A NATURALISTIC STUDY OF BRIEF PSYCHODYNAMIC PSYCHOTHERAPY FOR PANIC DISORDER: IDENTIFYING EMPIRICALLY SUPPORTED CHANGE PROCESSES

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Summary

Aims

This study sought to investigate the effectiveness of time-limited psychotherapy for panic disorder when conducted naturalistically by clinicians self-identifying as psychodynamic in orientation. Secondary analyses sought to identify the process correlates of outcome and determine the extent to which the treatment process conformed to ideal treatment process as described by expert clinicians from different theoretical orientations. The study also examined whether the degree to which the treatments conformed to prototypical process was correlated with positive outcome.

Methods

Participants were 17 patients between the ages of 24 and 55 meeting SCID-IV criteria for diagnosis of panic disorder at the Massachusetts General Hospital (MGH) outpatient psychiatry department in Boston. Clinicians who identified themselves as psychodynamically oriented and who did not object to audiotaping their sessions agreed to conduct a therapy as they normally would in their clinical practice. For the duration of the study, bi-monthly case conferences were held to review and discuss formulations of ongoing cases. Presenting clinicians would typically play segments of an audiotape containing material relevant to the questions or issues at hand. The mean number of sessions in this study was 21.
Outcome measures designed to assess patient functioning across a range of domains and from different perspectives (patient, therapist, independent rater) were administered at monthly intervals. Independent raters also assessed the severity and intensity of patients' panic at baseline and termination.

Therapeutic process was examined using the Psychotherapy Process Q-Set (Jones, 2000). Existing prototypes of ideal treatment process (Ablon and Jones, 1998, 2002) were also used in the process analyses.

Results

From pre-to posttreatment, patients reported statistically significant decreases in both the anticipation and experience of anxiety (Anxiety Sensitivity Index & Panic Disorder Severity Scale) as well as significant increases in overall functioning (Symptom Checklist & Quality of Life Enjoyment and Satisfaction Questionnaire). Consistent with the patients' perspectives, clinicians and independent raters reported a statistically significant decrease in panic and anxiety from baseline to endpoint. Clinicians and raters reported decreases in the severity of patients' panic attacks as well as improvement in general functioning (Clinical Global Impression, Multicenter Panic Anxiety Scale & Global Assessment of Functioning).

From clinicians' perspectives, patients demonstrated no statistically significant change in defensive functioning from pre- to posttreatment. Clinicians, however, did report statistically significant change ($p <. 05$) in aspects of object relations including patients' emotional investment in values and moral standards ($p = .02$) and changes in self-esteem ($p = .02$). Effect sizes suggest substantial improvement in outcome from baseline to endpoint. Fifty-three percent of patients achieved remission according to a criterion used in several other studies in the literature (Milrod et al., 2001; Otto, Pollack, Penava, & Zucker, 1999). Clinically significant change was calculated using a stringent method suggested by Jacobson & Truax (1991) by locating improvement relative to "normal" and "dysfunctional" means. Sixty-four and 70% achieved clinically significant change on the Symptom Checklist and Anxiety Sensitivity Index respectively.

Correlations with the prototype of ideal cognitive-behavioral (CBT) process (z score mean = .50, sd = .14) were the strongest followed by the ideal psychodynamic (z score mean = .35, sd = .16) and interpersonal prototypes (z score mean = .32, sd = .09) respectively. There was a statistically significant difference in adherence to the cognitive-behavioral versus psychodynamic and interpersonal prototypes ($t=-2.4$, $df=16$, $p<.05$; $t=6.2$, $df=16$, $p<.001$). No statistically significant difference in adherence to the psychodynamic versus interpersonal prototypes emerged ($t=.70$, $df=16$, $p=.496$).

Adherence to the psychodynamic prototype was significantly associated with positive outcome on one (Symptom Checklist) of the three outcome measures. Adherence to the interpersonal prototype was associated with statistically significant outcome on two (Symptom Checklist, Anxiety Sensitivity Index) of the three outcome measures. Adherence to the cognitive-behavioral prototype was not associated with positive outcome.

Of the 28 PQS (Psychotherapy Process Q-Set) items emerging as process correlates of outcome on the Symptom Checklist roughly the same number of items described patient (11) and therapist (10) within session characteristics, experiences, and qualities. Several items described the nature of the interaction between the two (7). Some of the process-correlate items appeared to be thematically related. Several items reflecting a focus on feelings and negative emotion by patients and therapists were associated with positive outcome. Another group of items describing common factors contributing to a strong therapeutic alliance emerged as robust predictors of positive patient outcome. Two other items generally characteristic of a psychodynamic viewpoint emerged as strongly associated with positive outcome: sexual feelings are discussed (11) and termination is discussed (75).

Many of the process correlates associated with negative outcome also shared thematic similarities. Several of these items reflected hallmark aspects of psychodynamic and cognitive-behavioral approaches to treatment: discussion of activities/tasks to do outside session (38), discussion centers on cognitive themes (30), and patient's feelings/perceptions are linked to past (92). Other items associated with negative outcome reflected therapists' attempts to structure the session or make suggestions.

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Implications for psychoanalysis

Clinicians self-identifying as psychodynamic appear to be highly effective in treating patients with panic disorder in brief psychotherapy. Results were consistent with empirically validated treatments with impressive rates of remission and clinically significant change.

Contrary to what was predicted, however, the therapeutic process fostered in these treatments did not adhere most closely to experts' ratings of a hypothetical and ideal hour of psychodynamic psychotherapy. Instead, as a sample, these treatments adhered most closely to cognitive-behavioral process, less closely to psychodynamic process, and least closely to interpersonal process. Previous research using the same process measure has indicated that psychodynamic clinicians tend to employ a diverse range of interventions when conducting brief psychotherapy, fostering as much of a cognitive-behavioral process as a psychodynamic process (Ablon & Jones, 1998).

In terms of predicting outcome, again contrary to what was expected, these results suggest that adherence to interpersonal not psychodynamic process most consistently predicted positive outcome. Results from a programmatic line of research indicate that the most prevalent aspects of therapeutic process are not necessarily the components predicting outcome (Ablon & Jones, 1998, 2002). Taken together one implication of these findings may be that the conceptualization of therapeutic interventions as "purely" one orientation or another may in the end be more of a conceptual than clinical reality. Another important implication might be that focusing on the predominant aspects of process alone can be misleading as it regards the active ingredients of a treatment.

A fine-grained analysis of process indicated that positive outcome was most robustly predicted by a focus on identifying/expressing (particularly negative) emotion/feelings. Process analysis also indicated that conflicts regarding dependence and independence were central in the therapy.

The results of this study indicate several important directions for future study. While the standard procedure for evaluating treatments is to test them as packages of intervention under controlled conditions before "exporting" them to clinical practice outside the laboratory, the results of this study suggest that in fact it may also make sense to study what it is that clinicians are actually doing in clinical practice that is associated with patient change and then to build and examine treatments under controlled conditions around these specific components (Westen, Morrison & Thompson-Brenner, 2004; Ablon and Marci, 2004). As the results of this study unequivocally demonstrate, judging a clinician by his/her self-described orientation or a treatment by its "brand name" can be as misguided as judging a book by its cover. Psychodynamic clinicians left to their own devices conducted a treatment characterized mostly by cognitive-behavioral process that effectively treated panic disorder. The active ingredients, however, were primarily interpersonal and psychodynamic, not cognitive, in emphasis. This study provides an example of how process research can be used to identify empirically supported change processes in naturalistic treatments as a complement to controlled clinical trials.

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Keywords

Cognitive-behavioral process, interpersonal process, naturalistic treatments, outcome research, panic disorder, process research, prototypes of ideal treatment process, psychodynamic process, psychotherapy, time-limited psychotherapy

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