment on the development of mentalizing functioning which psychoanalysis intends. Focussing on these changes with the newly adapted measurements during and after treatment can furnish a new 'window' on the psychoanalytic process. Application of the Periodical Rating Scale can also link the activities the analysts say they do (in a more systematised and standardised way) to the changes the patients show during and after treatment.

Empirical studies on clinical inference: Similarities and differences in the clinical work of psychotherapists with different theoretical approaches and levels of experience.

- Leibovich de Duarte, A. (1996). Variaciones entre Psicoanalistas en el Proceso Inferencial Clínico. [Variations among psychoanalysts in their process of clinical inference]. *Investigaciones en Psicología. Revista del Instituto de Investigaciones, Facultad de Psicología, UBA, 1(1)*, 27-38.
- Leibovich de Duarte, A. (2000). Más allá de la información dada: Cómo construimos nuestras hipótesis clínicas [Going beyond the information given. How do we construct our clinical hypotheses]. *Revista de la Sociedad Argentina de Psicoanálisis, 3*, 97-114.
- Leibovich de Duarte, A., Huerín, V.; Mandler, A & Torricelli, F. (1998) "Sobre la inferencia clínica en psicoanálisis: algunos resultados empíricos" [On clinical inference in psychoanalysis: some empirical results] Paper presented at the *4th. Meeting of the South American Chapter, Society for Psychotherapy Research*. Montevideo, Uruguay.
- Leibovich de Duarte, A. Huerín, V. Roussos, A. Rutzstein, G. Torricelli, F. (2000) "Explorando la construcción de hipótesis clínicas en psicoterapia" [Exploring the construction of clinical hypotheses in psychotherapy] Paper presented at the *2nd. Latin- American Research Conference on Psychoanalysis and Psychotherapy. 5th Meeting of the South American Chapter, Society for Psychotherapy Research*. Gramado, Brasil.
- Roussos, A. (1999). *La inferencia clínica y la elaboración de hipótesis de trabajo de los psicoterapeutas*. [Clinical inference and the construction of working hypotheses by therapists] Doctoral dissertation, Universidad de Belgrano. Buenos Aires.
- Rutzstein G. (in press). "Inferencias clínicas en el tratamiento de pacientes con trastornos de la alimentación. Una aproximación empírica" [Clinical inferences in the treatment of patients with eating disorders. An empirical approach] *VIII Anuario de Investigaciones: 2000*. Facultad de Psicología, Universidad de Buenos Aires.

Brief summary of approach

Clinical inference is, perhaps, the central activity of psychotherapists in the context of the psychotherapeutic situation. However, there are few systematic empirical studies dealing with the ways in which psychotherapists work with and construct their hypotheses about the material offered by their patients.

Several studies have been conducted to explore similarities and differences in the clinical work of psychotherapists with different theoretical approaches and levels of experience. The first (Leibovich de Duarte et al., 1998) studied the similarities and differences of Freudian and Lacanian psychoanalysts both senior (more than 20 years of clinical experience) and junior (less than 10 years of clinical experience). A second study, still in progress, (Leibovich de Duarte et al., 2000), investigates the same topic comparing psychoanalysts, cognitive and systemic psychotherapists. It explores which authors constitute the therapists' theoretical framework, the nature of the goals they set for their clinical practice, and it also has inquired into whether they use technical resources other than those proposed by their theory. In addition, possible connections between the moments in the patient's discourse from which the therapists select cues to elaborate their clinical inferences and CRA patterns (Mergenthaler & Bucci, 1999) that characterize the patient's discourse are explored.

Roussos (1999), in his study about psychotherapists' clinical inferences and construction of working hypotheses, explored the relation of the hypotheses produced by a group of psychoanalysts and cognitive psychotherapists on the same patient's session with the data obtained after applying empirical technical instruments such as the PPQS (Jones, Cumming et al., 1993), CCRT (Luborsky & Crits-Christoph, 1998) and CRA (Mergenthaler & Bucci, 1999).

Rutzstein (in press) studied similarities and differences in the production of clinical inferences by psychotherapists, experts in eating disorders and therapists with no expertise in the subject and explored how these two groups build their diagnostic hypotheses, decide intervention strategies and choose treatment plans.

In all these studies a tape-recorded first session of a psychotherapeutic treatment plus its verbatim transcript was the stimulus utilized. For each study the same session was used for all the participants. The sessions were selected because a prior group of psychoanalysts, cognitive and systemic therapists, who were not part of the study, had not been able to identify the treating therapist's theoretical orientation. Each participating therapist listened to the tape-recorded first session of a psychotherapeutic treatment, whilst simultaneously reading the verbatim transcript; they were asked to report their clinical inferences, clues and hunches about the material and to underline what they considered relevant. They were asked to stop the tape every time they had a hunch, an hypothesis, a commentary or a possible intervention, in order to formulate it. Once this phase was over the participants were interviewed to get their additional reflections and commentaries. Some specific other techniques were used in the different studies.

Major results

Only some of the findings about the inferential process of psychoanalysts and cognitive psychotherapists are included in this report.

1 Time elapsed before the formulation of the first inference from the patient's materials.

Those studies that considered how much time elapsed before the formulation of the first inference (Leibovich de Duarte et al., 1998; Leibovich de Duarte et al., 2000; Rutzstein, in press) found an interesting pattern. 65% of the therapists needed less than 6 minutes to produce their first inference. In two of the studies (Leibovich de Duarte et al., 1998; 2000) in which the same clinical material was used, more than half of that 60% produced their inferences in 2 minutes or less.

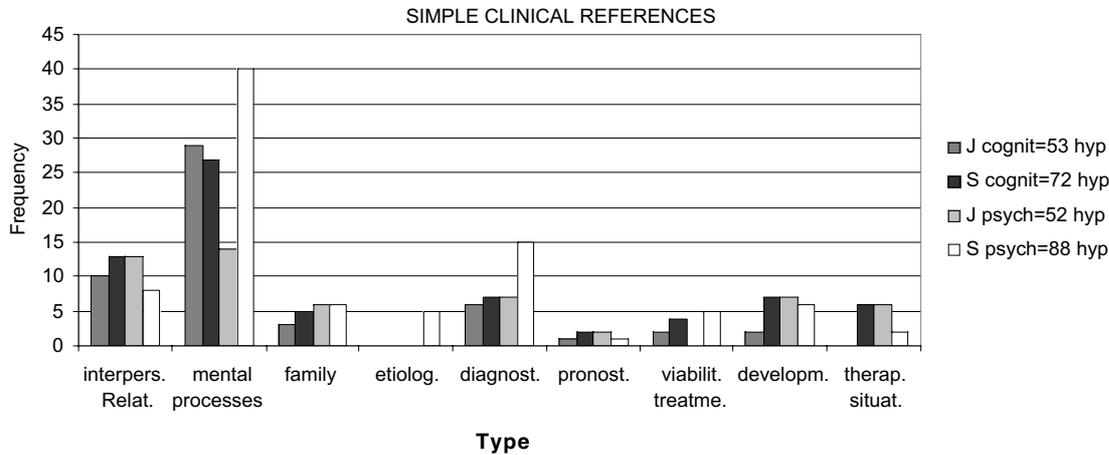
It is very interesting to underline that 6 psychoanalysts, both seniors and juniors, and 4 cognitive therapists who needed less than 3 minutes to express their inferences were later asked about their subjective impression of how much time had elapsed before their first inference. All of them answered that the time elapsed was no less than 10 minutes.

2 Types of inferential formulations

Different types of inferential formulations produced by the psychotherapists in two of the studies were analyzed (Leibovich de Duarte et al., 1998; 2000). A list of categories for classifying different contents of the material referred to by the therapists was constructed, including themes like interpersonal relations, mental processes, family issues, diagnostic, prognostic, etiological, developmental considerations, among others. The therapists' production was then classified according to how many categories from the aforementioned list were involved in each formulation. Reference to one category constituted a simple clinical inference and any combination of two or more was considered a combined clinical inference.

Therapists with more experience produced more clinical inferences, both simple and combined. In this regard, in the study of similarities and differences among, both senior and junior psychoanalysts, cognitive therapists, and systemic therapists (Leibovich de Duarte et al., 2000) a comparison of the amount and type of inferences produced by psychoanalysts and cognitive psychotherapists (n= 28) Therapists with more experience produced more clinical inferences, both simple and combined. Figure 1 shows the frequency distribution of the 265 simple clinical inferences.

Fig. 1: Frequency of clinical inferences made by junior and senior therapists with cognitive and psychoanalytic orientations



A total of 197 combined inferences were formulated in this study; senior psychoanalysts produced 96 of them, remarkably more than the 49 constructed by the senior cognitive therapists. Junior psychoanalysts and junior cognitive therapists formulated 25 and 27 combined inferences respectively.

Two of the studies (Leibovich de Duarte et al., 1998; 2000) show that, over time, senior therapists' simple inferences become articulated into more complex ones; expertise does appear to account for their tendency to establish more significant relationships among different contents of the material than junior therapists. Juniors produce inferences that are more limited in scope, less elaborated and less integrated than their more experienced colleagues.

Adherence to a particular theoretical school of thought was not reflected on the nature of the clues therapists selected, but theoretical differences did appear in the way those clues were organized and explained. This means that their clinical inferences were different, based on their different theoretical frameworks.

3 Reflections of the participants on their experience

Answers given by the psychoanalysts and cognitive therapists when they were questioned about their experience during this study are very revealing (Leibovich de Duarte et al., 2000): a) 26 out of 28 of all participant therapists considered that their clinical inferences were very close to the data. b) 20 out of 28 therapists indicated that the recurrence of themes during the session was an important point of reference for their inferences. c) in the opinion of 23 out of 28 therapists, prior experience with other patients was also relevant when making their inferences. d) the level of confidence in their inferences was high for all therapists: 3 points or more on a five points scale. e) psychotherapists considered that their theoretical framework has an important influence on their selective attention to the data and on producing their suggested interventions. f) even though there are few references to diagnostic and prognostic considerations in the therapists' clinical inferences (see Figure 1) most of the senior therapists (10 out of 14) thought that they had paid considerable attention to diagnostic and prognostic considerations.

An analysis of the answers to the questionnaire- an expression of the therapists' experience during this study- suggests that there were no remarkable differences among both senior and junior psychoanalysts and senior and junior cognitive therapists regarding the way in which they evaluate their approach to a patient's material.

4 Relation of the hypotheses produced by therapists with the data obtained after applying empirical technical instruments

Roussos (1999), in his study about psychotherapists' clinical inferences and their construction of working hypotheses, explored, among other issues, the importance of the psychotherapists' theoretical frameworks. Therapists' hypotheses were analyzed using the Q-sort items (PQS, Jones, Cumming et al., 1993). The analyses of the data indicate that when both the content and style of the hypotheses produced by the therapists were classified using the Q items criteria, two distinctive groups of hypotheses appeared corresponding to the two theoretical frameworks involved (canonical correlation= 0.873, $p= 0.015$). Each theoretical group produced a different and specific type of hypothesis. Also in this study, judges analyzed the therapists' hypotheses using the Q items. The results obtained were compared with the results obtained by Ablon & Jones (1998) in their study on how expert clinicians' ideal prototypes correlate with outcome in psychodynamic and cognitive-behavioral therapy. The comparison showed a very interesting coincidence: the hypotheses produced by the Argentinian psychoanalysts conformed to a similar prototypical pattern to that developed by American psychoanalysts. However, it was not possible to find the same coincidence between the group of Argentinean and American cognitive therapists.

5 Inferential work of psychotherapists who are specialists and non-specialists in eating disorders

Rutzstein (in press) has obtained interesting findings regarding the inferential work of specialists and non-specialists in eating disorders. 90% of the specialists, both psychoanalysts and cognitive psychotherapists, diagnosed the patient whose material they worked with as having an eating disorder while only 43% of the non-specialists arrived at that diagnosis. 90% of the cognitive therapists considered that interviewing is not enough to diagnose eating disorders; they need additional information provided by specific scales. As to the estimated treatment length for cases like the one considered in this study, 75% of the psychoanalysts suggested a duration of four years or more, while 90% of cognitive therapists recommended two years or less of treatment.

Brief evaluation of the approach

Even though these are not truly naturalistic studies, their designs come very close to the process used by clinicians in their everyday clinical work. It is to be expected that these studies will help us gain a better understanding of the clinical inferential process and contribute to make our work and expertise more accessible to others, mainly young trainees.

The therapeutic cycles model (TCM) in psychotherapy research: theory and measurement

- Mergenthaler, E. (1996). Emotion-abstraction patterns in verbatim protocols: A new way of describing therapeutic processes. *Journal of Consulting and Clinical Psychology* 64: 1306-1318.
- Mergenthaler, E. (1998). CM - the Cycles Model software. (Version 1.0). Sektion Informatik in der Psychotherapie. Ulm, Germany, Universität Ulm.
- Mergenthaler, E. (1998). Cycles of Emotion-Abstraction Patterns: A Way of Practice Oriented Process Research? *The British Psychological Society - Psychotherapy Section Newsletter* 24: 16-29.
- Mergenthaler, E. (2000). The Therapeutic Cycle Model in Psychotherapy Research: Theory, Measurement, and Clinical Application. *Ricerche sui Gruppi* 10: 34-40.

Brief summary of approach

The identification of therapeutic change agents is clearly necessary to understand and study psychotherapeutic processes. But is an understanding of the processes of change an adequate base for empirical research on them? What seems to be missing are models of therapeutic processes that prototypically define the interplay of change agents and describe their temporal sequence.

Karasu (1986, p. 693) argued that “all psychotherapies use some combination of affective experiencing, cognitive mastery, and behavioral regulation as therapeutic change agents”. The Therapeutic Cycles Model (TCM) (Mergenthaler, 1996) has been developed using computer assisted content analysis tools. The CM software (Mergenthaler, 1998a) is easy to use and allows for the modification of various parameters like word block size and smoothing. It makes use of two change agents, Affective Experiencing and Cognitive Mastery measured as “Emotion Tone” and “Abstraction” in the verbal expressions of patient and therapist in verbatim transcripts. It defines a prototypical sequence of Emotion-Abstraction Patterns which can be compared with real sequences to allow critical moments to be pinpointed.

The quantitative dimension of the linguistic measures Emotion Tone and Abstraction allows the differentiation of four classes, the Emotion-Abstraction Patterns. They are made up as a combination of the standardized relative frequencies (z-scores) for Emotion Tone and Abstraction words. The four patterns are defined, labeled, and interpreted as follows:

Pattern A - Relaxing: Little Emotion Tone and little Abstraction. Patients talk about material that is not manifestly connected to their central symptoms or issues. They describe rather than reflect. Further, it is a state patients return to as often as they feel the need to, thus regenerating both physis and psyche to prepare themselves for the next step of their ‘talking cure’.

Pattern B - Reflecting: Little Emotion Tone and much Abstraction. Patients present topics with a high amount of abstraction and without intervening emotions. This may be an expression of defence known as intellectualizing.

Pattern C - Experiencing: Much Emotion Tone and little Abstraction. Patients find themselves in a state of emotional experiencing. They may be raising conflictual themes and experiencing them emotionally.

Pattern D - Connecting: Much Emotion Tone and much Abstraction. Patients have found emotional access to conflictual themes and they can reflect upon them. This state marks a clinically important moment.

The model itself is derived from a specific temporal sequence of the four Emotion-Abstraction Patterns. It is based on the assumption that across a psychotherapy or within a psychotherapy session the flow of the linguistic measures Emotion Tone and Abstraction does not occur by chance. Rather a periodic process for the underlying concepts of emotional experience and reflective processes is assumed (see Mergenthaler, 1998b; 2000 for the phases of the model in its most recent version).

The TCM can be used for both micro analyses and macro analyses. In the macro-analytic perspective the patterns are computed for full treatments. A therapy can then be characterized by a given sequence of these patterns. From clinical experience it is known that in every therapy there are phases in which the patient has more working-through processes but also periods where defence mechanisms dominate or patients are occupied by emotional states. The TCM puts this experience into an ideal and prototypic order.

Microanalysis refers to the analysis of a single therapy session. Here the TCM describes the very moments of genesis, effect and end of therapeutic progress. From clinical experience it is well known that insight does not occur very often within a session and even not within every session. With regard to the TCM it is rather expected that the cycle fairly often can be observed partially.

Three principles contribute to the descriptive power of this approach. The first one is the principle of repetition which means that single phases of the model can be repeated. The second one is iteration when complete cycles are iterated. Finally the principle of recursion can be observed on the macro-analytic level: this means that one or more cycles can occur within a given major cycle. All three together constitute the descriptive power of the TCM.

Major results

The first validation of the TCM has been done with a cross sectional study covering ten improved and ten non-improved patients and with a single case study. It has been shown that improved patients show significantly more Connecting and less Relaxing than patients that did not improve. There were no differences for Experiencing and Reflecting. It was also shown that at the beginning of the therapies the two groups did not differ. It was concluded that improved patients learned to connect emotional experience with reflecting processes during their therapy. Thus Connecting may be seen as a necessary condition for therapeutic change. In the single case analysis a key session could be correctly identified and within the key session the two key moments. These findings could be interpreted clinically in the way the model proposes.

An increasing number of studies are using the TCM as a major component. The following list should indicate the diversity of possible approaches, but does not claim to be complete. Some of the studies are published or about to be published.

Therapeutic Orientations: Psychoanalysis (D. Baucom, A. Stern - Daniels Foundation, NC, USA); Psychoanalysis (A. Avila-Espada, J. Vidal-Didier, Salamanca, Spain); Group psychotherapy (M.I. Fontao, Buenos Aires, Argentina); Cognitive behavior therapy (A. Semerari, G. Nicoló, Rome, Italy); Process experiential therapy, Client Centered Therapy (L. Greenberg et al., York University, Canada); Supported/Self-Directed Constructivist Narrative Therapy (L. Glasman, L. Beutler, UCSB, USA); Supervision (G. Overbeck, A. Stirn, Frankfurt, Germany)

Textual material from other than psychotherapeutic sources: Prose: Analyses of two novels written by anorexia nervosa patients (A. Stirn, Frankfurt, Germany); Field post in the second world war: Analyses of correspondencies (K. Kilian, Berlin, Germany); Interviews with patients before bone marrow transplantation (N. Grulke, Ulm, Germany)

Diagnostic aspects: Psychotherapy with sexual offenders (F. Pfäfflin, Ulm, Germany); Psychotherapy with a torture victim (S. Varvin, Oslo, Norway); Psychotherapy with schizophrenic patients (S. Kraemer, M. Liehl, Munich, Germany); Psychoanalysis with borderline patients (O. Kernberg, Cornell, USA); Brief psychotherapy with a patient suffering from headache (R. Schors, München, Germany).

Comparing methodologies: Interpersonal regulation of interactions using SASB (K. Kalmykova, I. Tchesnova, Moscow, Russia); Mother baby attachment behavior during psychotherapeutic consultations (S. Gril, M. Altman, Montevideo, Uruguay); Adult Attachment Interview (A. Buchheim, Ulm); Discourse analysis (G. Lepper, University of Kent, England); Validation of translations (Frommer, Magdeburg); Comparing process notes with verbatim transcripts (E. Bailey, Loyola College, Maryland, USA).

Brief evaluation of the approach

The model of therapeutic change as it was presented here, allows for a formal and objective description of therapeutic processes within and across sessions. The variables used are identified as being sensitive in a sense of change agents as introduced by Karasu. Furthermore their definition is independent from orientations given by different schools. The graphical representation of patient's and therapist's speech behaviour, and the representation of the verbal activity of both allows a transparent view of the therapeutic process. But also the components that build up this model can be observed by the clinician him- or herself in the real therapeutic situation as: Negatively tinged language, positive Emotional Tone, reflecting processes, and narratives. All these are communication phenomena that can be realised by a therapist while in session with a patient, and therefore can help to control the dyad. It may therefore be considered as a step towards practise oriented research and improvement of process quality.

Computer-based textanalysis of the Adult Attachment Interview: The relationship between attachment representation, emotion-abstraction patterns and narrative style:

- Buchheim, A. (2000). Bindungsrepräsentation, Emotions-Abstraktionsmuster und Narrativer Stil: Eine computerunterstützte Textanalyse des Adult Attachment Interviews. University Ulm, Ulm.
- Buchheim, A., & Mergenthaler, E. (2000). The relationship among attachment representation, emotion-abstraction patterns, and narrative style: A computer-based text analysis of the Adult Attachment Interview. *Psychotherapy Research*, 10, 390-407.

Brief summary of approach

The aim of this study was to test the scope of the computer-based, economically compilable linguistic text measures (emotion abstraction patterns, Mergenthaler, 1996; computer-based referential activity, Mergenthaler & Bucci, 1999) for differentiating between less easily compilable complex attachment representations with the Adult Attachment Interview (Main & Goldwyn, 1998).

Measures

Mergenthaler's textanalytic approach makes use of two change agents, "Affective Experiencing" and "Cognitive Mastery", measured as Emotional Tone and Abstraction in the verbal expressions of communicating persons using verbatim transcripts. The Therapeutic Cycle Model is based on the assumption that across a psychotherapy, or a single session, emotion-abstraction patterns do not occur by chance, rather in a periodic process. Mergenthaler operationalized "Connecting" as the coincidence of high Emotional Tone and high Abstraction, a state in which patients have found insight into their problem.

According to Bucci's multiple code theory our inner experience is translated into words, and the words of others are translated back into nonverbal forms (Bucci, 1997). This process of connecting nonverbal experience with language is called referential activity (RA).³ The CRA dictionary (Mergenthaler & Bucci, 1999) includes high and low RA-words. Subjects with high referential activity speak in rich, concrete narrative style and describe specific events in a clear manner. They evoke interest in the listener. Subjects with low referential activity speak in abstract terms, their speech is vague and diffuse.

The coding of the AAI (Kobak, 1993; Main & Goldwyn, 1998) focuses, through analysis of the literal transcription, on the coherence of the discourse, as well as on the emotional and cognitive integration skills in the narrated attachment experiences. With regard to narrative style the three major attachment categories are classified as 1) Secure-Autonomous; narratives are coherent and open, responses are clear and relevant; statements about childhood integrate and reflect emotional aspects. 2) Insecure-Dismissing; narratives are incoherent and emotionally distant on a general and abstract level. 3) Insecure-Preoccupied; emotional conflicts in childhood are addressed concrete but incoherent; use of pseudo-psychological language without adequate distance to conflicts.

Method

40 subjects' complete AAI transcripts with the distribution: secure: n=20, dismissing: n=10, preoccupied: n=10 were examined. Two blind reliable raters analyzed the AAI-transcripts according to the Kobak-Q-Sort-method (both raters are also certified for the Main & Goldwyn system). The aim was to test whether Mergenthaler's and Bucci's language measures can contribute to a relevant construct validity of the defined attachment categories. Further they analyzed all transcripts, using each of the 18 AAI-questions as a scoring unit. They were expecting that different topics in the AAI (e. g. separation, illness, metacognition) would activate different linguistic variables and could contribute to a thematically relevant construct validity for the language measures.

⁴ For a detailed account of the RA scales and computer procedures, see the Appendix to this report.

Major results

The results showed that the textanalytic approach is useful to differentiate between the complex attachment categories on an objective level. The study of n=40 subjects produced the consistent result that of the two insecure attachment categories, the group “dismissing” (n=10) showed the lowest means on the text measures, whereas the group “preoccupied” (n=10) showed the highest means. The mean of the attachment group “secure” (n=20) lay between these groups. Looking at the single variables: Subjects from the group “dismissing” use the least words with emotional tone in the three-group comparison, show the lowest proportion of the emotion abstraction pattern “connecting”, but most frequently use the complementary pattern “relaxing”, a state of disorientation in which they hardly mention or consider feelings, or do not even know what to talk about. They also show a weakly developed narrative style, i.e. they rarely express themselves clearly, specifically, concretely or vividly. Subjects in the “preoccupied” group on the other hand most frequently use emotionally negative words in the three-group comparison. They show most frequently the emotional abstraction pattern “connecting”, i.e. they use both concepts emotion and abstraction more often at the same time. Their style of speech is characterized by clear, specific, concrete, and vivid expression. Obviously, the verbally excessive, enmeshed and conflict-laden character of this group reflects a comparatively high verbal productivity in most linguistic measures. Interesting and at the same time astonishing is the high coincident use of emotion and abstraction (“Connecting”). The subjects classified as “secure” show moderate values in all linguistic computer measures. This seems to indicate a balanced approach to the verbalization of feelings, thought processes and the contribution of narrative material. The moderateness of this group is consistent with other results from attachment theory which show flexibility and balance in the regulation of emotion and cognition in securely attached persons (Zimmermann, 1999).

Furthermore the semistructured AAI with 18 questions seems to be a suitable instrument to contribute to a construct validity of the disparate language measures. The segment analysis showed plausible correspondences between thematic focus of the question and linguistic category. The anova-analysis showed highly significant differences regarding the intensity of appearance of all language measures depending on thematically corresponding AAI-questions, e. g. AAI-questions with focus on negative emotions “threat/abuse”, “loss of a significant other through death”, “separation from own child” activated the language measure *negative ET* more frequently; AAI-questions with focus on a metacognitive perspective “transmission of own attitudes towards the child” and “effect of childhood on personality” activated the language measure *Abstraction* more frequently; AAI-questions with focus on narratives “adjectives father”, “adjectives mother”, “loss of a significant other through death” activated the language measure *CRA* more frequently.

The confirmation of the hypotheses made non-directionally in this study cannot be accounted for in terms of simple artefacts of measurement. First, all comparisons were carried out with relative frequencies. Already known differences in the speech activity of the three attachment groups do not therefore imply a differentially frequent use of cognitive concepts. Furthermore, the definitions of the attachment types on the one hand and the emotions abstraction patterns and narrative styles on the other hand are conceptually different from each other. It may be concluded that the concepts of EAP and CRA not only relate to clinical aspects of therapeutic change but are also sensitive to attachment representation.

However the discussion of the results in relation to the concept of coherence shows that the mere consideration of the score on the language measures within the attachment groups is not suitable as a direct substitution of a complex discourse analysis of the AAI according to the criteria of

Main & Goldwyn (Main & Goldwyn, 1998) and Kobak (1993). The group “preoccupied” with the highest proportion of “connecting” seems typically, from an attachment theoretical perspective, to be able to verbalize and at the same time reflect on conflicts. However, these people do not have the ability to integrate positive as well as negative emotions, nor to adopt an esteeming coherent metacognitive perspective. This raises the question of whether the coincidence of language markers for emotion and abstraction is adequate to discern “insightful” passages.

Both the “preoccupied” and “secure” groups showed a higher referential activity compared to the “dismissing”, which was a surprising result due to the fact that the latter often misleads with its detail and specificity, if one overlooks the incoherence (drifting from the topic at hand, anger). On the other hand, people classified as “secure” sometimes give the impression of being verbally excessive, although they do come back to the topic according to Grice’s (1975) coherence criteria. Text-analytically, these boundary-zones are barely identifiable since both groups presumably show a similar narrative surface-structure. It would be well worth discussing whether there may be an “excess” amount of referential activity which, despite the richness of detail, imagery, and specificity of the narrative style, represents an underlying irresolution and conflict-stricken state. The question here is what degree of referential activity seems optimal in order to achieve an adequate narrative style.

Brief evaluation of the results

This is a unique study with the potential to contribute theoretically and methodologically to psychoanalytic research. It offers a way of understanding the nature of attachment classifications that the AAI offers. Further, it holds out the potential of an automated coding system replacing the complex and cumbersome system of coding currently in use. A further strength of the approach followed is the respect for attachment theory demonstrated by the authors and the resistance of the tendency to reductionism which is often manifest in efforts at reworking coding systems evolved using a qualitative method into a quantitative text based system.

The research programme on private theories of pathogenesis and cure

- Levander, S. & Werbart, A. (1997). Rorschach-records from three apparently well adjusted women suffering from long-standing and diffuse somatic disturbances. In A.M. Carlsson, A. Cederström, & H. Janson (Eds.), *Research into Rorschach and projective methods: Selected papers from the First Nordic Symposium on Research into Rorschach and other Projective Methods*, Uppsala 1995 (pp. 93-101). Stockholm: Swedish Rorschach Society.
- Werbart, A. & Levander, S. (1998). La construcción de significado y las teorías privadas de la patogénesis y la cura. *Revista de Psicoanálisis*, 55:767-768.
- Werbart, A. & Levander, S. (2000). Pain in the body – pain in the soul: The need of private explanations when not feeling well. In P. Nilsson & K. Orth-Gomér, eds. *Self-rated health in European perspective*, pp. 136-151. FRN Report 2000:2. Stockholm: Forskningsrådsnämnden.

Every adult, like every child, from psychological necessity creates his or her own, private explanatory systems of enigmatic contexts. We try to comprehend what happens to us, by filling in the gaps with fantasies, popular folk ideas, and available pieces of real or distorted information. This search for meaning is especially obvious when we feel ourselves exposed to something unpredictable, or when our everyday context of meaning is ruptured. This research programme aims to investigate private theories of pathogenesis and cure, i.e. subjective explanatory systems about how the problems may have arisen and how they may be remedied, obtained from the narratives of patients and their clinicians in primary care, psychosocial support, psychoanalysis, and psychotherapy, as well as from a non-clinical sample. The researchers hypothesize that concordance or discordance between the explanatory systems of the two participants has an impact on the process of psychoanalysis or psychotherapy, thus influencing the long-term outcome. The research programme is conducted in four distinct steps.

Brief summary of approach

The first step in the research programme was an exploratory study (conducted 1994 to 1997) of the attempts of individual patients in non-therapeutic contacts to give meaning to their somatic and psychological difficulties and to include them within their private context. The empirical basis was 107 (out of 114 possible) interviews (repeated 6 and 18 months after the initial interviews) with three groups of patients: first-time psychotic (n=6) and chronically psychotic (n=6) patients, and patients from primary care with long medical contacts for diffuse somatic problems (n=7). The clinicians were also interviewed using the same questions: both patients and clinicians were asked to describe the patient's problem, when it began, why it started, and how the situation could be improved. The semi-structured interviews were recorded, transcribed and summarised following an especially designed model by three psychoanalytically trained, independent judges. The manual differentiated between the manifest narrative, recurrent themes; formal aspects of the narrative, such as important places and objects; degree of elaboration and plasticity, the degree of activity/ passivity of the hero; and the construction of the hypothetical core explanatory system. Theories of somatic and psychotic patients were compared, as well as early and late stages in the theory construction. Similarities and differences between the theories of the patient and the clinician were described. The group of first-time psychotic patients provided an opportunity of studying theories of pathogenesis and cure from their conception, whereas the two other groups enabled the researchers to study already well-established systems of ideas and fantasies. Stability over time, versus changes in these explanatory systems were studied over a period of 18 months.

The second step in the research programme is an ongoing prospective study (started 1997) of private theories of pathogenesis and cure obtained from patients in psychoanalysis and their analysts. The 8 analyses are investigated using a case study methodology. The research questions centre around the changes in these private theories during the psychoanalytic process, the degree

of concordance or discordance between the two participants, the interaction between the two different sets of understandings, and its possible effects on the process and outcome of psychoanalysis. Analysands and analysts are interviewed on six occasions: at the start of psychoanalysis, and then 6 months, 1.5 years, and 3 years after the first interview, at termination of analysis, and 1.5 years after termination. The methodological starting point for this project is a narrative approach. A manual for PT-interviews *How do you perceive your own/ the patients problems and difficulties?* has been constructed. The PT-coding system was developed, which combines tailor-made formulations, standard categories, and global ratings. A reliability study was able to demonstrate an impressively high degree of concordance between independent interpreters. The procedure used in the reliability study was also adapted for a study of concordance or discordance between the analysands' and the analysts' private explanatory systems.

The third step is a naturalistic, prospective and longitudinal study of young adults applying for and undergoing psychoanalytically oriented psychotherapy: Young Adult Psychotherapy Project (YAPP). An increased number of young adults (18–25 years) in Stockholm are seeking psychotherapy and psychiatric help. Clinicians seek better methods of dealing with the specific strains met by young adults at the beginning of psychotherapy. Experiences from the two previous steps are used in the applied integrative treatment model, built upon two principles: (1) the patient's own problem and goal formulations are taken as a starting-point for the shaping of a time-limited psychotherapy, (2) elements of assessment and evaluation are incorporated in the clinical situation. This study is planned to include 150 consecutive, self-referred patients (aged 18–25 years) at the Institute of Psychotherapy who started their psychotherapies during the period 1998–2001. To date 95 patients and their therapists are included. The patients in individual psychotherapy are randomised to the integrative treatment group and to the comparison group (treatment as usual). The third group consists of patients in group therapy.

The fourth step in the research programme is the Young Adult's Own Thinking, Understanding, and Managing of Everyday Life (YOUTH) study (started 2000) of private explanatory systems and personal strategies, created by young adults (aged 18–25; non-clinical population) in confrontation with strains and challenges on the threshold of adulthood. Previous investigations indicated that it is important to study young adults' ways of expressing their thoughts and feelings about difficulties they experience in life and how they go through them, not only in clinical population of young adults in therapy, but also in a non-clinical population of "ordinary" young adults. Using case study methodology, both successful and non-adaptive strategies are investigated, as well as differences between women's and men's private theories about their difficulties and ways of managing strains and challenges in life. The private theories of 24 young adults from a non-clinical population are compared with private theories of young adults belonging to the clinical population at the Institute of Psychotherapy. The research project has a longitudinal design, and integrates qualitative and quantitative methods. The material includes semi-structured in-depth interviews with 24 young adults in Stockholm from different social backgrounds and life situations. All initial interviews are already conducted. Follow-up interviews will take place 1.5 year later (end of 2001) and 3 years later (2003). The comparison group consists of the clinical population of young adults at the Institute of Psychotherapy in Stockholm. The interview is conducted according to a modified version of the PT-interview and focuses on the interviewees' own personal narratives about problems, private theories of pathogenesis, and personal strategies, both current and future. Next step is a survey in a representative random sample of young adults in Stockholm. A questionnaire about young adults' difficulties in everyday life, their thoughts of the background to these difficulties, and their ways of managing them, is constructed on the bases of case studies. The questionnaire will be administered to a representative random sample of young adults in Stockholm (approximately 1000 participants).

Major results

Step 1: All patients, no matter how long their problems had lasted, as well as their clinicians created their own, more or less elaborate explanatory constructions about pathogenesis and cure. None of the patients or clinicians relied on one theory only. The private theories presented also seemed to have striking similarities with psychiatric, psychological, and psychoanalytical explanatory models, not only as to content, but also as to the formal aspects. In the group of chronic psychotic and long-time psychosomatic patients it was striking how vivid the narratives still were when they spoke of the circumstances that originally made them start reconstructing their personal contexts of meaning.

Private explanatory systems seem to be remarkably stable across time. First-episode psychotic patients, however, had more theories about their problems than did long-term psychotic patients, especially in the first interview. This implies that some theories are selected in favour of others, as time passes. The material also suggests that patients stay with their first theories to a greater degree than do their clinicians, who seem to grasp for new theories when they don't get the first ones confirmed.

Clinicians' attitudes toward patients were governed not only by scientific knowledge and tested evidence, but also by personal theories and opinions of which the clinicians themselves usually seemed unaware. Clinicians seemed not to notice that their own thinking often was not related to the explanatory models of their patients. Most of the clinicians appeared not to know about the patient's private, psychological explanatory systems. In non-psychotherapeutic contacts, the patients' own understanding, as it appeared in such theories, often did not seem to be a part of the dialogue between the parties. There were some indications that this might have had a negative effect on the treatment process.

Step 2: This study is ongoing. Big differences were found between the analysands' and the analysts' formulations of problems, theories of pathogenesis, and theories of cure at the start of psychoanalysis. As to the cure, the parties had on the whole quite different theories, with similarities only at very low levels of analysis.

Step 3: The study is ongoing. The project is expected to generate clinically applicable knowledge of how therapists could approach and use the patients problem formulations and private theories of pathogenesis and cure in order to promote a good therapeutic alliance, to find ways to overcome ruptures in the alliance, and to achieve a good therapeutic outcome.

Step 4: The study is ongoing. In the sample of 24 young adults in YOUTH they found many individuals with personality related problems who did not seek psychotherapy. Another finding was the great difference between the subjective explanatory systems, created by men and those created by women, especially with regard to private theories of cure. The most frequent themes in the male and female narratives are used in construction of the questionnaire for the survey investigation.

Brief evaluation of the approach

Psychoanalysis probably ignores at its peril the conscious theories of patients about their illness, about the possibility of help, about the nature of treatment that they assume might be helpful and about the ways they assume it might operate both at the level of interpersonal interaction and intrapsychic change. Freud's observation that our knowledge of the unconscious depends on the patient's conscious productions is often ignored. The implication of the layering aspect of the mind from present conscious to past unconscious through preconscious and the present

unconscious, as the Sandler have demonstrated, implies that a full topography of the phenomenological might indeed be helpful in our understanding of the deeper layers. Further, advances in therapies alternative to the psychoanalytic suggest that changes aimed at the phenomenological might be far more enduring than we had expected in the past. Patient's understanding of disease and treatment are likely to be key moderators of change and might also be indicators or even mediators of the restructuring of the internal world.

Psychoanalysis as social interaction: a conversation analytic study

- Peräkylä, A. (2000). *Using conversation analysis in psychotherapy research*. Paper presented at the IPA Research Training Programme, London.
- Peräkylä, A., & Vehviläinen, S. (2001). *Interpretative sequences in psychoanalytic interaction*. Paper presented at the Colloquium on Talk, Interaction and Medical Work, King's College, London.
- Vehviläinen, S., & Peräkylä, A. (2001). *Turn design and trajectories in interpretative sequences in psychoanalytic sessions*. Paper presented at the Language and Social Interaction division of National Communication Association 2001 Convention, Atlanta, USA.

Brief summary of approach

The purpose of the research is to describe how psychoanalysis is realized in concrete interaction between the analyst and the analysand. The data consist of audio recordings from psychoanalytic sessions. The tapes are transcribed and analysed using the methods of Conversation Analysis (CA). Conversation analysis studies structures and patterns of social interaction in natural settings by examining ways in which participants construct their actions on a turn-by-turn basis in real-time situations (Boden & Zimmerman, 1991; Drew & Heritage, 1992; Heritage, 1997). CA studies are based on analyses of video or audio recordings of natural situations.

CA originated in the 1960's in the US from studies by Harvey Sacks (1992) and his colleagues. Their empirical work showed that *conversation is an ordered phenomenon in itself* with systematic and observable features. These are structures and devices that the conversationalists use to maintain the possibility for communication and social action, to act in various roles and to carry out various activities. Fundamentally, conversations are organised through turns and turn-taking. Furthermore, conversations are *sequentially organised*. Each turn displays an understanding of the prior turn, and presents certain possibilities for the following turn. Thus, participants show in their actions their interpretations of 'what is going on'. This provides for the possibilities for empirical observation of how participants construct social actions turn by turn.

Recently, CA has concentrated on the study of so-called institutional interaction, studying how conversational structures and mechanisms are applied to particular institutional, often professional-client, situations (see Boden & Zimmerman, 1991; Drew & Heritage, 1992; Heritage, 1984, 1997). The task is to identify interactional structures by which institutional tasks and activities are carried out and institutional identities are maintained. Prior research of institutional interaction has focused on issues such as question-answer sequences, advice, reports and statements in various institutional settings such as TV news interviews, courtroom examinations (Atkinson & Drew, 1979) and medical consultations (Heath, 1992; Peräkylä, 1998).

Although the study of institutional interaction has expanded to various professions, there is fairly little CA research on therapeutic interaction, and none of it has so far focused on psychoanalysis. However, CA has been applied to various interactional settings that are close to therapy. These prior studies show that CA is a useful method in the study of therapy. These studies have identified various practises which the therapeutical process is grounded in, which have not necessarily been recognized nor reflected on by the participants themselves. The presently planned study will be the first conversation analytical study of psychoanalysis.

Sample

The data for the study currently consists of 60 audiorecorded sessions from three dyads (2 analysts, IPA; male and female; one with two analysands and the other with one analysand). Each dyad have provided 20 consecutive sessions of "deep" classical psychoanalysis. The authors are in the process of recruiting a third, possibly even a fourth analyst with 15-20 sessions from one patient. All the material will be transcribed according to the CA convention.

Anticipated results

The planning of the project started in Autumn 1998. The tape recordings for the current database (60 psychoanalytic sessions from three analyst-analysand dyads) took place in September 1999-March 2000. Transcription of the sessions is ongoing; at the moment, 30 sessions out of 60 are fully transcribed. Preliminary data analysis focussing on the analysts' interpretative utterances has taken place. In summer 2000, the results of these preliminary analyses were presented at two Nordic seminars on research on institutional interaction, and at the IPA Research Training Programme in London. In the study year 2000-2001, Anssi Peräkylä and Sanna Vehviläinen have carried out empirical analyses concerning research themes 1 and 4 (see below). The results of these analyses have been presented in conferences and workshops in Finland, Europe and US and will be worked into journal articles by the end of 2001.

The overall research question in this study is *Which features of interaction are characteristic for psychoanalytic sessions?* Ultimately, the research aims at uncovering "what makes psychoanalysis psychoanalysis": which forms of asking questions, telling stories, listening, commenting etc. are characteristic for psychoanalytic interaction. Conversation Analysis is an inductive approach in which the more detailed research questions can only be formulated during the course of the actual data analysis. In the initial phase of the data analysis, study of the structure of interpretative sequences has proved most promising. Preliminary systematic data analysis has been conducted in this area. This and the other promising topic areas that the researchers hope to explore are briefly described below.

Theme A: *The structure of interpretative sequences.* Interpretations made by the analyst are understood to be in the core of the psychoanalytic method (cf. Sandler et al. 1992). In the preliminary data analysis, the following areas pertaining to the interpretations have been identified as susceptible of systematic description:

The sequential context of the interpretative utterances. The analysts' interpretative utterances occupy different sequential positions vis-a-vis the preceding talk by the analysand: they can be answers to the analysand's questions, they can expand the patient's self-reflective utterances, they can be commentaries on the analysand's answers to the analyst's questions, or they can interrupt the analysand's course of action prior to the interpretation.

The linguistic form of interpretative utterances. Some interpretations are inferences or reformulations based on the patient's talk while others are initiatory assertions by the analyst, not claiming to reformulate what has been said by the patient. Utterances that are not designed as assertions (e.g. questions) can also have an interpretative function.

The patients' responses to the interpretations. The patient's verbal and non-verbal responses to interpretations embody their initial acceptance, insight or resistance towards the suggested interpretation. In the preliminary data-analysis, it appears that patients' responses are often (but not always) rather minimal and they often involve a somewhat ambivalent stance towards the suggested interpretation.

The continuation of the interpretative sequences after the patient's first response. Interpretative sequences are usually not limited to one interpretative utterance followed by some form of response by the patient. They may involve longer interchanges between the analyst and the analysand, moving for example from "clarifications" and "confrontations" to deeper interpretations where the analyst proposes "explanations" of the patient's experiences and behaviour.

Theme B: *Practices of inviting and directing the patient's talk.* The research will examine the ways in which the analysts encourage the analysands to talk and the ways in which they direct that talk.

Theme C: *Telling and interpreting dreams.* A large part of the conversation in psychoanalysis involves the telling and interpretation of dreams. In narrating their dreams, the patients on one hand orient to everyday expectations (basic assumptions concerning time, place, causality etc) but on the other, also allow for dramatic differences between the dream world and the everyday world. The research will examine how the “reality of dreams” is constructed in the patients’ narratives, and how the analysts convey the underlying meanings of dreams to the patients.

Theme D: *Free association.* It is thought that when the patients are allowed to freely associate, without the analysts’ interference through questions or evaluations, this provides access to their mind, and ultimately, to their unconsciousness. At the same time, the patients’ talk is always influenced by the situation and the interaction with the analyst. Free association is, therefore, a practical interactional task for both participants. This research will examine conversational phenomena relevant to this task.

Brief evaluation of the approach

Qualitative research methodologies are becoming increasingly important in the armamentarium of social and medical science researchers. Conversational analysis is a well-developed qualitative research methodology and has potentially great relevance to psychoanalytic work. The present study represents the first attempt at applying these methods to psychoanalytic material. Although the research is at a relatively early stage, the application of CA to psychoanalytic text should yield important clues about what makes psychoanalysis a unique process. CA will also be quite essential in the comparison of psychoanalytic cultures (e.g. object relational versus intersubjective approaches) and in the comparison of psychoanalysis and psychotherapy.

Comparing psychoanalysis and psychotherapy: Statistically calculated ideal prototypes of the psychoanalytic and psychotherapeutic process

- Epstein, R. (2001). Comparing Psychoanalysis and Psychotherapy: Statistically Calculated Ideal Prototypes of the Psychoanalytic and Psychotherapeutic Process (poster). Presented at the 32nd Annual Meeting of the Society for Psychotherapy Research, Montevideo, Uruguay.

Brief summary of approach

The researchers attempted to establish the theoretic or ideal prototypes of a psychoanalytic and a psychoanalytical based psychotherapeutic session, using statistical calculations. Psychoanalysts of the Asociación Psicoanalítica de Buenos Aires were asked to organize the 100 items of the PQS that describe empirically clinical events of the session, following the methodology described in the PQS manual (see E E Jones, 2000; Jones et al., 1991). The Q-items can be divided into: 1) patient interventions, 2) therapists interventions and 3) clinical situations, describing empirical elements. Each colleague had to order them twice, describing their image of the ideal sessions, once for each one of the therapies. The items were ordered according to what the analysts considered characteristic and uncharacteristic of the ideal of each type of session, and distributed in a gaussian array.

The resulting item rankings were studied statistically with the PRINQUAL (Tenenhaus & Vachette, 1977) technique for multivariate discrete data. The method was selected as appropriate to reduce the bulk of data and evaluate the relative weight of each item position according to the weight attributed to each of the psychoanalysts in their individual arrays, and then the accordance between the colleagues (with respect to each item by itself). The ideal session prototype was defined with those items that obtained the highest “score” due to the accordance (which was related to their placement in the extremes of the continuum in the characteristic and the uncharacteristic tails). The values of the uncharacteristic extreme were signaled as negative.

Major results

The values reproduced in Table 1 are the scores (S), as defined in the preceeding paragraph, and the median (M) for each item, which is determined (Ablon & Jones, 1999) qualifying its weight considering its placement in the array of 9 categories of the PQS arrangement: 9=extremely characteristic or salient; 1= extremely uncharacteristic or negatively salient.

Table 1. Scorings of characteristic and uncharacteristic qualities of the therapeutic process of psychoanalysis and psychotherapy by psychoanalysts.

| P-ANALYSIS | | | | P-THERAPY | | | |
|------------------------|-------|-----|-----|------------------------|-------|-----|-----|
| Uncharacteristic items | | | | Uncharacteristic items | | | |
| Item | Score | Med | Dom | Item | Score | Med | Dom |
| Q 21 | -2.32 | 1 | T | Q 51 | -4.06 | 1 | T |
| Q 51 | -2.14 | 1 | T | Q 77 | -3.65 | 1 | T |
| Q 77 | -1.97 | 2 | T | Q 24 | -3.45 | 1 | T |
| Q 9 | -1.54 | 2 | T | Q 21 | -3.26 | 1 | T |
| Q 24 | -1.45 | 1.5 | T | Q 9 | -2.88 | 2 | T |
| Q 38 | -1.38 | 2 | S | Q 37 | -1.39 | 3 | T |
| Q 37 | -1.28 | 2 | T | Q 14 | -1.33 | 3 | P |
| Q 17 | -1.2 | 2 | T | Q 1 | -1.03 | 4 | P |
| Q 66 | -1.19 | 2 | T | Q 5 | -0.88 | 3 | P |
| Q 27 | -1.14 | 2 | T | Q 19 | -0.71 | 4 | S |
| Characteristic items | | | | Characteristic items | | | |
| Item | Score | Med | Dom | Item | Score | Med | Dom |
| Q 92 | 1.17 | 8 | S | Q 31 | 1 | 7 | T |
| Q 82 | 1.21 | 8 | T | Q 45 | 1.01 | 6.5 | T |
| Q 50 | 1.36 | 8 | T | Q 46 | 1.05 | 7 | T |
| Q100 | 2.08 | 8 | T | Q 3 | 1.07 | 7 | T |
| Q 93 | 2.24 | 8.5 | T | Q 89 | 1.18 | 8 | T |
| Q 91 | 2.63 | 9 | S | Q 65 | 1.25 | 7 | T |
| Q 32 | 2.64 | 8.5 | P | Q 63 | 1.33 | 7 | S |
| Q 90 | 3.0 | 9 | S | Q 23 | 1.36 | 8 | S |
| Q 98 | 3.14 | 9 | S | Q 69 | 1.43 | 8 | S |
| Q 67 | 3.49 | 9 | T | Q 4 | 1.48 | 8 | S |

P-analysis: psychoanalysis session by psychoanalysts; P-therapy: psychotherapy session by psychoanalysts. Dom: Domains (T: items reflecting the therapists actions and attitudes; P: items describing patients actions and attitudes; S: items attempting to capture the nature of the interactions or the climate of the encounter)

Looking at the table, one can see that for the “characteristic” items the matrix of the psychoanalysis session is more strongly defined than the matrix for the psychotherapy session: the values of the “scores” are more extreme and the medians of the items are less dispersed (psychoanalysis: S=3.5 to 1.2 and M=9 to 8 vs. psychotherapy: S=1.5 to 1 and M=8 to 6.5). With respect to the “uncharacteristic” items, the matrix for psychoanalysis shows less difference between extreme “scores” but more concentration of the medians (S= -2.3to -1.2; M=1-2). On the contrary, the values for the psychotherapy session items show high accordance for the 5 more extreme items, but less concentration for the medians (S= -4.1 to -1.3; M=1 to 4). One can observe that 6 of the 10 items items selected for the “uncharacteristic” submatrix are common to the two types of sessions, but there is no coincidence between the “characteristic” submatrixes.

The “narratives” produced by aggregating the selected items (in their original wording), ordered according to 1) the dominions, 2) their being “characteristic” or “uncharacteristic” and 3) following the sequence set by their scoring, are given below. The “uncharacteristic” items are included using their definition by the opposite, as given by the PQS Manual, and the item is signaled by the letter r (reversed).

Psychoanalysis

In the psychoanalysis session: the activity of the **analyst** interprets warded-off or unconscious wishes, feelings or ideas (Q67). The analyst is neutral (Q93) and draws connections between the therapeutic relationship and other relationships. S/He draws attention to feelings regarded by the patient as unacceptable (e.g. anger, envy or excitement) (Q50), and the patients behavior during the hour is reformulated by the analyst in a way not explicitly recognized previously (Q82).

The analyst refrains from self-disclosure even if the patient exerts pressure to do so (Q21r).

S/he conveys by her/his manner, tone of voice or comments, that s/he does not assume an attitude of superiority (Q51r). His/her comments reflect kindness, consideration, or carefulness (Q77r), and s/he is genuinely responsive and affectively involved (Q9r). The analyst's own emotional conflicts do not intrude in the therapy relationship (Q24r), and s/he does not assume a tutor-like role in relation to the patient (Q37r). The analyst does not exert actively control over the interaction (Q17r), and is not directly reassuring even if pressed to do so (Q66r), nor gives explicit advice and guidance despite pressure of the patient (27r). The **patient** achieves a new understanding or insight (Q32). In **the session** the therapy relationship is a focus of a discussion (Q98), patient dreams or fantasies are discussed (90), memories or reconstructions of infancy and childhood are topics of discussion (Q91). Patients' feelings or perceptions are linked to situations or behavior of the past (Q92), and there is no discussion of specific activities or tasks for the patient to attempt outside of session (Q38r).

Psychotherapy

In the psychotherapy session: The **therapist** acts to strengthen defenses (Q89), and clarifies, restates, or rephrases patient's communication (Q65). His/her remarks are aimed at facilitating patient speech (Q3), and s/he communicates with the patient in a clear, coherent style (Q46). The therapist asks for more information or elaboration (Q31) and presents an experience or event in a different perspective (Q80). The therapist conveys by his manner, tone of voice or comments, that s/he does not assume an attitude of superiority (Q51r). His/her comments reflect kindness, consideration, or carefulness (Q77r), and the therapist's own emotional conflicts do not intrude in to the therapy relationship (Q24r). The therapist refrains from self-disclosure even if the patient exerts pressure to do so (Q21r), and s/he is genuinely responsive and affectively involved (Q9r). S/he does not assume a tutor-like role in relation to the patient (Q37r). The **patient** somehow conveys the sense that the therapist understands his or her experience or feelings (Q14r) and expresses positive or friendly feelings about the therapist (Q1r). The patient readily comprehends therapist's comments (Q5r). In **the session** patient's current or recent life situation is emphasized in discussion (Q69), and the patients treatment goals are discussed (Q4). The dialogue has a specific focus (23) and patients interpersonal relationships are a major theme (Q63). The therapy relationship seems basically unsexualized (Q19r).

The psychoanalysts that have been studied using the PQS produce completely different theoretical matrices of the ideal psychoanalysis and psychotherapy sessions: the submatrices for this part of the description do not have any item in common. On the contrary, from the point of view of the uncharacteristic end of the items, the situation is practically the reverse since both submatrices share 6 items, and, moreover, those of maximum score or accordance: Q9, Q21, Q24, Q37, Q51 and Q77. For the psychotherapy session there is higher accordance for the 5 more extreme items of the uncharacteristic end, with a low accordance and less differentiation on the side of the characteristic items.

Once more in the field of "psychodynamic" based therapies, the similarities between the present data and that from other studies is more marked for the uncharacteristic. Looking at the items "recorded" by Jones and Pulos (Jones & Pulos, 1993) in psychodynamic psychotherapies and

Ablon and Jones (Ablon & Jones, 1999) in interpersonal psychotherapies, the common items for the uncharacteristic matrix for the three studies, the present one and those mentioned, amounts to approximately 70%, comprising 4 items (Q9, Q14, Q51 and Q77), recognized in the those studies. With respect to the characteristic side: when the data of the three studies under consideration are summed up, approximately 40% of the items may be found repeatedly, and between these there are three (Q63, Q65 and Q69) which are common to all of them.

Up to now they have been comparing the theoretical matrices of this study and those calculated from psychotherapy sessions, since they did not find studies on psychoanalytic sessions but for individual treatments. Nevertheless it seems interesting to comment something more, which can be thought of comparing the theoretical or ideal matrixes and those which come up from the study of sessions. In the present study it is obvious that the 10 items which compose the submatrix of the characteristic items for an ideal psychoanalytic session do not overlap with the ideal psychotherapeutic session. Now, comparing the ideal matrix built up in the study of Ablon and Jones (Ablon & Jones, 1998) for psychodynamic psychotherapy sessions, it becomes evident that it has a strong superposition with the ideal matrix for psychoanalytic sessions constructed in the present study: the 10 items which compose this last one find a place in that of those authors, but almost none of the items of the submatrix for the characteristic descriptors of a psychotherapy session (only 2 items) find a place there.

Brief evaluation of the approach

This is an important demonstration study of the use of the Q-sort on therapeutic material from a Spanish speaking treatment. This initial study of a small sample suggests that the Q-sort method might be helpful in highlighting the differences between psychoanalysis and psychotherapy.

■ Fertuck, E. A., Target, M., Mergenthaler, E., Clarkin, J. C.

Brief summary of approach

The aim of this research project is to develop an efficient, transportable, and valid methodology to systematically assess, from audio- and videotaped sessions of the therapist-patient discourse, theorized mechanisms of change for patients with borderline personality disorder (BPD; American Psychiatric Association, 1994). The researchers hypothesize that psychodynamic therapy can improve BPD patients' Reflective Function (RF; Fonagy et al., 1998), and that over time this leads to clinical improvements in intrapsychic structure, symptoms, and behavior. RF involves a self-reflective and an interpersonal component that allows the individual to discern inner experience from outer reality. Consequently, it is a psychological function that is related to affect regulation and interpersonal functioning. BPD patients exhibit impairments in RF that lead to a pathological pathway of emotional development and chronic, potentially lethal psychopathology. A computerized text analysis version of the RF scale will be developed as a first step in the development of a methodology designed to assess the mechanisms of change in TFP session transcripts. This will initiate a line of research that aims to identify the unique features of psychodynamic therapy and how they are related to clinical improvement in BPD patients. With this research the link between psychoanalytic technique and outcome can be better understood by clinicians, and articulated to patients, policymakers, and funding agencies. The instrument should be applicable to transcripts of any psychotherapy session, and other texts.

Sample

AAIs from at least 100 subjects, most of whom are psychiatrically diagnosed. There are three sub-samples from which the entire sample will be derived, one of non-clinical adult females, the second from adult, hospitalized psychiatric patients, and the third from a sample of young adult outpatients who later entered psychoanalytically oriented psychotherapy or psychoanalysis.

Method

The procedure for transforming a well established manual coding system to a computerized scoring method has been articulated by Mergenthaler & Bucci (Mergenthaler & Bucci, 1999). First, a corpora of text samples that have been reliably rated with the manualized scoring system are transcribed. One half of the texts are then chosen randomly and within these texts, extreme samples from both ends of the constructs' measurement are identified, one corpus High and one corpus Low. The next step involves the identification of Characteristic Vocabularies for each of the two High and Low corpora in reference to the other. In other words, words that are significantly more frequent in one text versus the other are identified. Low frequency and overly specific words are eliminated. The result is two word lists, High and Low. Once these word lists are identified, the texts are analyzed by a computer, which calculates the number of High and Low frequency words, subtracts the latter from the former, and divides this by the total number of words in the texts. The resulting numbers for each text can be used to predict the second half of the texts with High and Low judge ratings of the construct, and to correlate with the criterion measure (the original judges' scores). These two procedures establish the validity of the computerized measure.

Measures

The Adult Attachment Interview (AAI; Main & Goldwyn, 1991). This semistructured interview aims to elicit information concerning an individual's current representation of his or her childhood experiences. Several categories of experience are probed, including the general quality of early childhood-caregiver experiences, experiences of early separation, illness, rejection, losses, and maltreatment. Interviews are audiotaped and transcribed.

The Reflective Function scale (Fonagy et al., 1998). This scale is for AAI transcripts, and it assesses the interviewee's capacity to understand mental states and their readiness to contemplate these in a coherent manner. Raters are required to mark the presence or absence of a reflective stance in relation to self or other and use the frequency of these statements to score the subject on a scale from 1 to 9. For a more detailed account of the RF Scale, see the Appendix to this report.

Present status

One hundred AAIs have been transcribed and formatted for computer analysis, and approximately 70 have been scored for RF by an expert rater. After RF is scored on all the AAIs, the characteristic vocabulary will be identified.

Brief evaluation of the approach

Given the difficulties in coding this measure, both in terms of time invested in training and reaching reliability, it is desirable that there should be an automated version. It should be remembered that this would still require transcribing of the interviews, but given the success of other automated methods it could be an important methodological development.

Analytic process scales (APS) study of 3 audiotaped psychoanalyses

- Scharf, R. D., Waldron, S., Firestein, S. K., Goldberger, A., & Burton, A. (1999). *The analytic process scales (APS) Coding manual*. Unpublished manuscript.
- Waldron, S., Scharf, R. D., Crouse, J., Firestein, S. K., Burton, A., & Hurst, D. (submitted). Saying the right thing at the right time: Psychoanalytic interventions of good quality enhance immediate patient productivity.

Brief summary of the approach

This was a detailed preliminary study of audiotaped psychoanalyses. The Analytic Process Scales (APS) were employed to examine nine sessions of three psychoanalyses. They were applied to tape recorded sessions, enabling psychoanalysts to evaluate the nature and quality of the contributions of both analyst and patient to the psychoanalytic process. The APS makes it possible to study the impact of the quality of analysts' interventions on patients' immediately subsequent analytic productivity. The analytic work by both patient and analyst was characterized in a reliable and systematic way for sessions from these three analyses.

This research instrument, with an extensive coding manual, was developed by a group of experienced psychoanalysts using methods that would avoid problems encountered by previous investigators, by studying only the work of experienced analysts and using only highly experienced analysts as raters. They found that if they evaluated one session without understanding its context, their views were as discrepant from one another as reported by Seitz in his classical paper (Seitz, 1966). Therefore, it was required that raters listen to two or three preceding sessions for psychoanalytic context, before assessing the session at hand. The researchers chose central, unambiguous, experience-near process features of both patient and analyst, and defined their variables in the language of the clinical surface. The long process of conceptualizing variables, testing them on fresh recorded material, and then revising them led to the development of eighteen variables assessing the analyst's contribution and fourteen assessing the patient's, as both of these contributions vary during the course of each session. The APS Coding Manual (Scharf et al., 1999, 78 pages) defines and illustrates each variable to be rated. Brief clinical examples show how to assign ratings at the "0", "2", and "4" levels; the intermediate levels "1" and "3" are left to the judgment of the rater to use as necessary. Analysts need only brief training to achieve reliability using the manual. As little as one specimen hour suffices for training, followed by discussion of scores with a senior investigator, comparing them with those of senior raters. The central patient variable studied in relation to the analyst variables was patient productivity, measured as progress either in response to the analyst's intervention, or from the patient's own momentum. The analyst variables fall into three clusters. The first, *intervention quality*, comprises two variables: one measures how well the analyst follows the patient's productions, and the other measures the overall quality of the intervention. The second cluster, *core analytic activities*, measures the degree to which the analyst clarifies, interprets, and focuses on resistance, transference, and conflict. The third cluster, *affective involvement*, measures how much the analyst is confrontational and expressive of feeling.

To capture the back-and-forth flow between patient and analyst, sessions are divided into psychoanalytically meaningful segments. The division between segments often corresponds to a change of speaker, resulting in "analyst" segments and "patient" segments. When there is a rapid exchange between patient and analyst, a segment may include several changes of speaker, and is rated for both analyst and patient variables. Using the manual, psychoanalytically informed clinicians can segment sessions with substantial agreement. Applying the APS to successive patient and analyst segments throughout a session allows study of the interactional aspects of the work, specifically the relationships among what the patient communicates, how the analyst intervenes, and how the patient responds. It is possible to determine which qualities of the patient's work are enhanced by interventions over a series of segments, and how the patient's responsiveness and productivity shape the analyst's next intervention.

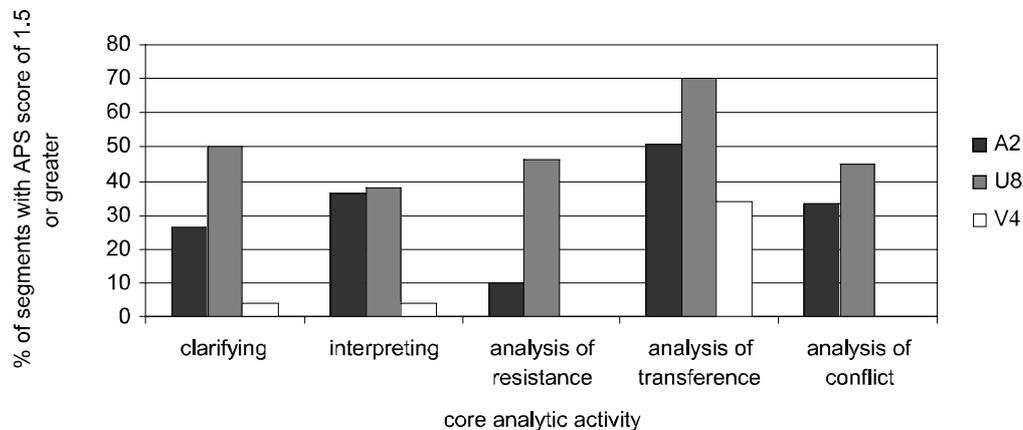
Nine sessions from three psychoanalyses drawn from the collection of the Psychoanalytic Research Consortium were rated in this study: four sessions were taken from various points in a 324-hour analysis, three were selected from early, middle and late in a 660-hour analysis, and two were drawn from the end of a 388-hour analysis. The first patient had done relatively well; the second appeared to be deadlocked after 660 sessions; the third was chosen as a good representative analytic process. The nine sessions produced a total of 123 segments to be rated for the analyst variables, and 117 segments to be rated for patient productivity.

The APS variables were chosen and defined to produce measurable differences between scores on each variable. These scores constitute the basic data. Relationships between the clusters of analyst intervention data and patient productivity data are checked for. Then by the method of partial correlation the effect of differing analyst-patient pair is held constant. By the method of multiple regression analysis the effects of the other variables are held constant in order to discover the contribution of each individual analyst intervention variable to immediate patient productivity. The data are arrayed to show analyst intervention scores in relation to the immediately prior and immediately subsequent patient productivity scores. This makes it possible to follow events of the session from two reciprocal perspectives: how the analyst's activity affects the patient's work, and how the patient's work facilitates the analyst's activity. When the patient becomes more productive, the analyst may be able to make higher-quality remarks, demonstrate better core analytic activity, and become more involved, so that any increased productivity following an intervention might not only result from the intervention itself but from the patient's productivity in the previous segment. Since subsequent patient productivity might reflect *both* the patient's previous productivity *and* the analyst's intervention, the relative influence of these two factors was assessed using the method of multiple regression.

Major results

Our sample of 123 segments of psychoanalytic work is summarized graphically in Figure 1. It shows that the levels of core analytic activities (clarification, interpretation, addressing resistance, addressing transference, and addressing conflict) were different for each of the three analyses. Although the analyst for patient U8 analyzed resistance much more than the analyst for patient A2, the activities of both were comparable in other respects: both used clarification and interpretation extensively, often making interventions focused on transference manifestations to point out their patients' conflicts. V4's analyst made a substantial number of transference interventions, but in contrast, generally utilized core analytic activities to a far lesser degree. These differences are consistent with both the clinical descriptions of the 3 cases and the marked differences found by the study's raters in the overall quality of the treatments.

Figure 1: Core analytic activity by analyst-patient pair



The majority of interventions were mixed. For example, about half the interpretations were combined with clarification; two-thirds of clarifications were mixed in nature, half of these being simultaneously classified as interpretations and the other half in other combinations. It was found that the interpretations which were combined with clarification received a higher rating for *quality* than interpretations given without a clarifying component. One other significant characteristic emerged from studying intervention types. It was anticipated that a clearly framed intervention would receive a score between “1” and “2” (1.5 or better) for at least one type (clarification, interpretation, etc.). It was found that the analysts differed in this respect. In the treatment that seemed to be going the best (U8) a large proportion of the analyst’s interventions (two-thirds) fitted at least one type. The next best treatment (A2) had about half the interventions fitting a type. But V4, the case which was judged as least successful by other criteria, had less than 10% of the interventions fitting a type. Thus, in this small sample, the typing of interventions on the APS not only characterizes the nature of the analytic activity, but offers an indication of the quality of interventions, with poorer work being less well delineated.

There was considerable variation in quality of intervention within each analysis, as well as substantial differences between them. It is possible that high quality interventions are a predictor of benefit even when they constitute a relatively low percentage of the total. In the two apparently more successful cases, only 7 and 8% respectively of interventions were scored 3 to 4, while the apparently unsuccessful case, V4, had no interventions at these levels. However, a much larger sample will be necessary to examine the relationship between successful treatment and infrequent but very high quality interventions.

Finally, the researchers asked how much of the variation in patient productivity they had accounted for by their variables. It turns out that differences in analytic productivity across segments are only partly accounted for by the variables they measured together with the momentum of the process itself. Thus, despite the significant effect of intervention *quality* and prior patient productivity on later patient productivity, more than half of the differences in subsequent productivity remains unexplained by the APS variables. This is expectable in view of the complexity of the process assessed, and the often delayed impact of interventions.

To summarise: In this study, substantial correlations were found between core analytic activities (clarification, interpretation, and analysis of resistance, transference and conflict) and the productivity of the patient in the immediately following segment. A multiple regression analysis

showed that the impact of these analytic activities was entirely dependent on the quality of the analyst's intervention. In addition, patient's previous productivity contributed as strongly as intervention quality to subsequent patient productivity. Statistical analysis also demonstrated that the level of work of the analyst and the patient were highly correlated in this sample.

Brief evaluation of the approach

The APS makes it possible to investigate psychoanalysis by studying aspects of each case in a way that is both statistically reliable and clinically valid. The variables serve to delineate cases using central psychoanalytic concepts. The authors have demonstrated that experienced clinicians can agree on the nature and quality of interventions, once they are sufficiently familiar with a case. Because the APS assesses the nature and quality of interventions sequentially throughout an hour they have been able to examine their effects on subsequent patient productivity in the very next segment of the hour. The reliabilities achieved in assessing core psychoanalytic dimensions suggest that systematic study of even the most complex aspects of the psychoanalytic process is possible with suitable analytic data. The problems of achieving consensus in evaluating psychoanalytic treatments are not insurmountable, and are resolvable by methodological innovation and the participation of experienced clinicians. This is a preliminary study with much that remains to be demonstrated. We do not know if interventions considered to be of 'high quality' are actually correlated with better treatment outcome. The small size of the sample of 117 analyst interventions and patient responses from only three patient-analyst pairs limits the generalizability of the results.

The Saarbrücken studies on unconscious interaction regulation: Multi-channel psychotherapy process research projects (SSUIR)

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Introduction

The research group created by Rainer Krause first started in Switzerland and then continued its work in Saarbrücken, Germany. Early research centered on the unconscious role relationship implantation in patients with different diagnosis and structural levels in everyday interactions with uninformed healthy partners. The research group showed that there is something like an unconscious micro-momentary interaction pattern of affect, which was determined specifically by the different structural level of personality and by the specific diagnosis affecting not only the partner but also the dyad in a feed forward process. Counter-transference feelings as well as the transference representations have a counterpart in the open behavioral system which could be described using dyadic patterns of facial expression, gaze behavior and the speech act. A computer-based algorithm was developed to integrate the different streams of behavior in the dyad. By means of a statistical tool designed by Magnusson, Schwab described choreographies of affects being characteristic for dyads with different structural levels (Schwab, 2001). A more detailed methodological paper can be found in Steimer-Krause, E., Krause, R. & Wagner, G. (1990).

The basic results are published in German in Krause (1998) as well as a brief version in English in Flack & Laird (Krause, Steimer-Krause, Merten, & Ullrich, 1998). Based on these results the research group did a series of studies testing whether the common denominator for successful psychotherapeutic processes could be that experienced successful psychotherapists of different orientations would unconsciously be able to counteract the subliminal enactment of the affect choreography that patients usually implant in their interaction patterns using the above-mentioned processes. In the first study 11 brief therapeutic treatments, affective facial behaviour of therapists and patients as well as the latter's Core Conflictual Relationship Themes (CCRTs) were investigated and related to treatment outcome and emotional experience (Differentielle Affekt-Skala, DAS).

Affective facial behavior in the first therapy session was analysed with a method for detection of hidden real-time patterns. The interactive emotional patterns found were the best predictors of outcome. High amounts of patterns indicate the implementation of maladaptive relationship-patterns in the therapeutic dyad. The higher the number of these indicators the worse the outcome was. It was also found that successful therapeutic processes were indicated by a reduction of emotional patterns. In the more successful therapies the amount of dyadic, emotional patterns in the last session was low, while in less successful therapies it was still high ($r=-.74$, $p=.05$).

Furthermore it was found that compensatory rather than reciprocal affective facial behaviour of the therapeutic dyad in the first session is indicative of therapeutic outcome. A scale describing reciprocity vs. compensation in facial behaviour correlated significantly positively with self-reports of outcome and symptom change.

The more successful therapists show more negative distance regulating affects like anger, contempt and disgust ($r=.81$, $p=.005$). These negative affects counterbalance the facial affective expression of felt happiness on the part of the patients ($r=-.67$, $p=.05$). Contrary to expectation, positive reciprocal behaviour initiated by the patient is related to worse outcome ($r=-.62$, $p=.05$); that initiated by the therapist shows a curvilinear relationship to therapeutic outcome ($b2=-.64$, $p=.05$).

Ten single cases were conducted to validate the group findings in the context of the different therapies. For example, two psychoanalytic treatments, one with the highest reciprocity and worst outcome and another with the best outcome and high compensation, were analyzed according to temporal development of affective exchange and narration across all 15 sessions. In both therapies, frequency of narratives was negatively correlated with frequency of facial affects of the patient, so that the hypothesis of a parallel processing of affective facial behaviour and narration could be ruled out. In the successful treatment, the therapist showed those affects during the narration of the patient, which could have been expected from the latter. A very distinct temporal pattern was seen within the successful treatment (including an enactment period, a period of instability and a period of consolidation), contrasting with a homogenous distribution of affect in the unsuccessful one.

In this research project, the affective facial behavior of patients with anxiety-disorders and that of their psychotherapists is to be analysed. Affective facial behaviour within the first session will be related to subjective ratings on the therapeutic relationship and to outcome data.

Sample

The sample will contain 20 treatments. All patients are female and have the Axis-I-Diagnosis Panic-Disorder, with or without agoraphobia. Each therapist is treating two patients. All therapists are male and are experienced psychoanalysts or psychodynamic therapists. They were requested to base their treatment on the “Manual of Panic-Focussed Psychodynamic Psychotherapy“ by Milrod et al. (1997). Treatments are limited to 40 sessions.

Methods

Facial affective behavior is analysed by using EmFACS (Emotional Facial Action Coding System) developed by Friesen & Ekman (1984). In this system prototypical facial patterns of primary affects are described. These patterns are seen as culturally invariable in their meaning and given by nature. The primary facial affects are anger, contempt, disgust, fear, sadness, surprise and happiness. For a fuller account of the FACS and EmFACS, see the Appendix to this report.

Patients and therapists ratings after each session: INTREX, DES, HAQ, TAB

Outcome measures: a battery of questionnaires, including GAS, subjective ratings of success and of contentment, pre-post-comparisons of SCL 90-R, FBL, BSQ, ACQ, STAI, INTREX

Research questions

Do patients with panic-disorder offer a specific relationship to their therapists? In clinical literature, the conflict between autonomy and attachment is emphasised. These patients have problems with separation and expression of negative feelings, because they fear the loss of their objects. The researchers expected that patients with panic-disorders would show a high frequency of facial happiness expressions. The facial expression of happiness can be seen as a strong reinforcement-system, designed to establish a positive relationship. As these patients are strongly dependent on maintaining a secure relationship, high frequencies of happiness-expressions and a low level of expression of negative affects like anger were expected.

The second question is: How do the therapists react to the facial behaviour of their patients? And what kind of dyadic relationship-regulation leads to a helpful therapeutic relationship? Usually, facial expression of happiness is very contagious. If someone smiles at you, it is a strong invitation, nearly a request, to answer with the same behaviour. Usually people do smile back. If the patients show the expected high amount of happiness, and the therapists answer with the same behaviour, one can assume that the patients have been able to establish a relationship in which they can feel secure and attached. This might be described as a good relationship – but is this helpful? If there is nothing else – just positive and secure – the patients probably will not learn anything new. The other part of the conflict – the autonomy-wishes, the negative affects – would be kept out of the therapeutic relationship. Patients need to experience within the therapeutic relationship that it is possible to express negative emotions without losing the object.

The third question is related to the personal interactive style of therapists. The fact that the therapist treats two patients, can give an outlook on the personal interactive styles of individual therapists, particularly if the two patients of one therapist show different interactive behaviour. Taking into account the models of the psychotherapeutic process, one could assume that the same therapist shows different affective facial behaviour when he is treating different patients with different role-offers.

Preliminary results

At present only preliminary results are available. Many of the treatments are as yet not finished. There are outcome-data only from a few treatments and no follow-up-data. So far, the first sessions of 18 treatments have been analysed with EmfACS.

Mean frequencies of facial expression of patients, 1st session, 50 min

| | N | min | max | mean | std.- dev |
|-----------|----------|------------|------------|-------------|------------------|
| happiness | 18 | 1,09 | 140,20 | 49,4902 | 36,6047 |
| surprise | 18 | ,00 | 9,38 | 1,4266 | 2,8732 |
| fear | 18 | ,00 | 10,00 | ,9028 | 2,4317 |
| sadness | 18 | ,00 | 33,33 | 6,8753 | 9,4403 |
| anger | 18 | ,00 | 42,55 | 8,3735 | 10,8656 |
| contempt | 18 | 1,02 | 89,58 | 24,0250 | 27,5875 |
| disgust | 18 | ,00 | 280,85 | 49,0324 | 85,3686 |

On average the most frequent affective facial expression of the patients is happiness, followed by disgust and contempt. Other affective expressions are rare. Fear is the facial expression with the lowest frequency. Although the expected predominance of happiness on the average-level is found, patients also show a high rate of negative facial expression (especially disgust and contempt) with high ranges and standard-deviations. Facial affective behaviour of female patients with panic-disorder in the first session is heterogeneous.

Mean frequencies of facial expression of therapists, 1st session, 50 min

| | N | min | max | mean | std.- dev |
|-----------|----|-----|--------|---------|-----------|
| happiness | 18 | ,00 | 59,78 | 26,3853 | 15,5556 |
| surprise | 18 | ,00 | 2,44 | ,3653 | ,7456 |
| fear | 18 | ,00 | 2,33 | ,2438 | ,6167 |
| sadness | 18 | ,00 | 26,04 | 7,6881 | 10,6437 |
| anger | 18 | ,00 | 193,02 | 22,0021 | 54,1954 |
| contempt | 18 | ,00 | 22,92 | 5,9001 | 6,4596 |
| disgust | 18 | ,00 | 93,02 | 17,4792 | 28,5166 |

On average the most frequent affective facial expression of the therapists is happiness also, followed by anger, disgust, sadness and contempt. Fear and surprise are shown very rarely. Ranges and standard-deviations of the facial expressions of the therapists are also very high.

When compared with the patients, therapists show less happiness ($p = .009$, Wilcoxon-Test for paired samples) and less contempt ($p = .004$). Other differences in frequency do not reach statistical significance.

Some of the therapists show almost the same distribution of affective facial expressions in interaction with different patients. Other therapists vary their behaviour when treating different patients. Although there is outcome-data only from a few treatments so far, it seems if the two patients treated by one therapist show different patterns of facial affects, and the therapist does not vary his pattern, one of the treatments will not be very successful. Therapists who vary their facial behaviour when treating different patients are more likely to be successful in both treatments.

Preliminary conclusions

Female patients with panic-disorder display varying patterns of facial affective behaviour. On the average, the most frequent affect is happiness, but other patients also show high rates of disgust or contempt, while their expression of anger is not very frequent. Variations could be grounded on different personality-organisations. For example, some patients with excessive disgust-patterns have been diagnosed as “Borderline Personality”, but this is not always the case. The patients with a predomination of happiness expression often got the Axis-II diagnosis “Dependent Personality” or “Avoiding-insecure Personality.” Axis-I diagnosis does not seem to provide the criteria to predict interactive behaviour, to predict the relationship-offer of the patients. If this can be confirmed, it is clear that manualized treatments, which take Axis-I diagnosis as a starting point, should fail for a certain subgroup of this sample of patients. The same must be taken into account for outcome studies, where two treatments are compared.

On average, therapists show less happiness and less contempt, but they also show a high variation in their facial behaviour. Some therapists seem to show a personal interactive style, regardless of the relationship-role-offers of their patients. If the interactive style of the therapist is rigid, treatment-success depends on how the patient fits to it. For some patients this style can create a helpful relationship, for others not. Other therapists seem to be able to adapt their interactive affective behaviour when treating different patients. Results indicate the importance of a *patient-specific behavioural answer* of the therapists to the role-offers of their patients. Helpful relationships seem to be balanced between development and maintenance of positive attachment on the one hand and on not avoiding negative emotional tension on the other.

In another investigation Benecke (2001) showed that successful therapies can be discriminated from unsuccessful ones through a specific form of re-arranging the relation between affect expression and mutual cognitive content of the speech process between therapist and the patient as well as within the patient. Within the unsuccessful therapies the affect remains interactive where as in the successful ones the affect expression becomes attached to the unconscious and conscious cognitive content.

Another stream of research is now dealing with the relationship between affect and its transference into language in “hidden ways” before it appears as purposefully verbalised meaning (Fabregat, 2001). Metaphor is proposed as a matrix that organises and structures both affects and secondary conscious processes and thoughts; and also as a bridge between the realm of signal language (in which facial expression is classified by semiotics) and semantic language. Other transference markers are proposed and empirically analysed as predictors of outcome in a sample of 4 good outcome patients and 4 bad outcome patients. Their patterns of appearance are also set on a time-series axis on the computer together with the “mimic choreography” to establish a comparison between the times of appearance of “signal language” and verbal language.

Evaluation

The use of facial affect coding during psychotherapy provides an important window on the non-conscious processes that predominate in every day therapeutic exchanges. Psychoanalysts, perhaps because of the use of the couch, have not shown much interest in the relationship of facial emotional processing and therapeutic outcome. This pioneering study suggests that therapists whose counter-transference (or counter-response) enactments are obviously collusive achieve inferior results when compared with therapists who respond with more resonance rather than implied awareness of unconscious (hidden) content of the communication.

At the present time, this research has evolved into correlating emotional experience and facial expression of patients and psychotherapists in detailed time-series analysis that describe the manifestation of counter-transference of unconscious nature, centered around contempt, as the main affect (*Leitaffekt*) of the therapist, and that leads to the failure of the treatment due to the lack of involvement in the interactive dynamics (Dreher, Mengele, Krause, & Kämmerer, 2001). Another stream of research is now being done by Benecke & Krause (2001) taking into account the small sample and the heterogeneous diagnoses of the first studies. In this ongoing research project the affective facial behavior of therapist and their patients with anxiety disorders are investigated. Each therapist treats 2 patients in order to investigate more clearly variations that could be originated on the part of the therapist.

MGH Naturalistic study of brief psychodynamic psychotherapy for panic disorder

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Aims

This study aims to (1) test the effectiveness of brief psychodynamic psychotherapy for the treatment of panic disorder and (2) describe the process and identify the active ingredients of the treatment.

Sample

Thirty patients who meet DSM-IV criteria for panic disorder as a primary diagnosis with a minimum clinician-rated severity level of “moderately ill” are being recruited via local advertisements in the Boston, Massachusetts area of the United States. Patients receiving anti-anxiety medicine are eligible provided they continue to meet diagnostic criteria for Panic Disorder, they have been on a stable regimen and dose for at least two months at the time of enrollment, agree not to make changes during the course of the study.

Treatment

As this is intended to be a naturalistic study, therapists conduct the treatments according to their usual therapeutic style, with no constraints imposed by the research study on the therapies, other than the definition of brief therapy as averaging 16-24 sessions. In this way, the treatments are conducted as they are in usual clinical practice. However, in order to maximize internal validity, the therapists attend weekly case conference meetings to discuss ways to understand and address the symptoms of Panic Disorder from a psychodynamic perspective. The case conference centers on a common understanding of the psychodynamic issues involved in Panic Disorder and the treatment foci and techniques derived from the manual for Panic-Focused Psychodynamic Psychotherapy.

Measures

Outcome

The Structured Clinical Interview (SCID) for DSM-IV is used to verify a diagnosis of Panic Disorder and to collect data on co-morbid disorders that can be used in subsequent data analyses with a larger sample size. The Shedler-Westen Assessment Procedure 200 (SWAP-200; Westen & Shedler, 1999a, 1999b) is completed by clinicians to describe personality subtypes and characteristics.

Outcome is conceptualized in multiple ways and measured from a variety of different perspectives. Overall symptomatology is assessed from the patient’s perspective using the Symptom Questionnaire (SQ; Kellner, 1987). Specific symptoms of anxiety and panic are assessed using the Anxiety Sensitivity Index (ASI; Peterson & Heilbronner, 1987; Reiss, Peterson & Gursky, 1986) and the Panic Disorder Severity Scale (PDSS), also known as the Multicenter Panic Anxiety Scale (MC-PAS; Shear, Brown, & Barlow 1997). Specific symptoms of panic and anxiety are assessed from the clinician’s perspective using the Panic Disorder Clinical Global Impression Scale (CGI; Guy, 1976), and clinicians also provide estimates of overall functioning using the Global Assessment of Functioning Scale (GAF; American Psychiatric Association, 1994).

Patients and clinicians also complete measures that attempt to evaluate improvement beyond the narrow definition of symptomatology. The Quality of Life Enjoyment and Satisfaction Scale (Q-LES-Q; Endicott, Nee, & Harrison, 1993) is completed by the patient to assess overall physical and psychological health and degree of functional impairment in different life areas. In order to assess aspects of functioning that may respond in particular ways to psychodynamic psychotherapy, clinicians also complete the Defensive Functioning Scale (DFS; American Psychiatric Association, 1994, p. 751-757) and an object relations scale (SCORS; Westen, 1995).

Process

This study will closely examine the process of the treatments as well the outcome. This will make it possible to determine not only *whether* the treatment is effective but also *how*. The Psychotherapy Process Q-set (PQS; Jones, 2000; Ablon & Jones, 1999), which provides a basic language for the empirical description of therapy process, will be applied by independent raters to audiotapes (which are made for every session) of three sessions from each treatment. Adherence to a prototype of psychodynamic psychotherapy will also be measured using the PQS.

Results

Preliminary outcome data from the first subset of 12 cases indicates that brief psychodynamic psychotherapy produces statistically significant changes across all symptom measures based on patient, clinician, and independent ratings. Patients begin treatment experiencing moderate levels of distress during attacks, intensity and frequency of attacks, and impairment in life functioning. At termination, patients experience only mild distress, intensity, frequency, and impairment. Patients also report being extremely satisfied with their treatment and deriving significant benefit in their interpersonal relationships outside the therapy. Effect size of symptom gain is equivalent to that of cognitive-behavioral therapy and pharmacotherapy using historical controls, even for patients who had failed previous trials of these treatments. Future analyses will include all 30 subjects and personality and process data.

Evaluation

This promising study suffers most from a lack of a control group with random assignment to treatment conditions, without which the efficacy of the treatment cannot truly be established. The importance of this study, however, also involves the focus on process correlates of outcome.

The Berkeley psychotherapy research project

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- Ablon, J.S. & Jones, E. E. (1998). How expert clinicians' prototypes of an ideal treatment correlate with outcome in psychodynamic and cognitive-behavioral therapy. *Psychotherapy Research*, 8, 71-83.

Introduction

A central difficulty for psychoanalytic process research lies in designing quantitative methods that both preserve the depth and complexity of clinical material while conforming to the requirements of empirical science. One method that meets these criteria is the *Psychotherapy Process Q-set* (PQS; Jones, 2000). The PQS is a 100-item rating instrument designed to provide a basic language for the description and classification of treatment processes in a form suitable for quantitative analysis. A coding manual provides definitions for Q-items along with examples of their application, and specifies the rules governing the use of inference in making Q-ratings. Almost all process rating scales rely on recordings of brief segments of therapy sessions, forcing judges to rate a dimension of presumed relevance on the basis of relatively brief impressions. In contrast, with the Q-technique an entire hour (audiotaped or videotaped) rather than a small segment is the time frame rated, allowing a greater opportunity to capture important events. Several studies have examined the reliability and validity of the Psychotherapy Process Q-set, consistently demonstrating high levels of inter-rater reliability, item reliability, and discriminant and predictive validity (Jones & Pulos, 1993). The Q-method is flexible in terms of research designs and data analytic strategies, and can be used in group comparison (or nomothetic) designs, in which Q-ratings of groups of cases (or hours) selected on some dimension of interest are compared, as well as in idiographic (or N = 1) designs. The possibility of moving between these two kinds of research strategies with the Q-Set allows the testing of hypotheses of varying specificity. The PQS is available in Spanish and German translation.

The Berkeley Project has systematically studied process factors contributing to successful outcome in diverse treatment modalities. Treatments of varying type and length have been studied, including crisis intervention, brief psychotherapies, cognitive-behavioral therapies, longer-term analytic therapies and psychoanalyses. Many of these studies have used samples of patients and therapists in group comparison designs. Jones is now pioneering new methods for quantitative single case research. His project is collecting an archive of recorded, long-term psychoanalytic psychotherapies and psychoanalyses that is unusual in terms of the completeness of records for each case and the kinds of assessments that have been obtained during and after treatment. A series of investigations (Jones, Cumming et al., 1993; Jones & Price, 1998; Pole & Jones, 1998) has evolved a new model for the study of single cases that takes into account the interaction of multiple variables or influences in clinical treatments using time-series statistical approaches.

Conventionally, samples of patient and therapist behavior or speech are used as predictors of outcome, or to examine session differences or contrasts between therapies. The data are typically aggregated (or averaged) and removed from the context of whatever else is going on in the treatments. In addition, little attention is given to how patient-therapist interaction might change over the course of treatments. In contrast, Jones' strategy is to focus on patterns of patient-therapist interaction ('interaction structures'; see below) and to explore the association of these structures with measures of patient change. Process is considered as a sequence of events that extends over time. This strategy takes into account time, context, and the effect of previous hours on subsequent events in therapy. Patient change measures (e.g. symptom scales) are collected at regular intervals throughout the treatments, and tapes or transcripts of therapy sessions are Q-sorted. Luborsky's P-technique is applied to the Q-ratings of therapy sessions. The P-technique is a factor-analysis of measures (in this case, the Q-sort ratings) collected over time for the same patient-therapist pair to identify potential underlying structures of interaction. Time-series analysis is then used to understand temporal variations or change in the scores on patient symptom measures as a function of Q-item patterns. Through the application of these methods, these researchers have been able to identify causal links between therapy process and patient change

Results

More than a dozen studies using the PQS have been completed which identify process correlates of outcome in randomized clinical trials of brief psychodynamic and cognitive-behavioral treatments. One study comparing these two treatments (Jones & Pulos, 1993) found that psychodynamic technique was significantly correlated with successful outcome in *both* psychodynamic and CBT treatments. In a replication study (Ablon & Jones, 1998) panels of experts developed prototypes of psychodynamic and CBT using the PQS. These prototypes represent templates or standards for how a therapy ought to be conducted from a particular theoretical perspective. The prototypes were used to assess the extent to which actual treatments conformed to these ideal standards in 3 relatively large treatment samples. The degree to which treatments adhered to the prototypes was measured quantitatively and correlated with outcome. The psychodynamic prototype constructed by experts was consistently significantly correlated with positive outcome in both psychodynamic and cognitive-behavioral therapy. The CBT prototype was not consistently significantly correlated with positive outcome in either type of therapy. Another study of the oft-cited NIMH Treatment of Depression Collaborative Research Program (Ablon & Jones, in press) suggests that even when treatments are 'manualized', they may be more similar than different, raising a question about the utility of randomized clinical trials comparing types of therapy.

An intensive investigation of a single psychoanalytic case (Jones & Windholz, 1990; Spence, Dahl, & Jones, 1993) served as a model for the study of single case and longer-term treatments. Transcripts were rated in random fashion with the Process Q-set and then scored by computer with a measure of free association based on the co-occurrence of words that are highly associated in normal language usage. Time-series analysis was used to identify causal relations. Findings showed that particular categories of the analyst's interventions, i.e. the interpretation of defenses, identifying a recurrent theme in the material, and the discussion of dream or fantasy material led to an increase in the patient's associative freedom. Increase in free association was also linked to patient improvement in a study of a longer-term analytic therapy (Pole & Jones, 1998).

The conventional manner of studying process attempts to identify the ways in which therapist actions or techniques influence patient change. Causal influences are assumed to flow principally in one direction. In two studies of a long-term therapy (Jones, Ghannam, Nigg, & Dyer, 1993; Jones & Price, 1998), a form of sequential analysis was applied that can capture processes in which causality is reciprocal rather than unidirectional. This analysis of causal effects in therapy showed that therapist and patient mutually influence one another. During the beginning phase of

therapy, the data showed that the therapist was more nonjudgmental, facilitative and neutral, and that the patient's severely depressive affect seems to have gradually drawn the therapist towards a more actively challenging and emotionally reactive and involved posture. This change in the nature of the process was predictive of the patient's gradual reduction in symptom level.

Based on these findings, the presence of 'interaction structures' was hypothesized, and the focus of the research shifted to whether such patterns of interaction could be identified, and to test whether they are linked to patient change. New statistical analysis of the data for Mrs. C was undertaken to identify the presence of interaction structures. The Q-ratings of each of the analytic hours were subjected to an exploratory factor analysis, which yielded a factor that captured such an 'interaction structure'. It was clearly an interpersonal interaction that both analyst and patient identified as repetitive and recurring. In fact, the analyst had a name for this 'interaction structure': Playing Stupid. In this repetitive interaction, the patient's thoughts become muddled and confused when she talks of sexual feelings and her wish to arouse men. The analyst found himself talking more than usual in an effort to explain matters. The patient has trouble understanding what the analyst is saying, demonstrating in the *interaction* what the analyst has been interpreting. The reciprocal, mutually influencing quality of these repetitive interaction structures could be seen in how the patient's stance evoked in the analyst his own counter-transference reaction. His interpretations were lengthy, carefully explanatory, and contained some exasperation. Jones hypothesizes that it is the experience, interpretation and comprehension of the meaning of such of repetitive interactions that constitutes a major component of therapeutic action (Jones, 1997). Further studies found additional research support for this hypotheses in several cases of longer-term, twice-weekly analytic therapy (Enrico E. Jones, 2000).

These findings led Jones to a theory of therapeutic action which addresses the complementary roles of *interpretation* and *interaction*. It brings together these polarities in a new framework, which emphasizes the presence and meaning of recurrent patterns of interaction in the ongoing analytic process. It has as its central postulate *interaction structures* — recurrent, mutually influencing interactions between analyst and patient — as a fundamental aspect of therapeutic action. Interaction structures provide a way of formulating and operationalizing empirically those aspects of the analytic process that have come to be termed intersubjectivity, transference-countertransference enactments, and role responsiveness. In this model, insight and relationship are inseparable, since psychological knowledge of the self can develop only in the context of a relationship where the analyst endeavors to understand the mind of the patient through the medium of their interaction (see Enrico E. Jones, 2000 for a full discussion).

Evaluation

It has been difficult to study causal relationships and mechanisms of change in psychoanalytic therapies. This research demonstrates how patient-therapist interaction can be studied, and how this interaction can be causally linked to change. Using single case designs, Q-methodology, and sophisticated statistical techniques, these investigators have managed to capture and study patient-therapist interaction in a formal way. They demonstrate how patterns of interaction can be identified, quantified, and linked to treatment outcome. This represents an innovative paradigm in clinical research. Based on these data, Jones develops a new theory of therapeutic action whose key construct is 'interaction structure'. The construct bridges and integrates cognitive-affective theories emphasizing psychological insight as a mode of therapeutic change, and developmentally oriented theories that emphasize the mutative effect of the experience of a new relationship with the therapist. The implications of this new, evidence-based theory for clinical technique are clearly drawn. The rationale for specific interventions can now be grounded in actual data, e.g., why it is important for the analyst to comment on the features of his or her interaction with the patient. This research bridges the divide between research and clinical practice and provides a model for linking empirical research, theory, and clinical application.

The Cassel personality disorder study

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- Chiesa, M. (2000). Personality disorder and hospital adjustment in a therapeutic community setting. *British Journal of Medical Psychology*, 73, 259-267.

Background

The effectiveness of hospital based models for personality disorder (PD) is still uncertain. In particular little evidence of specificity of treatment programmes has been demonstrated.

Method

Two PD samples allocated to a purely hospital based treatment model (longer inpatient treatment with no after care) and to a mixed hospital and community based model (shorter inpatient admission followed by outreach therapy in the community) were prospectively compared on symptom severity, social adjustment and global assessment of mental health at 6 and 12 months after admission. The relative effectiveness of the two models for the treatment of borderline personality disorder (BPD) and non-borderline personality disorder (NBPD) was also evaluated.

Results

Although both samples improve significantly over time, subjects in the mixed hospital and community based model do significantly better on global assessment of mental health (GAS) at 6 and 12 month and on social adjustment (SAS) at 12 month (Table 1).

Table 1 Outcome scores at 12 months in the two samples

| Variable | Hospital based sample n=46 | Hospital & community based sample n=44 |
|----------------------|-------------------------------|---|
| GSI mean (sd) | | |
| Intake | 2.07 (.60) | 1.86 (.82) |
| 6 months | 1.80 (.52) | 1.49 (.83) |
| 12 months | 1.63 (.63) | 1.39 (.91) |
| SAS mean (sd) | | |
| Intake | 2.68 (.45) | 2.56 (.54) |
| 6 months | 2.55 (.34) | 2.37 (.47) |
| 12 months | 2.46 (.42) | 2.17 (.58)* |
| GAS mean (sd) | | |
| Intake | 45.78 (6.76) | 46.70 (6.48) |
| 6 months | 49.16 (7.65) | 53.83 (9.43)* § |
| 12 months | 51.09 (9.66) | 58.71 (13.76)** §§ |

Post-Hoc contrasts of groups: *p<.05 **p<.01

Post-Hoc within group contrasts: § p<.05 §§ p<.001

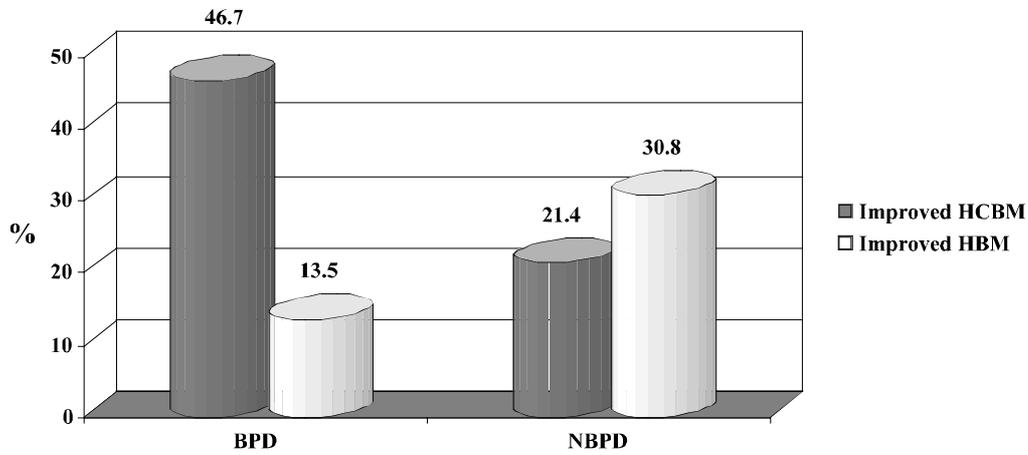
Significant differences in rates of reliable improvement in the GAS (43% v 17%) and SAS (39% v 15%) in favour of the mixed hospital and community based model were found (table 2). Subjects with BPD allocated to the mixed hospital and community based model improve significantly more than BPD in the one-stage model (figure 1).

Table 2 Reliable change at 12 months in the two samples

| Variable | Hospital based sample n=46 | Hospital & community based sample n=44 |
|---------------------|-------------------------------|---|
| GSI n (%) | | |
| Improved | 24 (52.2) | 24 (54.5) |
| Unchanged | 21 (45.7) | 14 (31.8) |
| Deteriorated | 1 (2.2) | 6 (13.6) |
| SAS n (%) * | | |
| Improved | 7 (15.2) | 17 (38.7) |
| Unchanged | 38 (82.6) | 24 (54.5) |
| Deteriorated | 1 (2.2) | 3 (6.8) |
| GAS n (%) ** | | |
| Improved | 8 (17.4) | 19 (43.2) |
| Unchanged | 37 (80.4) | 25 (56.8) |
| Deteriorated | 5 (10.0) | 0 |

*p<.05 **p<.001

Figure 1: Rates of Reliable Improvement in BPD and NBPD in the two treatment groups



Conclusions

A long-term phased model which combines hospital based and community based strategies has advantages over a purely in-patient model for the treatment of BPD.

This is a very important trial that highlights the limitations of long term hospitalization for severely personality disordered individuals while pointing to the value of shorter-term admission, with careful support following the end of treatment.

Adelphi University: Psychodynamic psychotherapy process and outcome research team

- Blagys, M., Ackerman, S., Bonge, D., & Hilsenroth, M. (2000, June). Measuring Psychodynamic-Interpersonal and Cognitive-Behavioral Therapist Activity: Development of the Comparative Psychotherapy Process Scale. Society for Psychotherapy Research, Chicago, IL.
- Blagys, M., & Hilsenroth, M. (2000). Distinctive features of Short-Term Psychodynamic-Interpersonal Psychotherapy: An Empirical Review of the Comparative Psychotherapy Process Literature. *Clinical Psychology: Science and Practice*, 7, 167-188.
- Blagys, M., & Hilsenroth, M. (2001, March). *Object Representations: Assessment, Reliability, Concurrent and Clinical Validity*. Society for Personality Assessment, Philadelphia, PA.
- Hilsenroth, M., Ackerman, S., & Blagys, M. (2001). Evaluating the Phase Model of Change During Short-Term Psychodynamic Psychotherapy. *Psychotherapy Research*, 11, 29-47.
- Hilsenroth, M., Ackerman, S., Blagys, M., Baity, M., & Mooney, M. (2000, June). Short-Term Psychodynamic Psychotherapy for Depression: An Evaluation of Statistical, Clinically Significant, and Dynamic Change. Society for Psychotherapy Research, Chicago, IL.
- Price, J., Hilsenroth, M., Petretic-Jackson, P., & Bonge, D. (2001, March). *Psychodynamic Psychotherapy with Adult Survivors of Childhood Sexual Abuse*. Society for Personality Assessment, Philadelphia, PA.

The work of this group provides empirical data on the effectiveness and efficacy of issues pertinent to psychodynamic theory and practice. These articles focus on one part of this research team's work examining treatment outcomes across a range of measures.

Objectives

The goals of this ongoing treatment program incorporate an evaluation of interrelated issues regarding psychological assessment, psychotherapy process and treatment outcome.

Recent advances in the methodology of psychotherapy research have shown the urgent need for an integration of effectiveness and efficacy designs (1996; Seligman, 1995). Both of these perspectives, which focus on clinical utility (effectiveness) and experimental control (efficacy), compliment one another and thereby answer vital questions regarding the validity of psychotherapy. Each method assesses the outcome of psychotherapy from a complementary perspective as well as eliminates alternative hypotheses. This research program combines the rigor of the efficacy method with the high external validity of the effectiveness method to exam clinical outcomes of Psychodynamic psychotherapy.

Outcomes are evaluated from three perspectives (Strupp, 1996) including: patient self-report, therapist ratings, and external rater via videotape. Measures include well-normed questionnaires evaluating psychiatric symptoms, social functioning (work, family, leisure), interpersonal functioning, and psychiatric syndromes; well-operationalized behavioral criteria, and survey material designed to obtain patient assessment of changes in productivity at work, interpersonal relations, improvement on the presenting problem, satisfaction with treatment and global improvement. These measures are administered longitudinally: prior to beginning treatment, at different (standardized) points during the treatment, and at the termination of treatment.

Design

The design of this treatment program is primarily an effectiveness model that has integrated the assessment and technique/training aspects of an efficacy model within a naturalistic setting (1996; Seligman, 1995). The incorporation of these efficacy features in this otherwise naturalistic treatment delivery setting allows for the measurement of treatment fidelity in a less rigidly specified treatment procedure, that is closer to the real world of service delivery, and to provide important information regarding the nature of the treatment that is not often evaluated in general

psychotherapy effectiveness studies. In this program treatment manuals were utilized for intensive training in technique. However, these manuals were used to aid, inform, and guide the treatment rather than to prescribe it. In this manner therapists were encouraged to provide the interventions in an accurate (Crits-Christoph, Cooper, & Luborsky, 1988), congruent (Piper, Joyce, McCallum, & Azim, 1993), competent (Barber, Crits-Christoph, & Luborsky, 1996), and optimally responsive (Stiles, Honos-Webb, & Surko, 1998) manner, instead of producing a high volume of certain techniques within a predetermined session framework. A potential difference between the findings from this program and those from an efficacy model would be this groups' decision to include all patients regardless of comorbidity (i.e., Axis II) as well as not setting an arbitrary time limit on the provision of treatment. As such, this program represents a naturalistic examination of patient change during Psychodynamic Psychotherapy as delivered in an, university based, outpatient community clinic.

Sample

The participants utilized in this program were patients consecutively admitted for individual psychotherapy to a Psychodynamic Psychotherapy Treatment Team (PPTT) over a twenty-six month period at a, university-based, community outpatient psychological clinic. The number of supervised treatment teams at this clinic ranged from three to five during the period of data collection. It is the standard protocol at this clinic for all sessions with patients to be videotaped (i.e. not just patients in the PPTT sample). Patients were accepted into treatment regardless of disorder or comorbidity. Cases were assigned to treatment practica and clinicians in an ecologically valid manner based on real world issues regarding aspects of clinician availability, caseload, etc. There was a range of DSM-IV (APA, 1994) Axis I & II diagnoses in the patient sample, the largest subgroup of which was Mood Disorder. Approximately one third of patients were diagnosed with an Axis II disorder. The presence of sub-clinical Personality Disorder features or traits was also recorded. Commensurate with samples drawn from, university-based, community outpatient clinics the level of psychological/emotional distress of the patients was primarily in the mild to moderate range of severity. This mild to moderate range of impairment was evidenced within the DSM-IV diagnostic categories, clinician rating scales, and self-report measures. Each patient provided written informed consent to be included in program evaluation research.

Treatment

Treatment consisted of once or twice weekly, sessions of Psychodynamic Psychotherapy. Treatment was organized, aided, and informed (but not prescribed) by the technical guidelines delineated in the following treatment manuals: Book (1998), Luborsky (1984), Strupp & Binder (1984), and Wachtel (1993). Additional technical material from Barber & Crits-Christoph (1995), Grove (1996), and Malan (1979) was also actively integrated into a number of treatments as needed. Key features of the STPP model included (Blagys & Hilsenroth, 2000): (1) Focus on affect and the expression of emotion; (2) Exploration of attempts to avoid topics or engage in activities that may hinder the progress of therapy; (3) The identification of patterns in actions, thoughts, feelings, experiences, and relationships. These patterns were explored/formulated using the Core Conflictual Relationship Theme (CCRT) format (Luborsky & Crits-Christoph, 1998); (4) Emphasis on past experiences; (5) Focus on interpersonal experiences; (6) Emphasis on the therapeutic relationship/alliance; and (7) Exploration of wishes, dreams, or fantasies. In addition to these areas of treatment focus, case presentations and symptoms are conceptualized in the context of interpersonal/intrapsychic conflict (Luborsky, 1996; Luborsky & Crits-Christoph, 1998). Also, when a termination date is set in the treatment this becomes a frequent area of intervention. Issues related to the termination are often linked to key interpersonal, affective, and thought patterns prominent in that patient's treatment.

Clinicians

Thirteen advanced graduate students (5 men and 8 women) enrolled in an American Psychological Association approved Clinical Psychology Ph.D. program were trained in the use of STPP using the 4 primary and 3 secondary texts described earlier. The study supervisor, a Ph.D. licensed psychologist with extensive training in STPP, also treated one patient in this investigation and utilized this treatment in a continuing case conference to augment therapist training. In all cases within the PPTT, the clinician who conducted the assessment procedures also performed the formal psychotherapy sessions. Each therapist received a minimum of 3.5 hours of supervision per week (i.e., 1.5 hours individually, and 2 hours in a group treatment team meeting) on the therapeutic assessment model/process, scoring/interpretation of assessment measures, presentation/organization of collaborative feedback, therapeutic model, case conceptualization, session process, interpretation, and clinical interventions. Prior to scoring the assessment measures utilized in this program, the 13 clinicians participated in both individual and group training where scoring and interpretation guidelines were reviewed. Individual and group supervision focused heavily on the review of videotaped case material and technical interventions.

Procedure

Each patient completed a videotaped semi-structured clinical interview that lasted approximately two hours and an interpretive/feedback interview that lasted approximately one hour. The clinical interview focused on a number of salient therapeutic topics such as presenting problems; past psychiatric history; past medical history; family history; developmental, social, educational, and work history; an exploration of both historic and current relational episodes; and a mental status exam that included an assessment of all DSM-IV symptom criteria for Schizophrenia, Major Depressive/Manic/Mixed episode, Dysthymia, as well as many anxiety symptoms. Each feedback session, also videotaped, was organized according to a Therapeutic Model of Assessment (Finn & Tonsager, 1992, 1997). This approach focuses on collaboration, alliance building, exploration of factors maintaining life problems (often relational) and identification of potential solutions, and therapist-patient interaction.

Treatment was not of a fixed duration, but was determined by the clinician's judgment, patient's decision, progress toward goals, and life changes. Treatment goals were first explored during the assessment period and a formal treatment plan was reviewed with each patient in the third psychotherapy session. This treatment plan then was subsequently reviewed in the 10th, 24th, 40th, 60th and 80th session for changes, additions, or deletions. Re-assessment of patient functioning on a standard battery of outcome measures as well as process ratings were completed by patients and therapists immediately after selected sessions prior to these review points (sessions 3, 9, 15, 21, 27, 36, 57, and 78). Patients were informed both verbally by the clinician and in writing on these forms that all of their process/alliance ratings would not be made available to their clinician and were returned to clinic administrative staff. Videotaped psychotherapy sessions were viewed and coded by PPTT clinical staff (however no clinician served as an external rater for their own patients) on a number of different process dimensions. At the end of treatment all patients receiving services from the PPTT complete an exit evaluation. Thus, measures of clinical assessment and psychotherapy process can be evaluated in relation to the outcome of treatment.

Measures

- Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1993)
- Social Adjustment Scale (SAS; Weissman & Both, 1976)
- DSM-IV: Major Depressive Episode (MDE; symptoms A1 - A9; APA, 1994, p. 327)
- DSM-IV: Global Assessment of Functioning scale (GAF; APA, 1994, p.32)
- DSM-IV: Global Assessment of Relational Functioning scale (GARF; APA, 1994, p. 758)
- DSM-IV: Social and Occupational Functioning Assessment Scale (SOFAS; APA, 1994, p. 761)
- Schwartz Outcome Scale (SOS; Blais et al., 1999)
- Social Cognition and Object Relations Scale (SCORS; Westen, 1995)

Development of the comparative psychotherapy process scale (CPPS): Measuring psychodynamic-interpersonal and cognitive-behavioral therapist activity

The CPPS (Blagys, Ackerman, Bonge, & Hilsenroth, 2000) is a measure of psychotherapy process designed to assess therapist activity, process variables, and psychotherapy techniques used and occurring during the therapeutic hour. Developed from an extensive review of the comparative psychotherapy process literature (Ablon & Jones, 1998; Gaston & Ring, 1992; Goldfried, Castonguay, Hayes, Drozd, & Shapiro, 1997; Goldfried, Raue, & Castonguay, 1998; Goldsamt, Goldfried, Hayes, & Kerr, 1992; Jones & Pulos, 1993; Kerr, Goldfried, Hayes, Castonguay, & Goldsamt, 1992; Samoilov, Goldfried & Shapiro, 2000; Wisner & Goldfried, 1993; 1998), the scale consists of 20 items to be rated on a 7-point Likert Scale ranging from 0 (“not at all characteristic”), 2 (“somewhat characteristic”), 4 (“characteristic”), through 6 (“extremely characteristic”). The CPPS may be completed by the patient, the therapist, and/or an external rater. One unique feature of the items on the CPPS is that they were derived from empirical studies comparing and contrasting Psychodynamic-Interpersonal and Cognitive-Behavioral oriented approaches to treatment. This scale consists of two subscales: a Psychodynamic-Interpersonal subscale (PI; 10 items) and a Cognitive-Behavioral subscale (CB; 10 items). The PI subscale measures therapist and patient activity found in empirical research to be emphasized significantly more in a Psychodynamic-Interpersonal oriented treatment than in a CB treatment. Items include (1) Focus on affect and the expression of patients’ emotions; (2) Exploration of patients’ attempts to avoid topics or engage in activities that hinder the progress of therapy; (3) The identification of patterns in patients’ actions, thoughts, feelings, experiences, and relationships; (4) Emphasis on past experiences; (5) Focus on patients’ interpersonal experiences; (6) Emphasis on the therapeutic relationship; and (7) Exploration of patients’ wishes, dreams, or fantasies (Blagys & Hilsenroth, 2000). Likewise, the CB subscale consists of items, which are significantly more characteristic of Cognitive-Behavioral oriented therapy. Items include (1) Emphasis on cognitive or logical/illogical thought patterns and belief systems; (2) Emphasis on teaching skills to patients; (3) Assigning homework to patients; (4) Providing information regarding treatment, disorder, or symptoms; (5) Direction of session activity; and (6) Emphasis on future functioning (Blagys & Hilsenroth, in press). Coefficient Alpha for the PI and CB subscales (N=101 rated sessions) are both reported as .93 (Blagys et al., 2000).

Judges in this study were two advanced graduate students in an APA approved Clinical Psychology Ph.D. program. Prior to rating therapy sessions for the present study, the two coders underwent 50 hours of supervised training in rating the CPPS. In training, the two judges rated videotaped therapy sessions conducted by both Psychodynamically-oriented and Cognitive-Behaviorally-oriented therapists using the CPPS. Fifteen psychotherapy sessions were rated during training and comprised a preliminary analysis of interrater agreement. After reaching an

acceptable level of initial interrater agreement ($> .60$), as measured by an intraclass correlation coefficient (ICC), (1) one-way random effects model (Fleiss, 1981; Shrout & Fleiss, 1979), judges began to rate videotaped sessions of patients in this research study. Regular reliability meetings were held during the coding process to prevent rater drift. Videotapes from 101 sessions for 33 patients were arranged in random order and *entire* sessions were watched by the two judges. Immediately after viewing a videotaped session, judges independently completed the CPPS. Also, each subscale (PI & CB) was coded in random order. One judge was always unaware of the session number being watched and rated (i.e. 3rd, 9th, etc) throughout the coding process.

The interrater reliability of the CPPS-PI and CPPS-CB subscales was evaluated using one-way random effects model intraclass correlation coefficient (ICC (*I*); Shrout & Fleiss, 1979) for 67 psychotherapy sessions that were rated by both judges. Interrater reliability scores [ICC (*I*)] for these 67 sessions were in the “excellent” range ($> .75$) for both the mean and total CPPS-PI (.81 and .93, respectively) and CPPS-CB (.83 and .96, respectively) subscale scores. A comparison of 34 sessions (17 Psychodynamic and 17 Eclectic/Cognitive-Behavioral) revealed significant and large effects across individual items and total subscale scores. As predicted a robust two-factor structure was evident and these two factors were negatively correlated ($r = -.54$) with one another. This brief (20 item), two-subscale, measure represents an empirically derived attempt to measure therapist activity in nonmanualized (i.e., assessing general clinical principles rather than manual specific techniques) Psychodynamic-Interpersonal and Cognitive-Behavioral treatments that may more readily generalize to “real-world” practice among clinicians.

Treatment outcomes of psychodynamic psychotherapy

In the initial outcome study from this research program Hilsenroth, Ackerman, and Blagys (2001) examined the phase model of psychotherapy change (Howard, Lueger, Maling, & Martinovitch, 1993; 1996) and assessed the domains of subjective well-being, symptomatic distress, and social/interpersonal functioning across the early stages of Psychodynamic psychotherapy. Specifically, these authors assessed evaluation/3rd session to 9th session changes in a group of 20 treated patients. Changes in these three domains were examined for both statistical and clinically significant change (Jacobson & Truax, 1991). This was one of the first studies to examine the dose-effect/phase model of change that has empirically evaluated treatment fidelity and credibility, both of which were found to be high.

As predicted, improvements in subjective well-being showed the largest changes in statistical effect ($t=4.42$, $p=.004$, $d = 1.1$) and percent of patients exhibiting clinically significant change (59%) through 9 sessions of psychotherapy. Also, almost all (88%) of those patients who completed the SOS at the 9th session recorded scores within a functional distribution. Both measures of symptomatic distress were found to make significant improvements during the first 9 sessions of psychotherapy (GSI: $t=2.70$, $p=.02$, $d = .62$ and GAF: $t=6.90$, $p<.001$, $d = .71$). This study also reported a moderate rate of clinically significant symptom change (through 9 sessions) for patient reported symptoms (GSI=29%) and clinician rated symptoms (GAF=25%). Analyses revealed statistically non-significant, but small effects for patient reported (SASG: $d = .36$) and clinician rated (SOFAS: $d = .27$) change in social functioning. However, a statistically significant ($t=3.79$, $p=.001$) and moderate effect ($d = .53$) was observed regarding clinician ratings of interpersonal functioning (GARF). In addition, changes in both subjective well-being (Beta=.36) and symptomatic distress (Beta=.40) contributed unique and separate variance to predicting changes in social/interpersonal functioning ($R=.63$, $p=.03$).

It is important to note that this study only examined changes through the 9th session of psychotherapy. Evaluations of pre-post changes during the course of this treatment are currently being conducted. The benefits of Psychodynamic psychotherapy may be even more robust when the full course of treatment has been completed and in subsequent follow-up period. Nevertheless, these initial results demonstrate that statistical and clinically significant improvement can occur in the domains of subjective well-being and symptom distress by even the 9th session of Psychodynamic psychotherapy. In addition, statistical and reliable improvement can be observed in relational functioning during the same time period. Finally, these results are consistent with differential effects predicted by the phase model of change during the early course of treatment.

In a subsequent study of treatment outcome Hilsenroth, Ackerman, Blagys, Baity, and Mooney (2000) examined a subset of 16 depressed patients (Major Depressive Disorder, Depressive Disorder NOS, Dysthymia) from this sample. Again, treatment fidelity, credibility, and satisfaction were empirically evaluated and all found to be high. Improvements on a number of patient rated subjective well-being scales all exhibited significant ($p < .05$) and large statistical effects ($d > .80$). In addition, a number of patient reported and clinician rated measures of general symptomatic distress, interpersonal and social functioning exhibited significant improvements ($p < .005$) over the course of psychotherapy, all with large statistical effects ($d > .80$). Furthermore, clinician rated scales of dynamic personality functioning (SCORS; Westen, 1995) all exhibited significant ($p < .05$) and moderate ($d > .50$) to large statistical effects ($d > .80$). Of particular interest with regard to Psychodynamic conceptualizations of depression were the very large adaptive changes exhibited for the SCORS variables Affective Quality of Representations ($d > 1.21$) and Self-Esteem ($d > 1.16$).

Specific measures of depressive symptomatology were also found to make significant improvements at the end of treatment (DSM-IV-MDE: $t = 5.93$, $p < .0001$, $d = 1.76$ and SCL-DEP: $t = 6.41$, $p < .0001$, $d = 1.17$). In this study rate of clinically significant symptom change for patient reported depressive symptoms (SCL-DEP=56%) to be substantial. Changes in both patient reported (SCL-DEP) and clinician rated measures of depressive symptomatology (DSM-IV-MDE) were significantly related to one another ($r = .82$., $p < .001$), after adjusting pre-test scores for regression to the mean and controlling for initial levels of variable severity. This finding indicates that the amount of change in depressive symptomatology reported by the patients were very similar to those changes observed and rated by clinicians. Most figural was the finding that the more Psychodynamic activity a therapist engaged in, as measured by the CPPS-PI subscale, was significantly correlated with changes in both patient reported (SCL-DEP: $r = .66$., $p = .004$) and clinician rated measures of depressive symptomatology (DSM-IV-MDE: $r = .62$., $p = .008$), again even after adjusting pre-test scores for regression to the mean and controlling for initial levels of variable severity. This relationship between the distinctive process elements of Psychodynamic-Interpersonal psychotherapy with positive treatment gains clearly support the efficacy of this intervention with depressed patients.

Evaluation

Limitations of these outcome studies include the absence of a placebo control group, small sample size, and variable length of treatment. The importance of these studies are enhanced by the significant process (i.e., Psychodynamic technique/interventions) with outcome (i.e., decreased depressive symptomatology) correlations.

Present status

A number of current projects are ongoing and many of these seek to extend the previous work by this group as well as findings from other Psychodynamic research programs. In the area of treatment outcome, preliminary analyses have been conducted for two separate studies that seek to further elaborate the positive pre-post treatment changes observed in this program. This first study (Price, Hilsenroth, Petretic-Jackson, & Bonge, 2001) examines the differential impact of childhood sexual abuse on the effectiveness of Psychodynamic treatment. The second study (Blagys & Hilsenroth, 2001) examines the differential rates of change between dynamic personality variables (SCORS; Westen, 1995) with patient reported and clinician rated measures of general symptomatic distress, interpersonal and social functioning. Finally, an examination of the relationship between psychotherapy process, alliance, and therapist activity with treatment outcomes are currently being organized.

The Ulm study of dreams: aggregating single cases (USD)

- Leuzinger-Bohleber, M. (1987). *Veränderung kognitiver Prozesse. (Changes of cognitive processes in psychoanalysis, Vol. 1 A single case study).* (Vol. Eine hypothesengenerierende Einzelfallstudie). Berlin, Heidelberg, New York: Springer.
- Leuzinger-Bohleber, M. (1989). *Veränderung kognitiver Prozesse in Psychoanalysen. Bd 2: Eine gruppenstatistische Untersuchung.* Berlin, Heidelberg, New York, Tokyo: Springer.
- Leuzinger-Bohleber, M. (1995). Die Einzelfallstudie als psychoanalytisches Forschungsinstrument. *Psyche*, 49, 434-480.
- Leuzinger-Bohleber, M. (Ed.). (1997). *"...die Fähigkeit zu lieben, zu arbeiten und das Leben zu genießen." Zu den vielen Facetten psychoanalytischer Katamneseforschung.* Giessen: Psychosozial Verlag.
- Leuzinger-Bohleber, M., & Kächele, H. (1988). From Calvin to Freud: Using an artificial intelligence model to investigate cognitive changes during psychoanalysis. In H. Dahl, H. Kächele, & H. Thomä (Eds.), *Psychoanalytic process research strategies* (pp. 291-306). Berlin,: Springer.

Brief summary

This study described and analysed changes in the problem-solving cognitive processes of five patients during their long-term psychoanalyses. Modifications of the way the patients themselves handled their dreams during psychoanalytic sessions were focused upon. One general goal of a psychoanalysis is that unconscious conflicts should become conscious as a precondition for being able to reach other more external goals of a psychoanalytic treatment such as the ability to work, to love and to enjoy life. The patient should learn to recognise unconscious conflicts in order to avoid their interfering with the satisfaction of his wishes and duties. In this special form of psychotherapy he is expected to develop specific problem-solving strategies for dealing with unconscious conflicts. Therefore the changes in problem-solving cognitive processes served as an example of the way the patient deals with unconscious material (i.e. his dreams).

In the first phase of the study, hypotheses were derived by exploring dream associations as recorded in a patient's diary during the first and last hundred hours of his psychoanalysis (Leuzinger-Bohleber, 1987). In the second phase, the hypotheses were tested by studying the verbatim materials of four psychoanalytic cases from the Ulm Textbank (Leuzinger-Bohleber, 1989b). Using two kinds of theory-guided content analysis, the dream reports taken from the first hundred along with those from the last hundred psychoanalytic sessions were evaluated case by case. At this point, the clinical outcome assessments - provided by independent clinicians - were compared to the findings on the cognitive changes. Across the five cases the estimation of clinical change corresponded very well to the changes in the cognitive functions measured by the patients' handling of dreams supporting the study hypotheses.

Recently an extension study was performed on material from one of the patients (Kächele, Eberhardt, & Leuzinger-Bohleber, 1997). In this study, all dreams were subjected to an analysis of changes in relationship pattern, dream atmosphere and problem solving. In this case there was no systematic variation of relationship constellation over the course of the analysis. There was, however, an impressive change of the dream atmosphere from negative to more positive affects and to more variation and an impressive change in a variety of problem-solving activities.

Evaluation

This is an innovative approach to the process-outcome problem. Changes in dream quality would not be predicted by any theory other than the psychoanalytic. The methods developed here need validating by other centres but the use of replicative single case design is one with many possible applications in this field.

Applying clinical and empirical approaches in research on psychic change in long-term treatments

- López Moreno, C., Dorfman Lerner, B., Schalayeff, C., Roussos, A. (1999). Investigación empírica en Psicoanálisis. *Revista de Psicoanálisis*, 56, 677-693.
- López Moreno, C., Birman, L., Dorfman Lerner, B., Koziol, S., Schalayeff, C., Roussos, A. (2000). *Research Project on Psychic Change in Psychoanalytic Psychotherapy. Process Tools, Methods and Outcomes*. First Latin American Research Conference on Psychoanalysis. Asociación Psicoanalítica Argentina. p. 293-307 (English). p. 271-292 (español).
- Caridad, V., Dorfman Lerner, B., López Moreno, C., Schalayeff, C., Valazza, A. M., Acosta, S., Vernengo, P. (2000) Incidencia en la tarea clínica de la pertenencia a un grupo de investigación empírica, trabajo. *Análisis terminable e interminable en el año 2000, trabajos libres*, Asociación Psicoanalítica Argentina. Vol. 1, pp. 199-206.
- Roussos, A., López Moreno, C., Dorfman Lerner, B., Schalayeff, C., Acosta, S. (2000). *A strategy to the use of empirical research to add systematized information to clinical treatments*. Paper presented in the Annual Meeting of the Collaborative Analytic Multi-Site Project. Fall Meeting of the American Psychoanalytic Association 2000. New York.
- Roussos, A. (in press). Un ejemplo de investigación empírica en psicoterapia psicoanalítica. In C. Wainerman (Ed.), *La trastienda de la investigación. Second Edition*. Buenos Aires: Editorial Belgrano.

Brief summary of approach

The aim of this research is to detect indicators of change in the therapeutic process of a psychoanalytic psychotherapy. To this end the results of a two year treatment of six patients are compared using clinical and empirical methods.

This is an ongoing report. A single case two-year treatment with all the techniques applied was presented in the second L.A.R.C. held in Gramado (Brazil) in September 2000.

This project studies the long-term treatments, that is, at least two years in length, of six patients selected from applications submitted to Centro Racker of Asociación Psicoanalítica Argentina by the general public demanding therapy. It should be underscored that this is the first investigation done in the Argentine Psychoanalytic Association (Centro Racker) with the written consent of patients who accepted to be tape-recorded all along their treatments and it is the first data base of complete long term ongoing tape-recorded treatments.

A secondary aim of the research is to create a text bank in Spanish language and to this purpose contact with other Spanish speaking centers.

One of the subprojects of this study is related to the elaboration of a protocol, the Differential Elements for a Psychodynamic Diagnostic (DEPD). This protocol aims to operationalize a patient psychodynamic diagnosis and standardize the information that comes out during the supervision. The protocol has two parts: the first is centered on the diagnosis and prognosis of the patient made by supervisor and supervisee. The second part is focused on the dynamic between patient-therapist, therapist-supervisor and an evaluation of the supervision itself.

In the future it should be possible to use this protocol as a standardized tool for the supervision of psychodynamic treatments. Simultaneously, these researchers are undertaking a validation study of the DEPD and are designing, to this purpose, a series of empirical tests to assess the general validity and reliability of this instrument (2000; López Moreno et al., 1999).

The original project, which received a grant from the Research Advisory Board of I.P.A. was presented at the first L.A.R.C. (Latin American Research Conference) organized by the I.P.A. Research Committee. That meeting was held in Buenos Aires (Argentina) on September 1998.

Instruments

This research is an exploratory one due to the type of general and working guidelines the researchers had in mind. These are:

- 1 Psychoanalytic psychotherapy produces psychic change.
- 2 The conjoining of the results of techniques and clinical observation helps in assessing psychic change.
- 3 The results of this kind of complementary analysis can serve as feedback to therapists.

In this study an operational definition of psychic change is used.

First area: Symptoms, inhibitions and conflicts.

Second area: subject's relational aspects; relational patterns with others and self; relationship among manifest wishes and actions to make them possible; defensive aspects related to defense mechanisms as conceived by psychoanalysis.

Third area: linguistic patterns and narrative styles taken as expression of mental processes.

Research team

The team in charge is composed by four therapists and two supervisors all of them trained in DEPD and DSM-IV; four members specialized in CCRT; two members specialized in CRA; two in SCL-90-R and in statistical methods.

Participant therapists

The therapist group is highly homogeneous, with therapists trained in the Asociación Psicoanalítica Argentina and graduated from its Institute. All of them had had supervision with one of the team's senior members prior to their inclusion in this investigation, so that they were informed about and consented to the working style of the researchers.

Sample

The aim was to obtain as homogeneous a sample as possible. As high compliance with treatment was desirable, it was decided not to take psychotic or in-patients for treatment (diagnosis according to DSM-IV). All patients were women between twenty and forty six years of age. Notwithstanding, there has been a dropout rate of nearly 50%. New patients have been therefore continuously added to the sample to maintain a constant the number of cases. This fact produces a slowdown of results due to the need to complete the two years treatment of the project.

Ethical safeguards

All the participants and the institutional authorities involved in this research were informed about their participation, and patients, therapist researchers, and director of the centers signed an agreement. This agreement follows the ethical points proposed by the Buenos Aires Psychologist Association, which are compatible with the American Psychologist Association guidelines.

Procedures, methods and techniques

This is a naturalistic study. The assignment of treatments are not randomized nor manualized. In spite of this, instructions about how to include the investigation procedures (how to invite the patients to participate in the research, include the tape recorder, administrate the symptom checklist, etc.) are given to the therapists involved in the project.

All of the sessions have been audio-recorded. Transcriptions of the third session and of the sixth, twelfth, eighteenth and twenty-fourth month were used. The transcripts have been completed by the oral reports offered by the respective therapists at the clinical meetings.

The approach of the material is taken from two different perspectives.

The clinical point of view comprises:

a Supervision

Fortnightly supervision has taken place. DEPD has been filled in both by supervisor and supervisee at the start of treatment and every six months.

b Clinical meetings

The frequency of the clinical meetings is once a month and all the team members participate. This encounter allows a fruitful interchange of clinical impressions about the results obtained by the empirical methods. At these meetings, the therapist presents the patient's first interview's synopsis and gives their clinical opinion of the introduced patient. The rest of the members give their clinical opinions, including psychodynamic diagnosis, defense mechanisms and latent conflicts, therapeutic strategies and prognosis. The results of this discussion are protocolized (Clinical meeting protocol)

The meetings fulfil several objectives:

- Enrichment of the therapeutic team due to the results given by the empirical workers.
- Empirical workers' better knowledge of patients.
- Providing the whole team with a sense of identity and feeling of belonging.
- Differential Elements for a Psychodynamic Diagnostic protocol (DEPD) based on psychoanalytic therapy (2000; López Moreno et al., 1999)

The empirical point of view includes the assessing of:

- CCRT (Lester Luborsky)
- CRA (Bucci and Mergenthaler)
- SCL-90 R (Derogatis).

Brief evaluation

Clinical and empirical techniques are used as complementary tools during the study of therapeutic processes, allowing the enrichment and interchange of information from both perspectives. From a clinical point of view the different empirical approaches show a high degree of concordance and complementarity. In relation to this, there is a need to utilize multiple empirical techniques. This multiplicity has enhanced the significance of combining the two. Following this criterion, a group of clinicians have begun to evaluate, from the clinical point of view, the impact of having empirical information in their psychotherapeutic practice (Caridad et al., 2000).

In this sense, the SCL-90 has been a sensible indicator, because the increase or decrease of symptoms can only be assessed as positive or negative in psychoanalytic psychotherapy when it is assessed against other empirical techniques and is estimated from a clinical point of view. The data obtained to date show the sensitivity of these techniques to patient's changes throughout treatment and their usefulness in tracing features of the patient's evolution.

The AHMOS (Amsterdam, Helsinki, Milan, Oslo, Stockholm) project: A multicenter collaboration of research on process and outcome of psychoanalysis

- Szecsödy, I., Varvin, S., Amadei, G., Stoker, J., Beenen, F., Klockars, L. et al. (1997) *The European Multi-site Collaborative Study of Psychoanalysis* (Sweden, Finland, Norway, Holland and Italy). Paper presented at the Symposium on Outcomes Research (Chair Otto Kernberg) International Psychoanalytic Association Congress, Barcelona, August 1997.
- Szecsödy, I., Varvin, S., Beenen, F., Stoker, J., Klockars, L., & Amadei, G. (1999). *Multicenter collaboration of research on process and outcome of psychoanalysis. Presentation of AHMOS*. Paper presented at the International Psychoanalytical Congress, Santiago.

Pilot study

With the ambition to establish a fruitful collaboration between clinicians and researchers, a qualitative study was conducted in the Psychoanalytic Institute of Amsterdam. Using retrospective data from interviews with 16 analysands and their analysts, the researchers wanted to study whether it was possible to detect elements and processes that produce change (curative factors). A combination of four curative factors emerged out of the material they collected, as being at the core of the psychoanalytic cure. This core combination consisted of (1) experiencing primary security (analysand), furnished by the analyst through attention, concern and acceptance. This accepting, non-judgmental attitude of the analyst encouraged (2) free expression of thoughts and feelings ('catharsis') by the analysand. In the interaction (3) the analyst actively offered structure (especially by setting boundaries) to the analysand. At the same time the latter received encouragement leading to a process of (re-) education. And (4) experiencing the direct emotional interaction in the relationship with the analyst led to new self-insight by the analysand, a process guided by the transference interpretations of the analyst. The study indicated that there were aspects of the function of the analyst as a new relational object that seemed important for outcome. These results were presented at the 38th IPA conference in Amsterdam in 1993 and at a workshop on Process and Effect Research in Psychoanalysis in Stockholm 1994, where the first plans were formed for a European collaborative study. At the first IPA Summer-school on research in London in 1995, members of the Amsterdam group, psychoanalysts from Stockholm, Oslo, Helsinki and Milan decided to form a network with the aims of collaborating in research on process and outcome of psychoanalytic treatments and evaluating the possibility of forming a multicenter-study.

Plans and instruments

Widely accepted outcome measures were chosen for the treatments conducted at the different centres, which include the following; questionnaires such as SCL-90, SASB INTREX, IIP, WBQ and CHAP (Change After Therapy Scale). This would allow comparisons to be made with other studies and formal contact has been made with a larger psychotherapy project at the Stuttgart Center for Psychotherapy Research. It may be possible to attach the AHMOS project to this if desired.

Further, a construct that at least theoretically could be seen as related to the changes one hopes to achieve in psychoanalysis had to be selected. This was found in the capacity for "Reflective Functioning", as proposed by Fonagy and colleagues (1997). This is related to the development of the mentalising function. For the study of reflective functioning the multicenter project agreed to use the Adult Attachment Interview (AAI) (George, Kaplan, & Main, 1996). This is an hour-long, semi-structured interview focusing on the description and evaluation of early attachment relationships and attachment related experiences. The interview includes features of both highly structured or "questionnaire" interview format and the more clinical interview. It asks participants both to provide several general overall evaluations of their experiences and to illustrate those evaluations with a description of specific biographical episodes. The interview is transcribed verbatim, and scored according to the reflective functioning manual. For further information on the RF scale, see the Appendix to this report.

Reflective-function is the operationalization of the psychological function, which is frequently referred to as mentalizing (Fonagy & Higgitt, 1989b; Fonagy, 1991; Morton & Frith, 1995). It contains both a self-reflective and an interpersonal component that ideally provide the individual with a well-developed capacity to distinguish inner from outer reality, pretend from ‘real’ modes of functioning, intrapersonal mental and emotional processes from interpersonal communications. Mentalising capacity is about seeing and understanding oneself, and individuals around one, in terms of mental states (feelings, beliefs, intentions and desires), and further about the capacity to reason about one’s own and other’s behaviour in terms of such mental states, through a process normally termed as reflection. The robustness of this capacity determines not just the nature of psychic reality of the individual, but also the quality and coherence of the reflective part of the self, which is at the core of the self-structure (Fonagy & Target, 1996a).

Mentalisation is important - as it enables the individual to see people’s action as meaningful through the attribution of thoughts and feelings, so that their actions become predictable, which in turn reduces dependency on others. Secondly it allows for recognition of the fact that someone is behaving as if things are a particular way does not mean that things are like that. Thirdly, without a clear representation of the mental state of the other, communication must be profoundly limited. Finally, mentalisation can help an individual to achieve deeper experiences with others, and ultimately a life experienced as more meaningful. One can assume that it is the successful connecting of internal and external that allows beliefs to be endowed with meaning which is emotionally alive and manageable. A partial failure to achieve this integration can lead to neurotic states; in more profound and pervasive failures of integration, reality may be experienced as emotionally meaningless, other people and the self are related to as things, and the relating itself occurs at a very concrete level. In the extreme, the individual may inhibit or decouple their tendency to treat themselves or others as motivated by mental states, resulting in a personality organisation sometimes denoted borderline (Fonagy & Higgitt, 1989b; Fonagy, 1991).

Psychoanalysis is supposed to influence the individual’s ability to relate to and integrate emotional experiences through a development of the capacity to tolerate mental frustration and pain. Reflective functioning can indicate the degree of ability for relating to and integrating conflicting emotional experiences. The manner and the degree in which this function changes during psychoanalysis could then be a *process-related outcome measure of psychic change* during psychoanalysis.

A central question is of course the *relation between process and outcome*. Modelling research on what has been criticised as the “drug metaphor”, the belief that there exists a causal relationship between certain aspects of the process and outcome, was not attractive considering the complexity of the psychoanalytic conception of process (Stiles, Shapiro, Harper, & Morrison, 1995). Time will not allow detailing the discussion that ensued. The fact remains, however, that an adequate model and design to address this question was unavailable. A tentative design was then created that has a structure which allows for considerable variation among the participating centers, such as timing (when to start to implement the different parts of the project), to focus on different aspects, to add specific instruments and to integrate research and quality assurance.

A further aim was to construct research approaches that generate a multi-window view on the process and/or the interaction between the analyst and the patient. The study aims to investigate whether it is possible to detect positive and/or negative critical moments, variables or developments in the process, and to see how fundamental changes take place and to find out to what extent are these characteristic and specific for the psychoanalytic process under study.

One way to collect process data was to use the *Psychoanalytic Process Rating Scale (PPRS)*, designed by the group in Amsterdam as an elaboration of the Session Rating Scale of the

Anna Freud Centre for Children and Adolescents in London. Through the PPRS one can collect the subjective opinions of the analysts, regarding the presence and/or absence and the type of their interventions about more than 200 items. Filling out the PPRS (with the help of a detailed instruction manual) produces a picture of the ongoing process, in a form that is a compromise between a naive descriptive and a more theoretical clinical kind of reporting, that is systematised and standardised. These items are divided into three sections and concern: i) General attitude: time keeping, missed sessions, quality of sessions, physical behaviour, affective moods, defences, resistance. ii) Conscious and unconscious content concerning: the body, self-esteem, object relations, sexuality, and aggression. [Further: schoolwork, employment; current life events; gender and age issues;] treatment parameters. iii) The form of transference themes; analyst's feelings; styles of interventions; reactions to interventions; analyst's feelings in the gross. The analyst will fill out this questionnaire monthly and the hope is that this, together with three-monthly clinical summaries, will create a profile of the analytic process as seen by the analyst, in a systematised and standardised manner. The PPRS is now used by the groups in Amsterdam, Milan and Stockholm. For further information on the PPRS, see the Appendix to this report.

Further there seemed to be a common interest in conducting regular interviews with the analysand during ongoing analysis. These are specially designed interviews: a) the *Therapist Attachment Transference Interview* (TATI, which is an application of the AAI with the focus on the way one is reflecting about the attachment on the analyst/therapist), which aims to measure the reflective function of the analysand during the process; b) the *Analysand Experience of the Process* (AEP) developed in Oslo, the aim of which is to give information about the analysand's ongoing experience of his/her analytic process. In addition the analyst is interviewed regularly at several centres. In Oslo a number of ongoing analyses are tape-recorded with the aim of detailed process analysis.

Current activities at different centres

Amsterdam

In Amsterdam the group (Folkert Beenen, Wouter Gomperts, Jan Stoker, Jolien Zevalkink) focuses mainly on a quality assurance program; in addition they have projects with different topics. About 25 staff-members of the Netherlands Psychoanalytic Institute who are engaged in the analysis of 45 analysands take part in a systematised feedback system, using the periodical rating scale (PPRS) and three monthly reports, for a description of each analysis. This system is integrated in the daily clinical practice of the Institute, in the course of which, by means of yearly staff-meetings, the progress of the treatment is discussed on the basis of the output of the filled out scales. The monthly PPRS is a picture at a given moment in time. They expect that collecting a sequence of these pictures would enable them to see a kind of movement over time, and to make the **ongoing process visible over time** regarding the development of content and form. Perhaps it can make it possible to specify at which points during treatment changes take place. As a second step they have started to join the Multicenter Project more closely, using AAI and TATI interviews to rate RF. To explore the outcome question a pilot follow-up study (n=20 ex-analysands) is now being executed, focusing on the interaction-elements in the analytic process by means of administering TATI-interviews to get a systematic picture of the attachment- and transference-relationship as experienced by the analysand. They score this interview with the Reflective Functioning Scale (which is translated into Dutch, also for training purposes) For this follow-up they also use a Curative Factors Questionnaire (CFQ), a version for the analysand and one for the analyst; which is an operationalization of the PEP-study presented at the 1993 IPA Congress in Amsterdam and at the Scandinavian workshop in Stockholm '94. After statistical

analysis, the Psychoanalytic Process Rating Scale has been recently reduced to 100 items. Moreover progress has been made in making applicable another process measure, the computerised Referential Activity (Bucci, 1997) for transcripts and interviews in the Dutch language.

Helsinki

In Helsinki (Camilla Renlund) the question of the mode of participation of psychoanalysts in the AHMOS research scheme is, at the moment, undecided.

Milan

In Milan (Gherardo Amadei and Sylvia Pozzi) the main focus is on patients who are treated with psychoanalytic and cognitive psychotherapy in the public health service. During the first 3 years they had 88 patients, 33 became dropouts while 55 patients stayed with the research. At the present time they have started to include also psychoanalytic treatments within the project, which will allow for a comparative design. Before treatment starts patients are interviewed both according to the AAI (restricted to the demand questions) and to be able to score for CCRT. SCL-90, IIP and SASB are used by patients, and therapists fill out PRS regularly. 6 patients have completed treatment and they plan to make RAP with them. In Milan they do not interview the therapists, nor ask patients anything other than AAI demand questions. The strength of this center is, that the participants work within a public health service, with the usual patients and treatments for this kind of service. The relation between the conducted psychodynamic and cognitive treatment respectively is 4/5 - 1/5.

Oslo

In Oslo (Siri Gullestad, Bjørn Killingmo, Inge Refnin, Sverre Varvin) the researchers are psychoanalysts in private practice, organised by the Norwegian Psychoanalytic Institute. 10 analyses will be included in the study. At present 8 analyses are in the project and 2 of them have already terminated. The aim is to have a certain number of analyses in the project studied on somewhat different levels of intensity (e.g. 5 are audio-taped). The core-battery is used. Patients are tested with a psychoanalytically informed qualitative Rorschach at the beginning and after termination. AAI interview will be administered at beginning and at follow-up. The analysand is interviewed every half year with Analysand-Experience Interview. They work with the assumptions, that psychoanalysis may lead to integration/maturation/flexibility/better relational ability, which may be reflected in two main areas: Reflective function and emotional differentiation, which may be measured by AAI/scoring of RF and Rorschach/scoring of emotional integration. RF could be seen as a measure of integration and be related to integrating processes in treatment. Rorschach in the same regard may be seen as a measurement of emotional integrating. Rorschach is used as an implicitly predictive instrument. That is, a Rorschach (based on B Killingmoes system) is made before treatment with a prediction of how this should/might change in a successful treatment. (In this sense it will be a project which validates Rorschach as a predictive instrument as well as its use for measuring outcome). AAI, Rorschach, the Analysand-Experience Interview plus the different instruments (SCL-90 etc.), are extra process measures used before, during and after treatment. Tape-recorded analyses and extensively reported analyses will provide data directly related to the process. Process-data from tape-recorded sessions are analysed according to CRA methods. (The group is conducting a pilot study analysing transcripts of tape-recorded sessions using CRA (computerised referential activity), "screening" narrative activity in the sessions (Bucci 1997) and the Cycles-model (Bucci, 1997; Mergenthaler & Bucci, 1999). With these methods they assume that moments of change and integration may be detected which then must be analysed qualitatively. The hypothesis is that it should be possible to detect

patterns and profiles of each analytic process both concerning content and form/ style and to relate change to other process variables such as intervention, analyst style etc. The goal being the detection and description of emotional dialogic interchange process that may be related to change in extra analytic processes.)

Stockholm

In Stockholm (Anna Krantz, Roger Karlsson, Daniela Montelatici Prawitz, Imre Szecsödy) the research group consists of a few members/candidates of the Swedish Psychoanalytic Society and the Swedish Psychoanalytic Association (a recent study group of the IPA). Supported by local funding a pilot study with two analyses has started. It is difficult to increase the number of analyses to be studied, due to two parallel ongoing empirical studies that compete for the potential resources of analysts and analysands.

The initial interview of the analysand is based on AAI and completed with questions from the Drew Westen Personality Diagnostic Interview. The interviewer also asks the patient to talk freely for 5 minutes about his/her expectations from analysis. The transcribed text of the interview is scored according to RF. During treatment, analysands are interviewed each year according to TATI as well as asked to free associate for 5 minutes about their experiences of the analysis (to be studied according to Wilma Bucci's referential activity). Each year a semi-structured interview is conducted with the analyst, who also is asked to fill out the PPRS each month and to write a clinical summary every third month. To study information both from the analysand as well as the analyst is an extremely interesting and enticing task, and might deepen our reflections about the analytic process. The transcripts of the interviews with the analyst are studied qualitatively, according to the grounded theory approach.

Ongoing and future goals

- 1 To present and share information on assessment instruments of the psychoanalytic process and treatment.
- 2 To discuss topics relevant to research into the psychoanalytic domain.
- 3 To act as each other's reviewers for research proposals and other research plans.
- 4 To help each other in matters related to funding research projects.
- 5 To be able to act as a European platform in international meetings.
- 6 To develop research projects similar on main strategies, topics, and methods in order to be able to compare results.
- 7 To encourage a wide range of research projects on certain psychoanalytic topics and/or instruments in order to obtain diverse research experiences.
- 8 To make use of bilateral contacts in case of training possibilities or other organised events.
- 9 To encourage bilateral research projects among its members.

Evaluation

This is a relatively mature group of researchers, who have made very significant progress in developing psychoanalytic research methodology for the study of both process and outcome measurement, as well as a unique methodology for collaborative psychoanalytic research. They have set an example for other psychoanalytic organizations to follow.

The Oslo II study: A process-outcome study of psychoanalysis (OIS)

■ Varvin, S., Norwegian Psychoanalytic Society

Background

This study is conducted by a group of practicing analysts at the Institute of Psychoanalysis in Norway. It is part of a multicenter study with participants from Finland (Helsinki), Sweden (Stockholm), The Netherlands (Amsterdam), and Italy (Milan). The design, methods and theoretical background for the project are partly worked out in collaboration with the multicenter group but the Oslo-group has developed its own research interests.

Psychoanalysis and the relation between process and outcome

The Stockholm study (Sandell, 1996) demonstrated generally favourable results of psychoanalysis compared to psychotherapy and the importance of long-term follow-up in providing evidence for this treatment. These findings support earlier findings (Bachrach, 1993; Kantrowitz, 1993; Wallerstein, 1986) on positive outcome of psychoanalysis. Although there are studies on process factors contributing to outcome (e.g. Kantrowitz et al., 1990b), this is an underdeveloped area in psychoanalytic research. The Oslo study addresses outcome but its main focus is on the relation between outcome and process. This is a difficult task since there are no well-accepted methods for describing the process of psychoanalysis and few research findings supporting suppositions on what it is in the psychoanalytic process that might bring about change. An endeavour in this direction must therefore necessarily be exploratory and designed also to test out methods and possibly develop new ones.

Outcome, as measured by traditional symptom-based measures such as SCL-90 (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974), is not necessarily congruent with the expected impact of psychoanalysis. More specific to psychoanalytic treatment are outcome measures related to conceptions of those personality and intrapsychic changes psychoanalytic treatment is thought to bring about. This endeavour is related to the aims of psychoanalysis and there have been many, often conflicting, claims concerning the desired aim or effect of psychoanalytic treatment, as well as claims about the curative aspects of the psychoanalytic process that may bring about these changes. These have altered greatly over time and are dependent on the theoretical background, affiliation and historical circumstances of the authors (Sandler & Dreher, 1997).

The research group in Oslo has chosen two broadly defined interrelated areas: the possible development of a mentalising function (psychological mindedness) and the structuring of emotional experience seen as part of integrative processes. These choices are based on clinical experience, theoretical reason and the availability of methods for measuring outcome which tap these areas.

Mentalising

Based on research on attachment, Fonagy and colleagues (Fonagy, 1998; Fonagy et al., 1995) have sought to define individual differences in adults' metacognitive capacities or what type of working model of the mind was operating in a patient. The crucial distinction was whether the subject could conceptualise their own and others' behaviour as reflecting states of mind. This capacity, coined "reflective function" (RF), would determine whether a person could tolerate and reflect on negative feelings, problematic behaviour by self and others and in that way be less vulnerable to conflict and psychic pain. A scale was developed to measure the degree of reflective function. This concept has corollaries in concepts such as psychological mindedness, and is well established as a hoped for capacity in analysands which would be expected to develop in relation to a psychoanalytic treatment. The valuation of reflective function is based on scorings of the

Adult Attachment Interview (Main & Goldwyn, 1995). In the Oslo study this interview will be administered prior to treatment and at the follow up. In addition to evaluating RF, this interview provides narratives of relations to important others which may be studied by other qualitative methods. The researchers aim to develop an interview which will tap the analysands' conception of their analytic experience and from which it will be possible to score RF. This interview would be administered once or twice a year. Interviewing the analyst at the same intervals is also being considered.

Differentiation and organisation of affective experiences.

Reflective function is related to mental states and the subjects' models of mind (for a more detailed account of RF, see the Appendix to this volume). Pathology is associated with little differentiation and difficulties in containing feelings. The Rorschach is a method which, used as a psychoanalytic research instrument, may be a good measure for describing the subjects' degree of ability to organise and differentiate affects (Killingmo, 1980, 1992). This differentiation is thought to make up the ability to sustain and endure emotional tension and conflict. Patients in this study will be tested with Rorschach (prior to treatment and at follow-up).

RF and the capacity for emotional differentiation may be viewed as dynamic outcome measures. The question being addressed concerns the relationship of characteristics of the psychoanalytic process and the outcome on these measures.

The aim is to tape-record as many analyses as possible. Others will be recorded by extensive session notes. The analyses will be intensively studied and will constitute the 'core-cases' in the project. The hypotheses under investigation are that the character of the relational style, the development of integration and the ability to tolerate feelings and conflicts, broadly speaking, are marks of a good analytic process. Particular concerns for the study are the identification of turning points where important changes surfaces.

Interviewing analysand and psychoanalyst during the process will provide an additional point of view in exploring interactive processes over time and, to a certain degree, countertransference aspects. The last is also expected to surface in the exploration of the therapeutic dialogue.

Research questions

At the present stage of planning the study, these are defined broadly as follows:

- a whether the outcome of psychoanalytic treatment as assessed by psychoanalysts corresponds to assessments in terms of RF and emotional differentiation.
- b whether clinical outcomes are reflected in specific features of the psychoanalytic process.
- c the relationship of process evaluations, RF/Rorschach assessments and symptomatic/psychometric changes.

Design

This is a multiple single-case design. Cases will be incorporated into the project as they become available. A multilevel participation model has been designed to facilitate engagement of as many analysts in the society as possible. It will be possible for the clinician to participate without tape-recording, but full process notes and systematic recording of the process will be mandatory.

The analysand/analyst couple can opt not to participate in the yearly independent assessment.

The lowest level of participation will be only the pre- post-psychometric measures and independent

interviews. It remains to be seen if this flexible model will stimulate members to participate. The participation in a multi-centre collaboration increases the number of cases and makes possible a group design within the project. The international collaboration also makes possible an extensive exchange of ideas and collaboration on developing and learning research instruments. The group may also apply for research funding for this and other purposes (e.g. conferences).

Methods

The following structured psychometric interview-based instruments are part of the core battery common for all the centres in the international collaborative study:

- a The Hopkins Symptom Check List (The SCL-90) (Derogatis et al., 1974), a self-report measure of the severity of somatic and psychological symptoms
- b Inventory of Interpersonal Problems (IIP) (Horowitz, Rosenbery, Baer, Ureno, & Villasenor, 1988), a self-report inventory of interpersonal problems
- c Structural Analysis of Social Behaviour (SASB-q) (Benjamin, 1974), an inventory assessing the internal representation of social relationships
- d Adult Attachment Interview (AAI) (Main & Goldwyn, 1995), an assessment of attachment history. This is an hour long, semi-structured interview focusing on the description and evaluation of early attachment relationships and attachment related experiences. It asks participants both to provide several general overall evaluations of their experiences and to illustrate those evaluations with a description of specific biographical episodes. The interview is transcribed verbatim, and scored according to the reflective-self manual. It may also be scored for attachment styles. These will be administered before treatment, yearly during treatment and at follow up.
- e The Rorschach will be given before and after treatment and at follow-up. It will be used for constructing a personality profile, and a hypothetical personality profile given a favourable outcome (the changes that would be expected in the follow-up Rorschach based on the pre-treatment protocol). Process data will be obtained through tape-recording of some of the analyses, extensive session notes, periodic session-notes (e.g. once a month) based on the periodic rating scale.
- f The Periodical Rating Scale (PRS) is filled in weekly or monthly in the other centres. It is a reduced form of the Session Rating Scale of the Anna Freud Centre and was constructed by the Amsterdam members of the multi-centre group (Beenen & Stoker, 1997) with the assistance of Peter Fonagy.

Through the Periodical Ratings Scale one can collect the subjective opinions of the analysts, regarding the presence and/or absence and the category of their interventions for more than 200 items. These items are divided into three sections: (a) *manifest content*. General attitude: time keeping, missed sessions, quality of sessions, physical behaviour, schoolwork, employment; current life events; gender and age issues affective moods, defences, resistance, (b) *conscious and unconscious content*: concerning the body, self esteem, object relations, sexuality, aggression, (c) treatment parameters, the form of transference themes, analyst's feelings, styles of interventions, reactions to interventions; analyst's feelings in the gross. The filling out of the PRS questionnaire (with the help of an instruction manual) is supposed to give a picture of the ongoing process, in a form that is a compromise between a naive descriptive and a more theoretical clinical kind of reporting, that is systematised and standardised. At present the Periodic Rating scale is not used in the Oslo-project. (The AAI-interview and Rorschach may be

seen as indirect process data.) At this point sampling for the purposes of statistical analysis has not yet been decided. The amount of data could be overwhelming, but at this point it has been agreed to keep tape-recording and session notes from as many sessions as possible, on all archival bases, with the aim of later making more informed sampling possible.

Methods for studying the dialogue under consideration are: SASB (Henry, in press), CCRT (Luborsky & Crits-Christoph, 1990), Frame analysis (Dahl, 1988), Dialogical sequence analysis (Leiman, 1997), Assimilation analysis (Stiles et al., 1990; Stiles et al., 1992; Stiles et al., 1991), Cyclical analysis and referential activity (Bucci, 1997; Mergenthaler, 1996) and Enunciation analysis (Rosenbaum, 1997). Data compatible with these procedures will be collected but any one or two of the methods will be selected based on evidence accumulated in the meantime. The aim is to identify key-sessions and “important periods” in the process for analysis with more time-consuming process analysis-methods. Table 1 includes an overview of the methods.

Table 1: Overview of measurement techniques and questionnaires under consideration in the Oslo Study.

| Instrument | Aims |
|--|--|
| Before treatment | |
| Clinical interview | Dynamic & psychiatric diagnoses |
| Adult Attachment Interview | Reflective functioning and attachment status |
| Rorschach | Psychodynamic emotional profile |
| SCL-90 | Inventory of somatic and psychological symptoms and problems |
| IIP | Inventory of interpersonal problems |
| SASB-q | Inventory of introjects |
| Interview of analyst (research interviewer) | Analyst's theoretical & practical attitude & expectations |
| During treatment | |
| Periodical clinical summary (analyst, 3-monthly) | Process data |
| Semi-structured interview of analysand (analyst) 1-2 times per year | Process data |
| Adult Attachment Interview | Representational change |
| Process/outcome data of analysand (start, end, follow-up) | Process data |
| Questionnaires (SCL-90, IIP, SASB-q) (patient, annually) | Symptomatic status |
| Tape-recording | Process data |
| Termination and follow-up | |
| AAI | Reflective-functioning |
| Rorschach | Emotional integration |
| Interview of analyst | Analyst's evaluation of treatment process |
| Questionnaires (patient) SCL-90, IIP, SASB-q | Symptomatic status |

Two and five years after termination the patient will be interviewed according to the CHAP (Changes After Therapy) Scale (Sandell, 1993) and fill out the WBQ (Well Being Questionnaire: Sandell, Blomberg, Lazar, 1996) in order to obtain comparability with the STOPP study.

Evaluation

This project is still in an early stage, with conceptual/theoretical issues, hypotheses, and the application of instruments and methods still under consideration. Eight analyses are now in the project. There is an ongoing pilot-study with one of cases using clinical and research data for reflection and discussion in the group by studying and discussing both process data (tape-recordings), Rorschach protocol, AAI and the questionnaires, with the aim both of deeper clinical understanding and refinement of theory and hypotheses. The overall aim is to at make the research clinically relevant and to keep it close to current clinical discussion in the Norwegian Psychoanalytic Society. This will be done by broad participation of the membership in the actual research process, research seminars and regular presentations at meetings of the society.

The Mexico City study: The psychodynamic psychotherapy of BPD (MCS)

■ Cuevas, P., Camacho, J., Rosario, I., Parres, R., Mendoza, J., & López, D.

In this study of the use of Kernberg's Manual for the psychotherapeutic treatment of BPD, 19 patients were selected from 60 consecutive patients who sought treatment for personality disorder from the Mexican Psychoanalytic Association with two questions in mind: (a) Can the manual be taught to therapists with a different background of training? and (b) Are there differences in the treatment process and outcome when contracts are made along the lines suggested by Kernberg, compared with the usual arrangements for therapy contracts? The treatment was a manualized psychodynamic psychotherapy delivered in two sessions a week, face to face, using clarification, confrontation and here-and-now interpretations of primitive defense mechanisms and pathological split of self and object representations with their linking affects. It was decided to limit the observation to one year of sessions with attendance of a minimum of 25 sessions to be considered for the trial. All psychotherapy sessions were face to face and videorecorded in the consulting room. All sessions were supervised once a week with supervisors. The assessment team measured BPD psychopathology and the global activity level of all 19 patients at entry and after every 24 sessions over two years.

Sample

Five training analysts from the Mexican Psychoanalytic Association were trained in the use of the manual at the New York Hospital. The manualized psychotherapy was delivered in two sessions a week, face to face, using clarification, confrontation and here-and-now interpretations of primitive defense mechanisms and pathological split of self and object representations with their linking affects. They then trained four psychoanalysts and 10 psychotherapists in the use of the manual. The four psychoanalysts had a mean of 12 years of experience (S.D.=1.15). The 10 psychotherapists had a mean of 4.67 years of experience (S.D.=4.23) There was a significant difference between the two groups of therapists ($U = 7.5, p < .002$). To be included in the study, the therapists were required to a) have a certified training in psychoanalysis or psychotherapy, b) complete a training course in the use of the manual, c) attend all the psychotherapy sessions and d) supervise weekly all videorecorded sessions. They were excluded if they failed to attend two or more psychotherapy sessions a month or more than two supervision sessions a month.

Patients were included in the study if they met at least 5 positive criteria for BPD (DSM IV); were of middle school age or more; and had an average IQ on the Wechsler Scale. They were excluded if they had a diagnosis of schizophrenia, bipolar, severe substance abuse and antisocial personality disorders, organic mental disorder and a below average IQ. 60 consecutive patients with personality disorder diagnosis were evaluated using the Structured Clinical Interview for Diagnosing DSM-IV Axis I and Axis II Disorders. 30 out of those 60 were diagnosed with BPD and were invited to participate. 19 out of those 30 patients accepted, signed an informed consent letter and were referred to the available therapists. Four of the patients were male and seven were unemployed although 10 were college graduates 12 patients met all BPD criteria and a further five met 8 or the 9. Eleven suffered significant neglect, physical or sexual abuse and a further four had been overprotected. Five of the 19 patients (26.3%) dropped out before the fifth session. These five were receiving treatment from the less experienced psychotherapists. The mean GAF for them was 52, 7 points higher than the mean for the remaining 11, which was 45. A further three patients dropped out after three months of treatment (mean GAF 48.3). The 11 patients who remained in treatment for 24 sessions had a mean GAF of 46.1.

Instruments

- Clarkin's Interview for BPD Dimensional Score (rates each one of the nine DSM-IV BPD criteria) from 1 (lesser severity) to 6 (greatest severity)
- DSM IV Global Assessment of Functioning Scale (GAF) psychosocial functioning from 1 to 100, where higher scores mean better functioning measured by the assessment team at entry and each 24th session during two years of treatment

Results

The 11 patients who completed the treatment had a similar distribution of sociodemographic and psychopathological characteristics and level of global activity in the groups that initiated treatment with psychoanalysts and psychotherapists (Mann-Whitney $U = 34.5$, n.s.). At the 72nd session measurement (after nine months treatment) none of the 11 patients met BPD diagnostic criteria any longer. Improvement on the number of BPD criteria met was significant. Almost all patients improved on impulsivity criteria by the 24th session and on affective instability criteria by the 48th with a number also improving also on identity disturbance. Additional improvement by the 72nd session was minimal, even in patients that completed almost two years of therapy. Therapists who lost patients under 3 months were more likely to be inexperienced (Mann-Whitney $U = 15$, $p < .02$). Patients who remained longest in treatment had the highest GAF scores at their first evaluation. There was a significant correlation between level of GAF at the beginning and number of sessions attended ($r = -.481$, $p < .037$). The Friedman test shows significant changes in GAF measurements along time (chi squared = 21.41, $p < .000$). A significant concordance coefficient in the percentage of GAF improvement from the entry was observed (Kendal's $W = .973$, $p < .000$). Patients' improvement increased as the number of sessions increased. Notably, while improvement on BPD criteria was small between session 48 and 72, improvements in GAF score were marked, suggesting that global adaptation improvements take longer.

The decisive factors in the patients' improvement were:

- The use of a psychotherapy manual with theoretical and clinical coherence in psychopathology concepts and a well described set of strategies, tactics and techniques.
- Close supervision to ensure adherence to the manual, through the videorecording of sessions.
- The consistent exploration of the therapist's countertransference in the supervisory sessions along the entire treatment.

Evaluation

The results suggest that significant improvements may be achieved by psychotherapy over a two-year period. It should be remembered that the study is not controlled and that the stability of PD symptoms is not known. These results need to be corroborated with comparative studies with other forms of treatment of BPD patients, i.e. cognitive-behavioral, supportive therapy, group therapy, hospitalization and the use of medication. It is also necessary to replicate the study with patients belonging to different social classes, assigning psychiatric residents and postgraduate psychotherapy students as therapists, with the aim of extending the application of this form of therapy to a wider population.

The Kortenbergh-Leuven study on inpatient psychoanalytically oriented hospitalisation for personality disorders

I Vermote, R., Corveleyn, J., Vertommen, H. University Centre St. Joseph, associated with the Catholic University Leuven.

Background

At the University Centre St. Joseph, associated with the Catholic University Leuven, patients with personality disorders can be treated in an intensive psychoanalytically oriented multicomponent programme. This programme is applied in two settings: a day-hospital of 16 patients and an inpatient ward of 32 patients. The stay is limited to one year, with a main stay of seven months.

The aim of the treatment is to foster a psychoanalytic process. Vaughan and Roose (1995) formulated a clinical and research definition of the psychoanalytic process in terms of free association, resistance, interpretation and working through. However this definition seems to correspond more to the neurotic level of functioning. There are arguments that at the borderline level another kind of psychoanalytic process takes place as borderline patients have mentalisation problems and act out in the here and now.

The therapeutic approach at this borderline level was conceptualised in three facets: object relational, mentalisation and psychoanalytic relation (therapeutic alliance). These facets are addressed in the different components of the programme.

Research questions:

The study aims to

- examine prospectively the relation between the analytic process and outcome in psychoanalytically oriented hospitalisation of patients with moderate and severe personality disorders.
- define the characteristics of the group for whom this form of treatment is indicated and of the group which does not respond to this type of therapy.
- assess the concepts on which this psychoanalytic treatment model is based and their relation to the psychoanalytic process.

Sample

100 patients with personality disorders who are referred to the in-patient psychoanalytically oriented hospitalisation unit. The diagnosis of a personality disorder is assessed by the SCID II (categorical DSM diagnosis) and the IPO (Inventory of Personality Organisation: structural diagnosis according to Kernberg and Clarkin).

Measures

Outcome measures

Clinical parameters: the Beck Depression Scale (BDI), the Symptom Check List (SCL-90-R), the Spielberger State Trait Anxiety (STAI), the Spielberger State Trait Anger (STAXI), a Self Harm Inventory and the Social Adjustment Scale (SAS).

Process measures

- 1 Therapeutic Staff: assesses the psychoanalytic process in patients by a bi-monthly evaluation on a 7-point scale.
- 2 External researchers assess the process in patients by a four monthly ORI (Object Relations Inventory), a semi-structured interview on which measures are scored, which are related to the psychoanalytic concepts on which the therapeutic programme is based:
 - *mentalisation*: the Reflective Functioning Scale of Fonagy and Target (RFS) and Bions GRID categories (GRID)
 - *object relations*: the Differentiation-Relatedness Scale (DRS) of Blatt apart from this ORI, the *therapeutic relationship* or therapeutic alliance is measured by the CALPAS
- 3 The patients rate their own evaluation using two new empirical instruments:
 - *the Louvain Psychotherapy Scale (LPS), a self-rating scale*
 - *the Event, Intervention, Affect- Inventory (EIAI)*

Evaluation

This project started in March 2001. It is, however, an extremely sophisticated design which should yield exciting findings in an important area.

Frankfurt – Hamburg long-term psychotherapy study: Process and outcome of psychoanalytically oriented therapy and behavior therapy – a study from private practices

- Brockmann, J., Schlüter, T., & Eckert, J. (in preparation). The effects of psychoanalytically oriented and behavior long-term therapy. A comparative study from the private practices of insurance-registered psychotherapists.

The study attempts to combine a naturalistic design with experimental test conditions. The results reported here are restricted to ‘hard data’ that may be of interest in an Evidence-based Medicine context for their relevance to both treatment (in this study, long-term therapy) and disorder (in this study, depressive disorders and anxiety disorders).

Sample

31 psychoanalytically oriented long-term therapies were compared with 31 long-term behavior therapies. The treatments were carried out in private practices. All patients passed a Diagnostic Interview (SCID) by an external interviewer before participating in the study. Only patients with depression and anxiety problems (according to Axis I of DSM-III-R) were included in the study. Patients with alcohol/drug addiction or psychotic symptoms were excluded.

Treatment

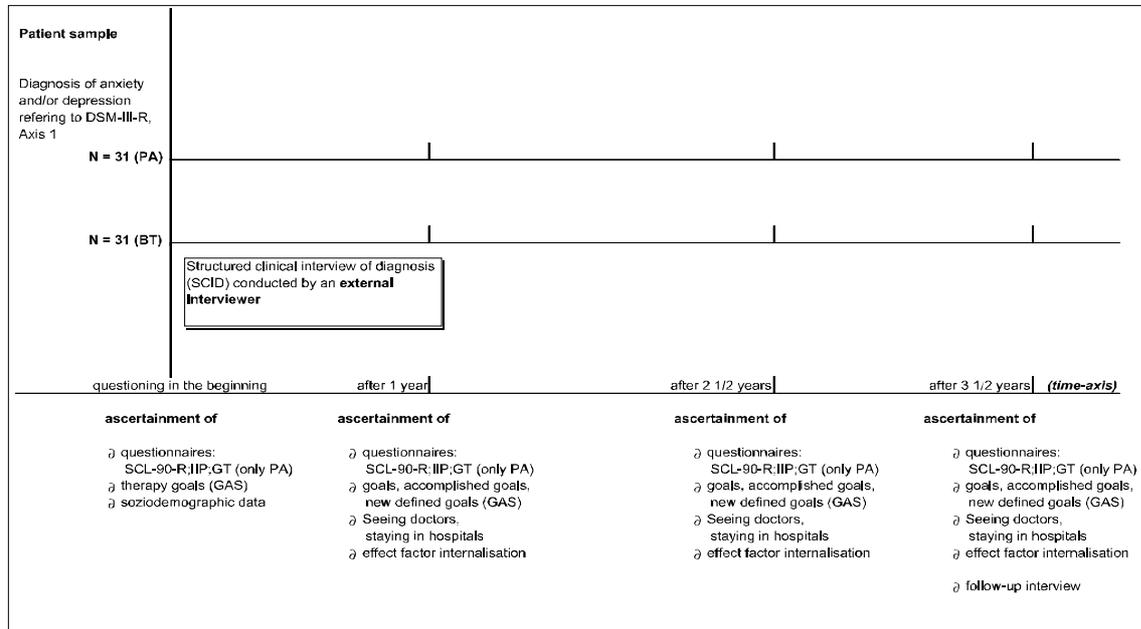
The behavior long-term therapies (BT) were treatments, that were conducted by behavior therapists who are licensed by the psychotherapeutic guidelines (German law). The average duration of the treatments was 63 sessions. After 2.5 years, 55% of the treatments were not yet concluded; treatments still in progress after 3.5 years constituted 16%. Psychoanalytically oriented long-term therapies were treatments, that were conducted by psychoanalysts who are licensed by the psychotherapeutic guidelines as well. Of the 31 psychoanalytically oriented long-term therapies (PA), 26 were conducted as psychoanalytic and 5 as psychodynamic treatment (all definitions according to the German health insurance system). The courses took an average of 185 sessions. After 3.5 years, 58% of the courses had been completed. The mean frequency of sessions in the completed courses amounted to 4.8 sessions monthly ($d = 1.9$); for the ongoing courses the figure was 5.4 sessions monthly ($d = 1.5$).

Measures

Data were taken at four instances: at commencement of treatment, after one year, after 2.5 years and after 3.5 years. The experimental plan with the instruments of ascertainment is shown on the table below (Figure 1).

Figure 1. Experimental Plan

PA: long-term psychoanalytically oriented therapy and BT: long-term behavior therapy



The follow-up interviews after 3.5 years were conducted by independent interviewers. The interviews have been tape-recorded. The therapy goals were defined by the patients (BT) or the interviewer (PA) at the beginning of their respective courses of therapy. The patients were also given the option at every interview occasion to drop goals and name new ones. The follow-up interview figures: 95% of the patients supplied answers after 3.5 years in the questionnaires (PA: 100%, BT: 90%) and 77% took part in the follow-up interview (PA: 90%, BT: 64%).

Results

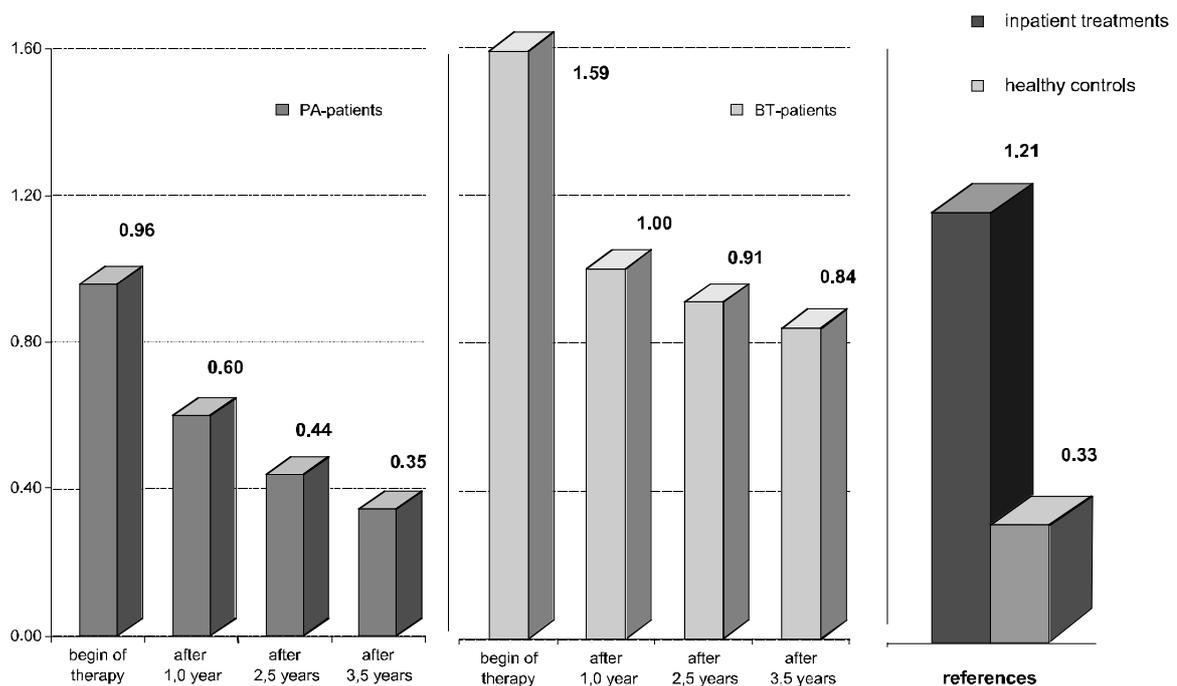
Differences between the patient groups at commencement of treatment

Notwithstanding comparable diagnoses, there were differences between the patients who were looking for or had been referred to behavior long-term therapy on the one hand and a psychoanalytically oriented long-term therapy on the other. The differences emerged in a number of characteristics – their schooling, their access to psychotherapy (referral by medical professionals vs. own initiative), the strain of their symptoms and the use of psychotropic medicines. Patients who had begun PA-oriented treatment had significantly better education, significantly fewer had come to a therapist via medical referral (but on their own initiative), they suffered significantly lower symptom strain in all scales and the total score of SCL-90-R, and there was significantly less use of psychotropic medicines (0.06% vs. 35%). The educational differences between the two groups of patients is corroborated by R ger & Leibing (1999), who incorporate studies by Linden et al. (1993) and Linden & Pasatu (1998) in their discussion. As long ago as 1958, Hollingshead & Redlich’s (1958) classic study found that patients of different social classes received differing forms of psychotherapy. Long-term psychoanalytic treatment was accessible mainly to the middle and upper classes.

Developments in symptoms and interpersonal problems

In patients who came to this treatment under naturalistic conditions, both psychotherapeutic approaches proved highly successful. Both the patients who had begun a psychoanalytically oriented psychotherapy and those receiving behavior therapy showed significant changes in the symptom strain throughout the SCL-90-R scales and in the overall score (Analysis of Variance with repeated measurements MANOVA), as shown in Figure 2.

Figure 2 Development of the characteristic value GSI of SCL-90-R over all measurement dates for psychoanalytically oriented and behavior long-term therapies (with references)



References

Healthy controls – average value for strain of symptoms in the general population

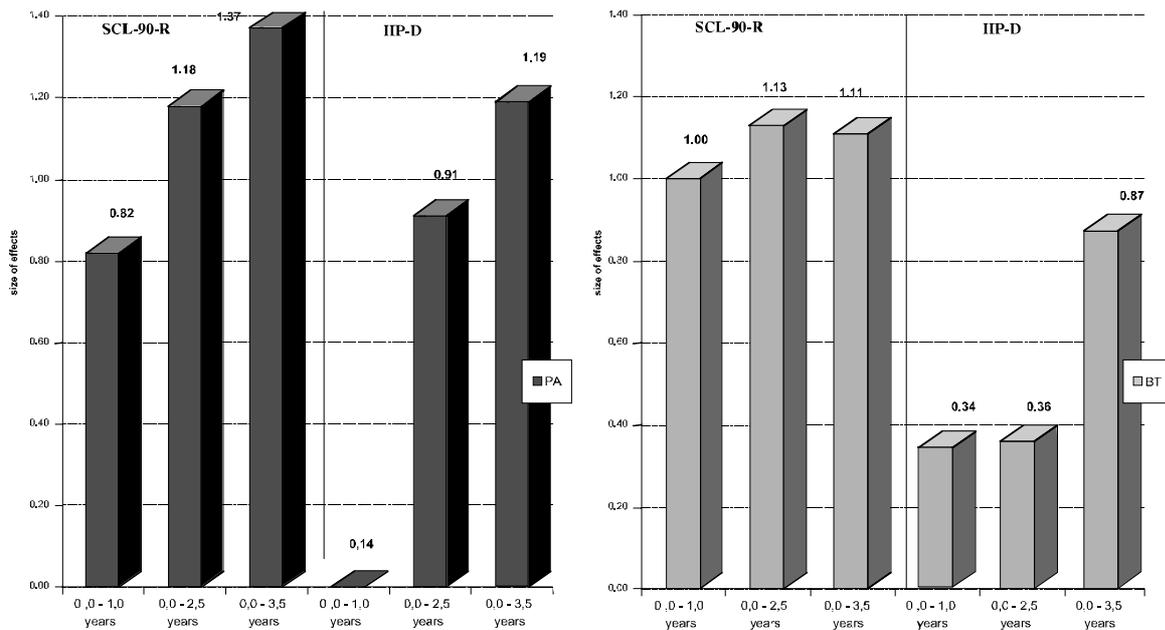
Inpatient treatments – average value for strain of symptoms in a sample of inpatients receiving psychotherapy (G. H. Franke, 1995)

Highly significant changes in interpersonal problems were also found, measured by the IIP, between the beginning of treatment and the repeat measurement after 3.5 years, in both treatment groups. For the patients in treatment group ‘PA’, substantial changes in this sphere could be ascertained in the period between the 1-year and 2.5-year points, while for the patients in treatment group ‘BT’ such change came even later, between the 2.5-year and 3.5-year test dates. The effect sizes for the changes in symptoms and in the interpersonal problems, as shown in Figure 3, have been obtained by a statistical method that tends to produce conservative results; so the effect sizes, especially for changes in interpersonal problems after 3.5 years, can be considered as high.

In both test groups, changes in the interpersonal sphere occurred later than changes in symptom strain. These results in this investigation confirm for long-term therapy the phase model set out by Lueger (1995) for psychotherapy outcome in short-term therapies.

Figure 3: Process of effect size of the characteristic value GSI of SCL-90-R and of the total IIP score, for the long-term psychoanalytically oriented and behavior therapies respectively.

Effect size formula $ES = (X_{post} - X_{prae}) / SD_{prae}$



Changes in experience, behavior and goal attainment

In their experience and behavior, measured by VEV (Zielke & Kopf-Mehnert, 1978a), and in goal attainment (GAS), significant changes over the test periods in both groups were again found. The patients – in both groups – redefined some 1/3 of their therapy goals after a year. The long-term therapies, under naturalistic conditions, took a rather discontinuous course in terms of time. This applies to both the beginning and the process of therapy. 1/3 of the patients had taken one or more courses of treatment prior to the therapy under investigation, and the latter was not infrequently interrupted, in both treatment groups.

Results specific to disorders

The sample for patients with diagnosed anxiety disorders is too small in both groups for an examination of the differences between the two therapy approaches to be split into diagnosis type and still enable any generalised conclusions to be drawn.

Therefore only the effect sizes are tabulated here (see Table 1), which reveal the following differences in trend: patients with diagnosed depressive disorders appear in the long term, as inferred from the follow-up at the 3.5 years test point, to profit more from long-term treatment of the psychoanalytically oriented than the behavior therapy. The converse seems to be true of patients with anxiety disorders. The 1-year-point reading indicates that they profit sooner, and subsequently also more, from long-term behavior therapy than from long-term therapy on psychoanalytical lines.

Table 1 Effect sizes for diagnostic groups 'Depression' and 'Anxiety'

$$ES = (X_{post} - X_{prae}) / SD_{prae}$$

| ES ES ES | | (0 - 1,0 J.) (0 - 2,5 J.) (0 - 3,5 J.) | | | | | | |
|------------|----------------|--|------|------|-----------------|------|------|------|
| Depression | | | | | | | | |
| PA (N=22) | GSI (SCL-90-R) | 1.08 | 1.72 | 1.96 | IIP total score | 0.34 | 1.20 | 1.42 |
| BT (N=19) | GSI (SCL-90-R) | 0.80 | 0.95 | 0.80 | IIP total score | 0.15 | 0.21 | 0.65 |
| Anxiety | | | | | | | | |
| PA (N=9) | GSI (SCL-90-R) | 0.55 | 0.53 | 0.85 | IIP total score | 0.28 | 0.40 | 0.97 |
| BT (N=10) | GSI (SCL-90-R) | 2.08 | 1.83 | 2.14 | IIP total score | 0.69 | 0.55 | 1.52 |

It is not possible within the present limits to establish conclusively whether these differences derive from the different methods of treatment or from the differences between the patients in their education, use of medicines, etc.

Evaluation

The prospective study, of naturalistic design, shows that comparative therapy studies with parallelised samples do not always do justice to the reality that is their subject. A regrettable fact is that the number of patients with anxiety disorders in this sample is so low. The follow-up period (3.5 years after the beginning of the therapy) proved too short for an entire group of long-term therapies; they had not been completed at that point. Therefore a further follow-up sample (7 years after the beginning of therapy) is in preparation.

Reanalysis of the NIMH multicentre trial of affective disorders

- Blatt, S. J., Quinlan, D. M., Pilkonis, P. A., & Shea, M. T. (1995). Impact of perfectionism and need for approval on the brief treatment of depression: The National Institute of Mental Health Treatment of Depression Collaborative Research Program revisited. *Journal of Consulting and Clinical Psychology, 63*, 125-132.

This benchmark study reported in a number of papers and summarised by Elkin (1994) examined the efficacy of cognitive-behavioural psychotherapy and interpersonal psychotherapy. Neither treatment is strictly psychodynamic, although interpersonal psychotherapy has its roots in the ideas of an interpersonalist psychoanalyst, Harry Stack Sullivan (1953). IPT focuses on current interpersonal problems rather than past relationships and is a brief rather than long-term therapy. Thus the findings have limited relevance overall to the efficacy of psychoanalysis and the study is considered here simply in terms of Blatt's reanalysis of the findings.

Sample

The research was carried out at three research sites in the United States. Overall 560 outpatients were screened and those meeting criteria for unipolar depression were included; 250 patients with moderate to severe depression were selected and 239 patients entered the trial. Sixty percent had been depressed for more than 6 months and only 36% did not have a previous episode.

Treatments

Patients were randomly assigned to one of four conditions: clinical management with imipramine; clinical management with placebo; CBT; and IPT. Clinical management consisted of weekly meetings of 20-30 minutes to discuss medication, side effects and the patient's clinical status. Both the medication conditions included some psychotherapeutic components including encouragement, direct advice, support, etc.

Measures

Patients were assessed before treatment and at 4, 8, 12 and 16 weeks and followed up at 6, 12 and 18 months. Throughout standardised measures of symptomatic status were used including the Beck Depression Inventory (BDI) and the Hamilton Rating Scale for Depression (HRSD). After discharge progress was assessed using a semi-structured interview designed to assess the longitudinal course of psychiatric disorders.

Results

There were no significant differences between the treated groups and all conditions resulted in a significant improvement between pre and post treatment, including the placebo group (Elkin et al., 1989). Using a strict criteria of clinically significant change (Jacobson & Truax, 1991) with the Hopkins Symptom Checklist, 78%, 93% and 87% of the CBT, IPT and imipramine groups respectively were designated as showing clinical improvement in contrast to 65% of the placebo group (Ogles, Lambert, & Sawyer, 1995). More severely depressed patients did somewhat better with imipramine than with CBT and there was a similar trend for IPT to be superior to CBT for this group (Elkin et al., 1995). Follow up of patients over 18 months revealed that only 20% of the original sample were free of episodes of depression of at least two weeks duration (Shea et al., 1992). The groups were not statistically significant in terms of relapse rates, but clearly the study unequivocally demonstrated that the vast majority of patients who recover during brief treatment tend to relapse pretty soon afterwards.

The reanalysis of the data by Blatt et al (1995) indicated that self-critical introjective patients did not get better in any of the treatment conditions in this study. These patients were also more likely to make suicide attempts. These results are interesting, when taken together with the findings from the Menninger project, as well as the project reported by Blatt and Ford (1994), which showed that introjective perfectionistic patients do relatively well in psychoanalytic and psychoanalytically oriented intensive psychotherapeutic treatment - even though they do poorly in short-term psychotherapy. In the Blatt and Ford study, patients were treated four times a week for fifteen months and they were shown to do better than patients with a similar severity of illness, but with an anaclitic personality structure.

Evaluation

This interesting result could suggest an important role for long-term psychodynamic treatment with self-critical introjective patients.

The Hamburg Study: Psychoanalytic focal therapy versus client-centred therapy

■ Meyer, A. E., (ed). (1981). The Hamburg short-term psychotherapy comparison experiment. *Psychotherapy and Psychosomatics*, 35, 77-220.

The main aim of the study was to compare the efficacy of two forms of short-term psychotherapy. Such short-term procedures could be the solution to the well-known disparity between demand for and availability of psychotherapy in highly industrialised nations. This solution could prove to be illusory, however, if the efficacy of these short-term procedures is low or nil.

An additional motivation for this project stemmed from the fact that both Client Centred Therapy (CCT) and PT were derived from psychoanalysis but that each capitalised on different aspects of it (Meyer, 1981). Only in retrospect was it suggested (Meyer & Niemann, 1984) that CCT could be considered a focal therapy, albeit with an invariant focus identical for each and every patient. The focus of CCT was considered to be as follows: "Learn to perceive and express your emotional experiences (needs and reactions) and to accept your own self, and you will have learned how to live".

Method

Subjects and selection

Beginning in 1972 and continuing over the next 1.5 years, all psychoneurotic and psychosomatic patients who applied for treatment intake at the outpatient department of the Hamburg University Clinic, who were between 20 and 40 years of age, and who reported receiving no previous psychotherapy were invited to undergo intake testing for the research program. Of 286 patients invited 72 did not show up. The remaining 214 patients started intake assessments but only 177 were entered into the study; the others either declined participation or were excluded because of contraindications (e.g.. psychoses or absence of motivation).

The case histories of these 177 patients were presented by the intake interviewer to the focus formulation seminar. This seminar formulated a therapeutic focus and a psychotherapy prognosis (suitability). The prognosis for psychotherapy was considered good for 88 patients and these patients were then randomly assigned to PT or CCT conditions. Not all patients accepted the offer of treatment but 34 of them started therapy in each therapy group.

Post hoc statistical examination indicated the success of the randomisation procedure. The patients refusing therapy differed in only two respects from those accepting therapy: they were less sick and less sophisticated than their peers who accepted psychotherapy assignment. As is often the case, young, attractive, verbal, intelligent and successful patients (Goldstein, 1971) were over-represented in the sample. This was not caused by therapist selection factors, however, because these characteristics also typified the intake sample (Kimm, Bolz, & Meyer, 1981).

Instruments

The investigators considered that psychotherapy outcome evaluation required the measurement of a number of variables representing different aspects of outcome. Therefore, evaluators were employed and a number of different measurement devices were used with repeated assessments (Burzig, Speidel, Bolz, & Meyer, 1981; Meyer, 1981).

The measurements included: sub-tests of a differential intelligence test; a personality inventory for personality factors such as neuroticism, extraversion, and psychosomatic disturbances (the Freiburg Personality Inventory - FIP); a personality questionnaire based on psychoanalytic theory; an anxiety questionnaire adapted from the Taylor Manifest Anxiety Scale; and a symptom checklist that contained 152 items incorporating neurotic and psychosomatic complaints.

Clinical assessment scales and ratings included the interviewer's assessment (symptom change, well-being and insight); the patient's self-ratings (of symptom change, well-being and interpersonal change); and blind ratings by a group of experts of the transcripts of the two follow-ups (for assessment of symptom change, wellbeing, aspects of insight, etc.) - adjusted to ensure confidentiality of the identity of the patient, blindness as to type of therapy and length of follow-up.

Process scales included the patient session questionnaire, the therapist session questionnaire, a content-analytic catalogue for interventions and interaction and Rogerian rating scales (of empathy, warmth, self-exploration, etc). Identification and rating were also carried out for crucial incidents (Rice & Greenberg, 1984).

Procedures

Comparison of the efficacy of short-term psychotherapy. All of the patient test variables were assessed five times: during the waiting period before assignment, immediately before therapy began, after therapy, at Follow-Up 1 (3 months) and at Follow-Up 2 (9 months). Thus, it was possible to analyse the test results in two different ways. For the within-group or own-group comparison, 13 PT patients and 12 CCT patients whose treatment had been delayed were used. In this analysis, the waiting period to the treatment period for each therapy was compared by means of one-way analyses of variance (ANOVAs). For the between-groups, or reference group, the two waiting groups were combined into one untreated control group (n = 25) and compared with 21 PT patients and 22 CCT patients who began their therapy immediately (bifactorial ANOVAs).

Clinical assessment. Each patient was assessed at 3 and 9 months during follow-up. These follow-up evaluations were performed by the same clinician who had conducted the initial intake interview. Independent clinical experts were asked to make blind ratings of the transcribed interview. In addition, patient self-ratings were collected at these times.

Process research. Both randomly chosen therapy sessions and sessions selected on the questionnaire (e.g., "good hours") were subjected to a content analysis and associated ratings. These process data were used to assess differences between the two therapy groups and to investigate the interactions that occurred between patients and therapists in the sessions and were correlated with outcome variables.

Long term follow-up. After 12 years the patients in this study were invited for another interview which was conducted and coded by independent experts. The patient again answered the FPI, an anxiety questionnaire (SAL) and a social questionnaire concerning post-therapeutic developments (e.g. symptom change, further medical aid and psychotherapy, partnerships, work, and sexuality).

Results

Psychological tests. To ensure a conservative interpretation of psychological test findings, only those differences that were replicated in the own and reference control comparison and that were still observable at the 9-month follow-up were considered. Even using these rigorous criteria of change, significant gains in sociability for patients in both types of therapy were found. Additionally, significant reductions in psychosomatic disturbance, depression and anxiety among patients in CCT were observed.

In direct comparison of psychological test scores between CCT and PT groups, few significant differences emerged and none of those that did were replicated in subsequent analyses. Thus, although more significant differences were observed for CCT than for PT, the advantage that this suggests for CCT is small.

Clinical ratings. When the dependent variables produced by the blind ratings of clinicians were analysed (Meyer, Bolz, Stuhr, & Burzig, 1981), a somewhat different pattern of between-treatment differences emerged. First, PT patients developed more insight as related to the concepts described in and outside of the focus formulation than did CCT patients. Second, at Follow-Up 1, CCT patients showed a larger reduction of secondary symptoms than their PT counterparts. This difference vanished by Follow-Up 2, however, as a result of a slight additional reduction of symptoms in the PT patients and a slight symptom increase among those in the CCT sample. Third, in the general domain defined as personality and human relations variables, patients in PT received higher ratings than those in CCT for introspection at Follow-Up 1 and patients in CCT received higher ratings for attitude toward self at Follow-Up 2. Fourth, there was a general indication that at Follow-Up 2 more CCT patients than PT patients felt that therapy had helped them.

Interactions among rating sources. When a factor analysis of the three different sources of ratings (blind clinical raters, intake interviewers and self reports) was undertaken four factors emerged:

- a) All three groups of raters agreed that treated patients felt better, had fewer symptoms and were better able to cope than they had been before treatment. This factor was labelled ‘Gain in Subjective Symptom-Oriented Well-Being and in Coping Competence’.
- b) The ratings of independent (i.e., blind) clinicians emerged as a second factor reflecting a dimension of insight.
- c) The intake interviewers’ ratings also emerged as a separate factor, unrelated to that defined by the independent clinicians, but as one that appeared to reflect a dimension of insight.
- d) The final factor described the patient’s belief that others act differently towards and see changes in him or her.

Process differences. The results of the content analyses of therapist interventions corresponded with the theoretical concepts of each therapy school. The strongest differences found in this study indicated that CCT therapists relied on verbal repetitions, emphasised the verbalisation of emotions and supported patient defences, whereas PT therapists focused on working through, emphasised the importance of past experience and used the focus formulation to direct their interventions.

Process-outcome relationships. The process-outcome analyses based on Rogerian rating scales (e.g. empathy, warmth and self-exploration) were not closely related to outcome in CCT as had been assumed. Nonetheless, the emotionally warm, concrete and active CCT therapist was associated with changes reducing patients’ introversion. In contrast to these findings, it was observed that the PT patient’s process ratings (but not the PT therapist’s ratings) of such dimensions as emotional involvement and acceptance of one’s own feelings were positively related to reductions in neuroticism. An unusually active PT therapist, however, produced non-constructive effects on aggression and self-confidence in interaction with highly resistant patients.

Pattern of change. A cluster-analytic investigation of different clinical assessments suggested that it is possible to identify patterns of outcome that distinguished between the treatments. For example, one cluster comprised CCT patients who had been successfully treated as judged by a reduction of symptoms and improved ratings but who did not show corresponding changes or increases in insight. On the other hand, another cluster comprised PT patients who gained insight but did not improve in symptom-oriented well-being. Two clusters were found comprising

patients from both therapy groups, one with non-responders to therapy and the other with successful outcomes (particularly as indexed by changes in variables related to introspection and attitudes toward themselves). Finally, two patients did not fit into any of the foregoing clusters, suggesting that there existed some highly specific outcome configurations.

Long-term follow-up. The 12-year follow-up study, obtained further relevant information from many patients. The patients who had been offered psychotherapy but did not accept it were used as a reference control group. They showed small but at times significant gains (which can be interpreted as spontaneous remission). Compared with this control group, only changes indexed by the Extraversion scale were of sufficient magnitude to suggest the long-term advantages of both short-term psychotherapies. Additionally, long-term treatment advantages were observed on the Depression scale among patients in CCT. Among those in PT there was a tendency for changes to be observed somewhat later during the follow-up period. PT patients also reported having more subsequent treatment during the follow-up period than those in CCT. These findings suggest that psychoanalytic short-term psychotherapy may be a more mobilising experience than CCT.

Our global clinic results concerning symptomatic changes and coping skills showed no significant differences between the treatment groups and the non-treatment groups after 12 years.

Evaluation

The relevance of this study for psychoanalysis is limited by the short term nature of the original intervention. The limited observed efficacy of PT may be explicable in terms of the inadequate dose at which this treatment was administered. Of greater interest was the observation that long-term effects of PT included what may be interpreted as greater openness to change by the PT group as well as so-called sleeper effects (positive effects of therapy manifesting after termination of the treatment). Most evaluations of short-term PT do not have long follow-up periods. The Hamburg findings suggest that without such follow-up the full impact of psychodynamic treatment may not be observed.

The Norwegian psychotherapy study

- Høglend, P. (1993). Personality disorders and long-term outcome after brief psychodynamic psychotherapy. *Journal of Personality Disorders*, 7, 168-181.
- Høglend, P. (1993). Suitability for brief dynamic psychotherapy: Psychodynamic variables as predictors of outcome. *Acta Psychiatrica Scandinavica*, 88, 104-110.
- Høglend, P., Sørli, T., Heyerdahl, O., Sørbye, Ø., & Amlo, S. (1993). Brief dynamic psychotherapy: Patient suitability, treatment length and outcome. *Journal of Psychotherapy Practice and Research*, 2, 230-241.

This was a study of moderate length psychodynamic psychotherapy which is of relevance here because it emphasises the importance of long-term treatment if psychoanalytically oriented therapy is offered to personality disordered patients.

Sample

Forty- five outpatients presenting in an outpatient psychotherapy clinic were offered psychotherapy. The patients were moderately disturbed and had an average GAF score of 62. DSM III diagnoses were established on the basis of a structured interview. There was a subsample of 15 personality disordered individuals whose outcome is contrasted with that of the rest of the sample.

Treatment

Patients were treated by experienced psychodynamic psychiatrists using a therapy manual based on the work of Malan and Sifneos. The length of the therapy varied from 9-53 sessions. The treatments were open-ended and the sessions were audio-taped. Treatment adherence was ensured by peer supervision.

Measures

There was a two year and a four year follow-up. Patients were rated on the GAF, on a target complaints inventory and a psychodynamic scale with adequate reliability but unknown validity. Ratings were made on the bases of interviews conducted and audio-taped by the clinicians who were not blind to pre-treatment evaluations or length of treatment. The group of clinicians listening to the interviews independently rated the patients' outcome.

Results

Patients with personality disorder diagnosis did less well than those without at the end of treatment and at two year follow-up. Four years after therapy there were no significant differences between the PD group and the rest of the sample. There were no differences between DSM cluster B and cluster C personality disorders.

For the PD group alone, there was a significant correlation between degree of insight and number of sessions of treatment two years after therapy and degree of dynamic change and number of sessions four years after termination. The results imply that long-term improvement only occurred after more than 30 sessions of treatment. Patients with PD who had less focused treatments, allowing for more free association and a less exclusive focus on pre-assigned dynamic goals, did better. Level of insight achieved after two years predicted dynamic change at four year follow-up.

Evaluation

There are major methodological weaknesses in this study. There were no self-report or standardised measures of outcome. The sample size was small. The findings are incidental observations in a study designed to examine the effectiveness of focused psychotherapy in general. The raters were not blind as to treatment length. They were, however, blind to the hypothesis of the study with regard to the effect of personality disorder on treatment outcome. The results are suggestive rather than definitive in the absence of an experimental design with random assignments into treatments of different lengths. This is a hypothesis generating study which produced interesting results which now require experimental testing.

McLean's Follow-on study (MCFO)

- Najavits, L.M., & Gunderson, J.G. (1995). Improvements in borderline personality disorder in a 3 year prospective outcome study. *Comprehensive Psychiatry*, 36, 296-302.

This was a naturalistic study of patients who entered psychotherapy following a period of hospitalisation.

Sample

Thirty seven female patients meeting criteria for a diagnosis of BPD were consecutively recruited.

Treatment

The patients were in psychodynamic psychotherapy once or twice a week.

Measures

Assessments were made at baseline (discharge from hospital) and at one, two and three years.

Results

Patients generally improved, although they showed a fluctuating course. Co-morbid anxiety-related disorders were associated with a relatively poor outcome.

Erica process and outcome study (EPOS) of goal directed, time-limited child psychotherapy with parental counselling

- Carlberg, G. (1999). *Vändpunkter i barnpsykoterapi. Psykoterapeuters erfarenheter av förändringsprocesser*. [Turning points in child psychotherapy. Psychotherapists' experiences of change processes]. Dissertation, Department of Education, University of Stockholm. Edsbruk: Akademityck.
- Boalt Boëthius, S., & Berggren, G. (2000). *Forskning om barn- och ungdomspsykoterapi. En kunskapsöversikt*. [Current research in child and adolescent psychotherapy. A comprehensive overview.]. Stockholm: The Erica Foundation.
- Carlberg, G. (1997). Laughter opens the door: turning points in child psychotherapy. *Journal of Child Psychotherapy*, 23, 331-349.

Background

EPOS –The Erica Process and Outcome Study is based on earlier studies of change processes in child psychotherapy (Carlberg, 1999) and on a comprehensive overview of current research in child and adolescent psychotherapy (Boalt Boëthius & Berggren, 2000). These two projects were in turn founded on knowledge acquired from international research (Fonagy & Target, 1996b; Kazdin, 1995).

Aim

The aim of the project is to study a form of psychotherapy that can be performed in ordinary clinical settings in Sweden. The increased pressure on child psychiatry makes it necessary to develop time-limited and well-defined psychotherapeutic methods. In this project both outcome and process in such child psychotherapies will be studied. The aim is to deepen knowledge of the connection between process and outcome.

Sample and treatment

Extensive data will be collected from 24 cases. Child guidance clinics from different parts of Sweden will be involved in the project. The form of psychotherapy studied is defined as “goal directed, time-limited child psychotherapy with parallel parental counselling”. Therapy frequency will be 1-2 sessions a week with a duration of 1-2 years. The parents meet their counsellor once a week or at least every fortnight. Therapists and parents formulate goals and frames for the therapies as carefully as possible at the start of therapy. The children are between 5 and 10 years of age at the beginning of therapy. Each clinic makes a diagnostic assessment and decides about the choice of psychotherapy form.

In order to compare the children studied with a group of children receiving “treatment as usual”, co-operation with other child guidance clinics has been initiated. The children in the control group will be assessed with SDQ, have been referred for the same reasons, and will be age and sex matched.

Measures

In this study the process of change will be followed with the help of various specific research instruments, questionnaires and interviews. These will be used at the start, during and after the treatment period. A follow-up after three years is planned. Processes in the child psychotherapies and the parallel parental counselling will be studied.

Besides routine psychological assessment at the *start of therapy* the following instruments will be used: DSM-IV, HCAM–The Hampstead Child Adaption Measure, and SDQ–Strength and Difficulties Questionnaire (parent and teacher versions). The same instruments will be used after therapy.

In connection with each session the child psychotherapist and the parental counsellor will make process notes and complete a form, FWC–Feeling Word Checklist, in order to follow the therapists’ countertransference feelings and to facilitate studying sessions of special interest.

Every third month questionnaires will be distributed to the therapists and parents. The questionnaires focus on important themes and changes inside and outside therapies during the time period studied. The therapeutic alliance and changes in the goals of therapies will also be investigated.

Taped interviews with therapists, parents and, sometimes, children will be conducted in 12 of the 24 cases, twice during the treatment period.

Data will be analysed using both qualitative and quantitative methods.

Results

The project started in September 1999 with planning, selection and testing of instruments. Collection of data started in January 2001. Data collection will be completed 2003.

Evaluation

This is a small scale study from a new research team in an under-researched area, which may have quite a lot to contribute to the process-outcome literature.

Limitations of the evidence

It is easy to be critical of psychoanalytic studies. There are no definitive studies which show psychoanalysis to be unequivocally effective relative to an active placebo or an alternative method of treatment. There are no methods available that might definitively indicate the existence of a psychoanalytic process. Most studies have major limitations which might lead critics of the discipline to discount their results. Others have limitations that are so grave that even a sympathetic reviewer might be inclined to discount the findings. For example, is the analyst in a position to judge the outcome of a treatment? Not only is there the issue of a self-serving bias, but also is the context of free association not totally incompatible with the systematic gathering of data concerning adjustment and the like? Amongst the most common problems are: the lack of use of standardised diagnoses, inadequate specification of the treatment procedures, lack of control for selection biases in sampling, the absence of intent to treat controls and the failure to follow up drop outs, the use of inexperienced therapists, the lack of homogeneity of the patient groups considered, heterogeneous methods of intervention and related to this the lack of a generally accepted manualised method of intervention, the lack of statistical power, the lack of random assignments to treatment groups, lack of independent assessment of outcome, lack of standardisation of measures of outcome, questionable validity of some outcome measures, poorly matched comparison groups, absence of control for the law of initial and of regression to the mean, failure to take adequate baseline measures, and related to this reliance on retrospectively collected data, inadequate detail on statistical analysis and inappropriate statistics reported, inadequate control for intercurrent treatments, and so on.

Notwithstanding the many limitations, however, the sheer number of studies available is encouraging, particularly the range of ongoing studies. This was by no means an exhaustive review. Limitations of time principally prevented us from reviewing a large number of investigations, some very well known, many with findings consistent with those which were included. The review is labelled “open” to underscore our intention to include further studies as time permits and as these are brought to our attention. The emphasis has been on some less well publicised studies and studies with challenging findings, not necessarily on investigations with the best methodology. Many of the conclusions should therefore be heavily qualified in the light of the questionable internal validity of the observations reported. In summarising these results, however, we will adopt a cautiously optimistic attitude in relation to the evidence presented. It is not that in this way we are turning a blind eye to the weakness of the evidence, but rather we wish to highlight what could be shown by these studies and which way the evidence currently points. Many of the ongoing studies are methodologically “state of the art” and this is of course encouraging from the point of view of persuading sceptics in the field. The present review, however, is intended for “internal” consumption. As psychoanalysts we all know that psychoanalysis works. Our own analytic experience is probably sufficient in most instances to persuade us of its effectiveness. The purpose of the review was to assist in making accessible studies which have systematically explored the patient groups which benefit from treatments administered by members of our organisation. In general, the findings underscore the effectiveness of our work and should encourage us to undertake further, even more rigorous, explorations of treatment outcome.

The psychoanalytic process rating scale (PPRS)

- Sandler, A.-M. (1993). Introduction to the one-day conference on the work of the Anna Freud Centre's Young Adults Scheme: Development Issues in Psychoanalytic work with Young Adults. *Bulletin of the Anna Freud Centre*, 16, 3.
- Beenen, F., & Stoker, J. (2001). *Psychoanalytic Process Visualised, first version* (available only in Dutch, no English publication yet): Dutch Psychoanalytic Institute (NPI).

Aim

By means of the PPRS the course of treatment in psychoanalysis and long-term psychoanalytic psychotherapy, especially the form and content of the curative psychoanalytic process, can be captured, visualised and evaluated.

Description

The PPRS is a systematic clinical judgement scale of about 250 items that represent relevant aspects of the psychoanalytic process. It has been constructed and tested in clinical practice by Beenen and Stoker at the Dutch Psychoanalytic Institute (NPI). The scale had as its starting point the about 500 items of the Session Rating Scale of the Anna Freud Centre in London (Bulletin Anna Freud Centre, 1993).

The PPRS items are subdivided in three chapters. Chapter I, General Aspects of the Treatment, representing significant form elements like general attitude of the patient, treatment commitment and quality of the sessions in the period rated. Also basic defence and resistance patterns of the patient are being checked, including his or her general mood states in the analysis.

The items in Chapter II, The Psychic Content, refer to the conscious and unconscious material that dominates the treatment period under consideration. Next to 'classical' areas like sexuality and aggression, the focus is also on issues like bodily sensations, types and vicissitudes of patient's object relationships and so on. The psychic content either is actual or was present in the past, and can be conscious or unconscious. Chapter III more or less takes up the issues of Chapter I again, but now the focus is on the (curative) interaction between the analyst and analysand. Transference themes, the analyst's style of work and the analysand's reactions to his attitude, interventions and interpretations as well as the analyst's (countertransference) feelings and general feeling of (dis)satisfaction about the treatment are examples of the content of this chapter.

The PPRS can be used to judge one or more sessions (a period of treatment). It uses a 4-point scale to determine presence/absence or agreement/disagreement and/or the item was, yes or no, subject of intervention or interpretation.

Practical issues

Applying the PPRS, which in principle should be done once a month, at the moment takes 1 to 1.5 hours for the ratings and ten minutes for a secretary to process the scores into the computer. After six or more filled in PPRS's it makes sense to produce an overview of the process, which can be done at the NPI by a special computer program (also applicable to other languages). Interpretation of the output takes another 0.5 to 1 hour. At the moment a substantially shorter form of the PPRS (about 100 items) is under construction and will be ready in the course of 2001. This will make regular clinical application much more attractive. The PPRS and its manual can be obtained from the NPI (contact person Jan Stoker, email address: kc@npsai.nl).

Psychometric properties

To test the inter-rater reliability of the list is problematic, as each time it concerns the clinical judgement of this analyst about one of his or her analyses/analysands. No third party is or can be involved directly. Moreover, themes like countertransference feelings and so on are by definition personal and subjective. An extensive manual was constructed in which every item is described as clearly and operationally as possible, in order to increase the chance for reliable judgements. In practice, that after some training and some experience with using the list, the majority of the clinicians interpret and score the items in a similar enough way.

The validity of the PPRS still has to be proved, i.e. how relevant are (differences in) PPRS - measured courses of process for success or failure of the treatment. And moreover, do analyses that during treatment have been 'corrected' or guided by the PPRS results on the whole produce better outcomes than those that have been not. So, in all cases systematic and reliable follow-up studies of the treatments are obligatory.

In the meantime at the NPI an extensive follow-up programme of psychoanalytic treatments has been implemented.

Clinical utility

This is a core strength of the PPRS. At the NPI it has been used so far for 55 psychoanalyses to monitor the treatment and this resulted in a big step forward, away from clinical 'fairy tales' and judgement/decisions by hierarchy. The yearly 'objective' PPRS- picture of the analytic process furnishes the analyst with a self – constructed mirror of his view on and position in the treatment. It is also a systematised and standardized clinical recording of the process, which enables a systematic comparison of the same treatment over time as well as comparison of different treatments on the same base.

Referential activity (RA): Scales and computer procedures

- Bucci, W. (1995). The power of the narrative; A multiple code account. In J. Pennebaker (Ed.), *Emotion, Disclosure and Health*. Washington, D.C.: American Psychological Association.
- Bucci, W. (1997). *Psychoanalysis and Cognitive Science: A Multiple Code Theory*. New York: Guilford Press.
- Bucci, W., Kabasakalian, R., & al., (1992). *Instructions for scoring Referential Activity (RA) in transcripts of spoken narrative texts*. Ulmer Textbank, Ulm, Germany.
- Bucci, W., & Miller, N. (1993). Primary process: A new formulation and an analogue measure. In N. Miller & L. Luborsky & J. Barber & J. Docherty (Eds.), *Psychodynamic Treatment Research* (pp. 381-406). New York: Basic Books.
- De Coro, A., & Caviglia, G. (Eds.). (2000). *La valutazione dell' attivita' referenziale*. Roma: Edizioni Kappa.
- Dubé, J. E., Roussos, A. J., & Bucci, W. (2001). *New procedures to ensure cross-cultural validation of the Computerized Referential Activity dictionaries*. Paper presented at the 32nd Annual Meeting of the Society for Psychotherapy Research, Montevideo, Uruguay.
- Mergenthaler, E. (1985). *Textbank Systems. Computer science applied in the field of psychoanalysis*. Heidelberg & New York: Springer.
- Mergenthaler, E., & Bucci, W. (1999). Linking verbal and non-verbal representations: computer analysis of referential activity. *Br J Med Psychol*, 72, 339-354.
- Roussos, A., Acosta, S., Juárez, C., & Mergenthaler, E. (in press). Introducción a las Técnicas De Investigación sobre Procesos Terapéuticos Asistidas por Computadora, "Modelos de Ciclos Terapéuticos". *Revista Interamericana de Psicología*.
- Solano, L. (2001). *Tra Mente e Corpo: come si costruisce la salute*. Roma: Raffaello Cortina.

Aim

The construct of the referential process, as defined in the theoretical context of the multiple code theory (Bucci, 1997), concerns the function of connecting nonverbal experience, including emotional experience, with language. The referential process plays a central role in psychotherapy; the patient needs to express subjective emotional experience in the shared verbal code, and to connect the words of the therapist back to these emotional representations to bring about change. Measures of RA have been developed to represent this process, to trace its fluctuations in therapeutic interactions, and to identify factors determining treatment effectiveness.

Description

Variation in activity of the referential process is shown in features of language style. Two methods for assessing RA variation are in use: scales rated by judges and a computerized procedure. The rating scales measure the Concreteness, Imagery, Specificity, and Clarity of speech. Concreteness is based on degree of perceptual or sensory quality, including references to all sensory modalities, action and bodily experience. Imagery refers to the degree to which language evokes corresponding experience in the reader or hearer. Specificity refers to amount of detail; a highly specific text involves explicit descriptions of persons, objects, places or events. Clarity refers to clarity of an image as seen through the language; how well-focused is the linguistic image. For all scales, the rating is done on an 11-point range, from 0 to 10. Scores on the four scales may be averaged to yield an overall RA score. Scale descriptions and rating procedures are provided in the manual for scoring RA (Bucci et al., 1992).

To facilitate the application of this measurement in large sample and longitudinal studies and in psychotherapy research, a computerized referential activity measure (CRA) was developed by modeling the overall RA score as rated by trained judges in a large and varied set of texts. (Mergenthaler & Bucci, 1999). Essentially, the CRA consists of two list of highly frequent words: one most closely and uniquely associated with texts rated as High in RA, and the other with texts

scored Low in RA. To apply the CRA, these word lists are compared to a text or text segment, the number of matches (tokens) are counted for the High and Low lists, and the difference between the matches are computed as a proportion of total word count in the text. (Also see Roussos et al., In press.) The CRA differs from traditional computer assisted content analysis measures in that the items in the list are indicators of style rather than representative elements of particular content areas. The procedures followed by Mergenthaler and Bucci yielded a very small list of less than 200 exceedingly frequent words (types) which together account for approximately half of all words (tokens) in most spoken and written texts.

Practical issues

For the rating scales, scorers are trained by following instructions and scoring sets of practice excerpts provided in the scoring manual, then discussing deviant scoring, and scoring additional practice items until an acceptable interrater reliability is achieved. In addition to the English version of the manual (Bucci et al., 1992), an approved Italian version is available (De Coro & Caviglia, 2000) and French and Spanish translations are in preparation. A program for application of the CRA is available through the University of Ulm. New PC versions and other foreign language versions, including Spanish, Dutch, Norwegian, Italian and French are in preparation (Dubé et al., 2001).

Psychometric properties

a) Inter-rater reliability of RA scales: Roussos et al. (Roussos, Boffi Lissin, & Bucci, in preparation) found current scorers after brief training achieved high reliability in a pairwise comparison (ICC mean R square = 0.75) on a set of text excerpts. In a correspondance analysis, considering the whole group rather than pair-wise comparison, all scorers were considered to evaluate the excerpts in a similar way (matrix trace > .05). The rating procedure shows excellent stability; an ICC mean R square = 0.70 was found comparing current scorers with ratings carried out more than ten years previously, following the same manualized instructions. RA is an easily scored measure that taps natural linguistic intuition, and is also an implicit part of the clinical listening process. Psychology undergraduate and graduate students and experienced clinicians, scoring the same excerpts after reading the manualized instructions, without training, did not show significant differences from the trained scorers in a correspondance analysis (matrix trace > .05). The trained group, however, showed a substantially lower range of dispersion among judges (-.02 to .25 on axis 1) compared to the nontrained groups (-.48 to .36 on axis 1).

b) Reliability of CRA: The broad coverage, accounting for approximately half of all words spoken, makes CRA an exceedingly powerful dictionary, requiring a minimal text size of only 15 words to achieve adequate reliability (with an error estimate of 5%) according to the power analysis procedure as applied by Mergenthaler (1985). (The issue of inter-rater reliability does not apply for computerized procedures).

c) Validity of RA scales: The construct validity of RA has been developed in the theoretical context of the multiple code theory. Connections to emotional experience are expressed in the specific and concrete stories people tell about their lives; RA has been found to be significantly higher in texts identified as narratives than in non-narrative texts (Moore, 1992). Studies in the areas of object relations, attachment and physical health have validated the role of the RA function in bodily and emotional self regulation and interpersonal interaction; some of these are summarized in Bucci (1995; 1997), and Mergenthaler & Bucci (Mergenthaler & Bucci, 1999).¹

¹More recent studies are summarized in Bucci, W., "State and trait features of the Referential Activity Dimension," working paper

In a meta-analysis of 23 RA studies, Samstag (1996) found a significant relationship, with moderate to strong effect size, between RA measures and the capacity to synthesize cognitive, linguistic and emotional experience. Discriminant as well as convergent validation has been developed. RA has been shown by Solano (2001) and his colleagues to be associated with levels of physical health, but distinct from alexithymia and affective tone. RA also varies independently of standard verbal intelligence, and Experiencing and Insight measures applied to the same text material, as summarized in Bucci and Miller (Bucci & Miller, 1993), Bucci (1997), and Mergenthaler and Bucci (Mergenthaler & Bucci, 1999).

d) Validity of CRA: The criterion and construct validity of CRA have been outlined by Mergenthaler and Bucci (Mergenthaler & Bucci, 1999). CRA showed a pooled correlation of $R' = .47$ with RA scale ratings, across 6 large text samples. Several studies summarized by Mergenthaler and Bucci have shown significantly higher correlation of CRA with narrative than non-narrative speech, providing independent support for the construct validity of this measure. The findings suggest that high CRA language is dominated by the special narrative features – the setting of time and place and the introduction of other persons, usually in relation to oneself – that are associated with descriptions of episodes.

Clinical utility

The RA measures have been applied to many types of texts, including brief monologues, early memories and Thematic Apperception Test (TAT) protocols, as well as transcripts of therapy sessions, and have been used with a wide range of populations, including children, adolescents, and adults, in clinical and nonclinical contexts. The CRA has been extensively applied in psychoanalytic and psychotherapy process research; fluctuations in CRA (along with associated computerized procedures and rating scales) reflect the patient's movement through the phases of the referential process, and enable tracking of change from dissociation to connection within emotion schemas.

The TCA Rating Methodology for Psychotherapy Process

- Foelsch, P.A., Normandin, L. & Clarkin, J.F. (1997). *Transference and Countertransference themes as Indicators of Structural Change*. Paper presented at the Annual Conference of the Society for Psychotherapy Research, Geilo, Norway.
- Foelsch, P.A. (1998). *Transference and Countertransference Themes as Indicators of Structural Change*. Paper presented in D. Diamond, Ph.D. (Chair), *Attachment style, transference-countertransference dynamics and structural change in borderline patients*. Symposium at the 18th annual spring meeting of the Division 39, American Psychological Association, Boston, MA, April 25th, 1998.
- Normandin, L. & Foelsch, P.A. (1999). *Transference Counter Transference Analysis (TCA): A System to Assess Structural Change in Severe Personality Disorders Throughout Treatment*. Paper presented at the Annual Conference of the Society for Psychotherapy Research, Braga, Portugal.
- Normandin, L. (1991). *Le contre-transfert comme élément constitutif du travail et de l'espace thérapeutiques*. Thèse de doctorat inédite. Université de Montréal.
- Normandin, L. & Bouchard, M.A. (1993). The effects of theoretical orientation and experience on rational, reactive, and reflective countertransference. *Psychotherapy Research*, 3(2), 77-94.

Aim

The TCA is designed to assess the moment-to-moment changes in psychotherapy process by rating the Modes of Mental Activity of both the patient and therapist. It also provides an index of structural change for the patient in psychotherapy.

Description

The TCA (derived from “Transference Countertransference Analysis”) is a rating system applied to videotapes of psychotherapy sessions. Raters are trained to code utterances (defined as turns of speech) in the session for the Modes of Mental Activity (Reactive, Rational, Reflective), Dominance (which of these three modes is most salient in the utterance), Theme (the content of what is said), Agreement of Focus (codes the extent to which the therapist and patient are communicating about the same topic and its priority within the session), and Affect (codes for the intensity and type of affect expressed in the utterance).

The Modes of Mental Activity have been conceptualized by Normandin (1991) and are based on an integration of the classical Freudian, Kleinian, and Lacanian models, and the contemporary schools of object relations’ theory on the subject of countertransference. Each Mode of Mental Activity (MMA) characterizes a type of communication used by both the patient and therapist, expressed via the patient’s transference and therapist’s countertransference manifest in the session. Briefly, the Reactive mode is characterized by the patient/therapist as an unaware, unconscious participant in the process. Rational mode is evident when the communication is primarily cognitively based without insight or integration of affect. The Reflective mode is characterized by the patient/therapist being at least partially aware of his or her experience as a participating subject. When the Reflective Mode is coded, the rater then rates the level of reflectivity, “emergence”, “immersion,” and “elaboration.” Each level indicated a deepening awareness and integration, moving from preconscious to conscious. While the MMA are rated independently, the “Dominance” code allows the rater to select the MMA that is most salient, or predominant in the utterance. This rating allows for a “clinical” or “subjective experience” code by the rater.

The Theme, Agreement of Focus, and Affect ratings (in process) in the rating system will provide additional ways to monitor points of intervention, assess alliance, and the use of affect within a session.

Practical issues

The TCA requires access to all channels of communication, verbal and non-verbal and thus requires videotapes of psychotherapy sessions. These are not always practical to acquire outside of research protocols. Thus far, these researchers have had the most success training raters who have had some clinical experience, and who have the ability to access their own countertransference reactions. Training consists of a didactic review of the manual, coding a video tape with an “expert rater” to see the definitions operationalized, then coding a series of videotapes independently (usually a minimum of five) to compare with expert ratings. Interrater reliability is assessed to determine when training is completed.

Psychometric properties

Inter-rater reliability was established for the TCA method following 20 hours of training. After training, two judges independently rated 8 randomly chosen psychotherapy sessions recorded on videotape. The goal was to categorize the modes of mental activity reactions inferred from therapist and patient’s verbal and non-verbal reactions. Kappa coefficients (Cohen, 1988) were calculated at each step of the TCA scoring. Rational mode showed moderately good agreement ($k = .53$). Reactive mode results suggested good agreement ($k = .62$). Reflective mode showed judges reached high agreement ($k = .71$). Thus good Interrater reliability was established for the TCA ratings. Individual ratings that differed following this initial rating were compared between raters and discussed. Consensus was reached for those items. Pilot data looking at the relationship between changes in TCA ratings and changes in patient symptoms and functioning indicate that the TCA correlates with patient changes in the hypothesized direction.

Clinical utility

This rating system provides a measure of therapist activity in the psychotherapy session and its relation to patient activity. This allows therapists and supervisors to identify areas of potential difficulty in the therapy process and allows for focused review and analysis. This ability to target both the areas of the process and the specific modes of mental activity leads to direct interventions to improve the psychotherapy process. The TCA has been used as a training tool for both beginning and advanced therapists.

The Psychotherapy process Q-set (PQS): Studying how patients change

- Albani, C., Blaser, G., Jones, E.E., Thomae, H., & Kaechele, H. (2001). Amalia X in lichte des "Psychotherapie-Prozess Q-sort" von E. Jones". In U. Stuhr, M. Leuzinger-Bohleber, & M. Beutel, (Eds.). *Langzeit-Psychotherapie: Perspektiven fuer therapeuten und wissenschaftler*. Frankfurt: Kohlhammer Verlag (pp. 213-221).
- Ablon, S. & Jones, E. E. (1999). Psychotherapy process in the National Institutes of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology, 67*, 64-75.
- Jones, E. E. (2000). *Therapeutic action: A guide to psychoanalytic research*: Northvale, N.J.: Jason Aronson.
- Jones, E. E., Hall, S.A., & Parke, L. A. (1991). The process of change: the Berkeley Psychotherapy Research Group. In L. Beutler and M. Crago (Eds.), *Psychotherapy research: An international review of programmatic studies*. Washington, D.C. American Psychological Association, pp. 99-106.
- Jones, E. E. & Pulos, S.M. (1993). Comparing the process in psychodynamic and cognitive-behavioral therapies. *Journal of Consulting and Clinical Psychology, 61*, 306-316.
- Jones, E. E. & Windholz, M. (1990). The psychoanalytic case study: Toward a method for systematic inquiry. *Journal of the American Psychoanalytic Association, 38*, 985-1015.

Aim

A central difficulty for psychoanalytic process research lies in designing quantitative methods that both preserve the depth and complexity of clinical material while conforming to the requirements of empirical science. One method that meets these criteria is the *Psychotherapy Process Q-set* (PQS; Jones, 2000). The PQS is a 100-item rating instrument designed to provide a basic language for the description and classification of treatment processes in a form suitable for quantitative analysis. It forms the basis for an observationally grounded research. In order to use clinical (observational) data to test psychoanalytic constructs, clinical phenomena must be intersubjectively observable, which is to say that different judges can independently agree about whether they occur and their characteristics. Disagreements about the interpretation or meaning of the same case material are commonplace in clinical work and constitute important grounds for criticism about the scientific status of psychoanalytic methods for acquiring knowledge. It is crucial that any research methodology establish the extent of consensus, or reliability, among judges about the presence and nature of a clinical phenomenon. The PQS provides a language and rating system that helps clinical judges achieve reliable descriptions of complex treatment processes.

Description

The PQS yields a score from 1 to 9 for each of 100 descriptive variables or items describing patient attitudes, behaviors or experience; the therapist's actions and attitudes; and the nature of their interaction. Each statement can be rated from extremely characteristic to extremely uncharacteristic for a given treatment hour. The items are conceptualized at clinically meaningful levels and anchored, as far as possible, to specific, concrete behavioral and verbal cues that can be identified in recordings of therapy hours. Accurate records of the therapist's and patient's speech are essential in attaining rater reliability, especially for those processes that require inference. A coding manual (Enrico E. Jones, 2000) provides the items and their definitions along with examples of their application to minimize potentially varying interpretations. It also specifies the rules governing the use of inference in making Q-ratings. Since the items are not closely bound to particular theoretical concepts, but rather to notions of analytic and therapeutic *process*, the influence of observers' theory on their descriptions of the process is subdued within the framework provided by the Q-set (Jones et al., 1991).

The initial item set was drawn from a wide variety of sources. The set was revised and refined through an iterative revision process in which the item set was repeatedly piloted on new samples of therapy transcripts and tapes. Almost all process rating systems rely on recordings of brief

segments of therapy sessions, forcing judges to rate a dimension of presumed relevance on the basis of relatively brief impressions. In contrast, with the Q-technique an entire hour (audiotaped or videotaped) rather than a small segment is the time frame rated, allowing a greater opportunity to capture important events. The rating procedure permits judges to form hypotheses and study the material for confirmation or alternative conceptualizations. The ratings conform to a normal distribution, which requires judges to make multiple evaluations among items, thereby avoiding either positive or negative halo effects.

The PQS is used in research involving group comparison designs, in which Q-ratings of groups of cases (or hours) selected on some dimension of interest are compared (Ablon & Jones, 1999; Jones & Pulos, 1993) as well as in N=1 designs (Jones & Windholz, 1990). The special value of the Q-method is that it provides a way of quantifying the qualities of the analytic or therapeutic process. It can capture the uniqueness of each treatment hour while also permitting the assessment of the similarities or dissimilarities between hours and patients.

Practical issues

Q-sorting. The 100 Q-items are printed on 2 x 3.5 inch cards to permit easy arrangement and rearrangement. Clinical judges watch a videotape or read the verbatim transcripts of an entire therapy hour and then sort the 100 items in the Q-set on a continuum from least characteristic or negatively (category 1) to most characteristic or salient (category 9). The middle pile (category 5) is used for items deemed either neutral or irrelevant to the particular hour being rated. Each item contains a description of the two opposite ends of the continuum along which the items are to be rated. It is important to note that placement in the uncharacteristic direction does not signal that a particular behavior or experience is irrelevant. On the contrary, an uncharacteristic ranking signals that the absence of the item is meaningful and important to capture in the Q-sort the description. Most items have specific instructions that provide examples of the distinction between uncharacteristic and neutral ratings. For example, Q-item 9 describes the therapist as “distant or aloof” when rated in the characteristic range. However, when rated in the uncharacteristic range, the item indicates that the therapist was “genuinely responsive or affectively involved” (the opposite of “distant or aloof”). Only if the item were irrelevant to the description of the hour would it be placed in the neutral range. The number of cards sorted into each category of the Q-sort (from 5 at the extremes to 18 in the middle or neutral category) conforms to a normal distribution, requiring judges to make multiple evaluations among items thereby avoiding halo effects and response sets. The items are tied to specific actions, behaviors, and statements. A detailed coding manual provides the Q-items and their descriptions as well as operational examples. When rating, judges are asked to take the position of a “generalized other” i.e. an observer who stands mid-way between patient and therapist and who views the interaction from the outside. In placing each item, judges are instructed to ask themselves: Is this attitude, behavior, or experience clearly present (or absent)? If the evidence is not compelling, the judge is asked to search for specific evidence of the extent to which it present or absent. A transcript or videotape of a therapy hour typically requires 1.5 to 2 hours to Q-sort.

Training. Raters can be trained to Q-sort to acceptable levels of reliability relatively quickly if novice raters have had exposure to the fundamentals of therapy and some minimal clinical experience. Usually one year of supervised psychotherapy is sufficient. Training can be accomplished most efficiently in small groups in which trainees, after having studied the Q-sort Manual (Enrico E. Jones, 2000), independently sort a videotape or transcript of a treatment hour. Trainees then compare and discuss their item placements. The mechanics of Q-sorting, varying interpretations of the clinical material, and rules regarding the use of inference can all be taken up, using the manual as a guide. Calculating inter-rater reliabilities and presenting them to raters

as a form of feedback is helpful. Three or four group sessions are usually sufficient to train raters to reliability, especially if they are clinically experienced. Thereafter, occasional calibration sessions are useful in preventing rater 'drift', i.e. the tendency of some raters to use items in stereotypic or idiosyncratic ways after Q-sorting a number of hours.

The Q-sort is available in German and Spanish translation (contact author).

Psychometric properties

The PQS is an observational instrument used for the description of interaction, and is not closely tied to a particular theory of therapy. It has been used to rate treatment sessions of psychoanalysis and psychodynamic therapy, as well as cognitive-behavioral, client-centered, Gestalt, and rational-emotive therapies. The PQS has consistently demonstrated high levels of inter-rater reliability, item reliability, and concurrent and predictive validity (Jones & Pulos, 1993) across a range of studies and treatment samples. Interrater reliability, which is calculated by correlating the Q-sorts of multiple raters across all 100 items of the PQS, has been consistently satisfactory, with alpha coefficients ranging from .83 to .89 for two raters. If inter-rater reliability for two judges fall below .50, a third rater should be added. Reliability calculated at the individual Q-item level has also been consistently satisfactory, ranging from .50 to .95 across several different samples.

FACS (Facial Action Coding System)

- █ Ekman, P., Friesen, W. V., & Ellsworth, P. (1972). *Emotion in the Human Face*. New York, N.Y.: Pergamon Press.
- █ Ekman, P., & Friesen, W. V. (1978). *The Facial Action Coding System (FACS): A technique for the measurement of facial action*. Palo Alto, CA: Consulting Psychologists Press.
- █ Ekman, P., & Rosenberg, S. E. (Eds.). (1997). *What the Face Reveals: Basic and Applied Studies of Spontaneous Expression Using the Facial Action Coding System (FACS)*. New York: Oxford University Press.

FACS is a method for descriptively registering every facial movement that is anatomically feasible on the basis of innervations of the facial muscles. Each movement is assigned to a so-called action unit (AU). Training time with a self-training guide is approximately 80 to 100 hours.

Reliability

Comparison of experts (Ekman and Friesen) and six coders just having learned FACS:

- Mean ratio across all six coders compared to experts: .82
- Intercoder agreement of the six coders: .76
- Mean ratio across all six coders when considering differences in intensity scoring: .78

Validity

Inferences can be made from the following affective states: happiness, fear, contempt, disgust, anger, surprise and sadness according to a dictionary based on action unit combinations. Reliability of the affect- inferences is as high as the one for the action units since the dictionary is defined completely through the combination of action units. In addition, blends (simultaneous activation of two affects), masking (one affect masking another one), and degree of experiencing the emotion happiness can be measured reliably. The dictionary is rather conservative, pushing reliability, leaving usually forty to sixty percent of the action unit combinations uninterpreted. Combinations that a clinician would often use for his interventions can have different meanings related to the core conflict the patients are suffering from. The context variables mentioned in the next section may be usually helpful to make inferences on the nature of the conflict. (Intrapsychic or interpersonal in the sense of transference). Additional information can be extracted from semantics (especially metaphors, polysemia, etc.).

EMFACS (Emotional Facial Action Coding System)

Friesen, W. V., & Ekman, P. (1984). *EMFACS-7. Unpublished manual.*

EMFACS is a method for objectively scoring *emotional* facial action. It is based on FACS, but is a short, modified version of it and differs in scoring rules and measurement procedure. EMFACS is a selective instrument: only emotional or affective expressions are scored within the stream of behaviour. AUs (action units) are specified that are used to express emotions that have universal facial patterns. A computerized emotion dictionary is based on cross-cultural studies, laboratory studies and experiments. Anger, contempt, disgust, fear, sadness, surprise, happiness are registered, also blends and masks; felt and unfelt and controlled and uncontrolled events are differentiated.

Reliability

- Comparison of FACS and EMFACS: 60 samples, scored by two coders. EMFACS does not detect as many events as FACS, but is capable of detecting differences between behaviour samples in a way comparable to FACS rank-orders of behavioural samples are quite similar
- Inter-coder reliability of EMFACS is satisfactory (comparing the way in which two coders ordered the samples; Kendall Taus range from .560 up to .873)

Advantages

EMFACS is a useful, economical tool when one is interested solely in the frequencies of emotional facial expressions (not, for example in the exact course and duration of the facial action or in the succession in which certain action units occur in an emotional expression). Depending on the interest of the research, the limited set of AUs can easily be expanded. It is a conservative method that avoids over-interpretation. EMFACS enforces strict separation between the objective scoring and following interpretation.

Disadvantages

The emotion dictionary identifies only some emotions; other expressions that may be of importance in clinical context are not included in the dictionary (e.g., crying, charming behaviour and so on). Only fully expressed emotional patterns receive an interpretation in the dictionary; rudiments that may nevertheless be indicative for emotional activity receive none. There is a danger of attributing emotional facial signs to experienced feelings of a person. EMFACS is less precise and less sensitive than FACS.

QuickFACS

- Benecke, C. Mimischer Affektausdruck und Sprachinhalt im psychotherapeutischen Prozess. Dissertation in der philosophischen Fakultät III der Universität des Saarlandes.
- Merten, J., & Krause, R. (2000). What makes good therapists fail . In: Philipot , P., Coats, E. J. , Feldmann, R.S. (Eds.). Nonverbal behaviour in clinical settings. Accepted for publication.
- Schulz, S. (2001). Affektive Indikatoren struktureller Störungen. Dissertation an der philosophischen Fakultät III der Universität des Saarlandes.
- Merten, J. (2001b). Context analysis of facial affective behaviour in clinical populations. In Katzekitis, M. (Ed.) Human facial measurement and meaning. Clover Academic Publishers.
- Schwab, F. (2001). *Affektchoreographien. Eine evolutionspsychologische Analyse von Grundformen mimisch-affektiver Interaktionsmuster*. Berlin: Dissertation de Verlag im Internet.
- Steimer-Krause, E. (1994). Übertragung, Affekt und Beziehung. Theorie und Analyse nonverbaler Informationen schizophrener Patienten. Bern. Peter- Lang- Verlag.

QuickFACS a method developed by the Saarbrücken Research Group to tackle the problem of sampling, essential within clinical research. With structurally disturbed people the problem is easier to handle because they are more homogeneous. With hysteric as well as some borderline patients the patterns change remarkably with changing identifications, the duration of which might be very short.

QuickFACS allows a description of the raw distribution patterns of affects. It is done in the following way: two coders look at real-time up to three times through the video using the AU Table for Affects trying to find an affect pattern according to the list. If both detect one it is registered as an affective event. A real content related coding has to be done using EMFACS or FACS.

Additionally the following indices were developed by the Saarbrücken Group:

- a Idiosyncrasy level (percentage of uninterpretable action units related to the affect: (Highly relevant for alexithymia as well as low level psychosomatic personality structure)
- b Repertoire affect describes sequential and nomothetical variability as well as lead-affect (the affect with the highest percentage) This is very relevant for inferences on the structural level (disgust as lead affect for the lowest, and psychosomatic structure, contempt for low structure and psychotic) Description of the relation of affect according to hedonic, information processing unhedonic affect. Dyadic indices defined as synchronisation reactions. Very relevant for the identification of schizophrenics and the prediction of psychotherapeutic outcome (Steimer-Krause, 1994).
- c Another dyadic Index is called attunement using gaze and speech- patterns in dyadic interaction. Inferences can be made on different structural level of personality organisation, especially the absence respectively presence of the capacity to mentalize. The methodology can be found in Merten (2001b). A software tool for graphical context analysis is described there.

In addition a pattern recognition technique by Magnuson has been successfully used on dyadic facial and context patterns to describe different forms of successful and unsuccessful short psychotherapy treatments as well as different forms of interaction patterns of healthy and mentally disturbed people (Schwab, 2001). This tool can be downloaded on the web from http://www.dissertation.de/html/schwab_frank.htm. Methodology for pattern detection within the psychotherapy-process- research can be found in detail in Merten (2001a). A brief English summary can be found in Merten (2001b). In general caution has to be taken because the validity

often mistakenly takes for granted inferences on feelings or internal states. This is usually not the case. The only inference which can be made and which is validated is in the field of attribution of emotion to other people. This involves seeing the action unit patterns in a very high percentage of different people, disregarding race, sex and status. Inferences on other sub-systems of the emotion-like feeling of physiology need additional context information like the above-mentioned case and speech patterns as well as the content of speech. It can be shown that the algorithm connecting the different modules of the emotion system differ according to psychiatric disturbance. By the end of a successful psychotherapy, one can observe a change in the way that facial affect is attributed to mental objects. In unsuccessful treatments, facial affects remain interactive.

Other measures referenced in this review

Some further instruments that have been used in the studies reviewed below are listed here:

Structured instruments

Goal Attainment – Individual Treatment Goals

Heuft, G. and colleagues (Heuft et al., 1996) Langzeitoutcome ambulanter psychoanalytischer Psychotherapien und Psychoanalysen. *Forum Psychoanal.*, 12, 342-355.

Therapist's Ratings of Clinical Findings

Rudolf, G. (Rudolf, 1981). Untersuchung und Befund bei Neurosen und Psychosomatischen Erkrankungen. Materialien zum *Psychischen und Sozial-Kommunikativen Befund* (PSKB). Beltz, Basel.

Operational Psychodynamic Diagnostics

Cierpka, M. and colleagues (Cierpka, 1995). Die erste Version einer Operationalisierten Psychodynamischen Diagnostik (OPD-1). *Psychotherapeut*, 40, 69-78.

Rudolf, G. and colleagues (Rudolf, 1995). Struktur und strukturelle Störung. *Zsch. Psychosom.Med.* 41, 197-212.

Arbeitskreis OPD (Hrsg). (1996). *Operationalisierte Psychodynamische Diagnostik*. Grundlagen und Manual. Hans Huber, Bern-Stuttgart.

CHAP : Change after psychotherapy

Sandell, R. (1987a). Assessing the effects of psychotherapy II. A procedure for direct rating of psychotherapeutic change. *Psychotherapy and Psychosomatics*, 47, 37-43.

Sandell, R. (1987b). Assessing the effects of psychotherapy III. Reliability and validity of "Change after psychotherapy". *Psychotherapy and Psychosomatics*, 47, 44-52.

The Hampstead Child Adaptation Measure

Psychometric Instruments:

Patient focussed self-report instruments

- Symptom-Check-List SCL 90-R (Derogatis et al., 1974)
- Beck-Depression Inventory BDI (Beck et al., 1961)
- Inventory of Interpersonal Problems IIP (Horowitz, Rosenberg et al., 1988)
- Introject Questionnaire INTREX (Benjamin, 1974; Tress, Benjamin, 1991)
- Questionnaire of Coping Strategies FKS (Hentschel, 1995)
- Questionnaire of Social Satisfaction SOZU (Sommer, Fydrich, 1991)
- Basic Documentation (Broda, Dahlbender, Schmidt, von Rad, & Schors, 1993)
- Freiburg Personality Inventory FPI-R (Fahrenberg et al., 1985)
- Narcissism Inventory (Deneke & Hilgenstock, 1988)
- Symlog: social interaction in small groups (Bales and Cohen, 1982)
- Inventory of Quality of Life (Huber et al., 1988)
- Inventory of Change in Experience and Behaviour VEV (Zielke, Kopf-Mehnert, 1978)
- Helping Alliance Questionnaire HAQ-P (Bassler et al., 1995)
- AIR questionnaire (Roose et al., 1994)

Therapist focussed psychometric instruments

Short documentation of the initial interview (diagnosis, psychodynamic hypotheses, aims, assessment of level of personality organisation, of basic conflicts, of main defences).

- Helping Alliance Questionnaire: HAQ-T (Luborsky et al., 1996)
- Process-Rating-Scales (with questions concerning transference, resistance, analytic work, technique, setting, relevant hours, counter-transference and main transference themes)
- Global Assessment Scale (Endicott, Spitzer, Heiss, & Cohen, 1976; Luborsky & Bachrach, 1974)
- Level of Functioning Scale (Carter and Newman, 1980)
- Life Functioning Scales (Howard et al., 1993)
- Therapeutic Assets Questionnaire (Daskovsky, 1988)
- Personal Style - Therapist Form (Howard et al., 1988)
- Therapeutic Contract Questionnaire – Session Form (Howard et al., 1988)
- Therapeutic Procedures Inventory – R (Orlinsky, 1987)

Independent researcher based assessments:

Clinical diagnostic assessment interview (audio taped) as a basis for:

- ICD-10 Diagnosis check list IDCL (Hiller, Zaudig, Mombour, & Bronisch, 1993)
- Impairment Severity Scales BSS (Schepank, 1995)
- Global Assessment of Functioning Scale GAF (DSM III-R) (Luborsky & Bachrach, 1974)
- Scales of Psychological Capacities SPC (Wallerstein, 1992)
- Goal Attainment Scaling GAS (Kiresuk and Sherman, 1968; Kiresuk et al., 1994)
- OPD-Assessment of level of personality organisation, basic conflicts, main defenses and psychodynamic hypotheses
- Computer-based quality evaluation in routine practice (System AQUASI, Kordy, 1997; Scheidt & Wirsching, 1998).

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