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# **An open door review of outcome and process studies in psychoanalysis**

Third Edition

2015

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Prepared by the Research Committee of the  
International Psychoanalytical Association.

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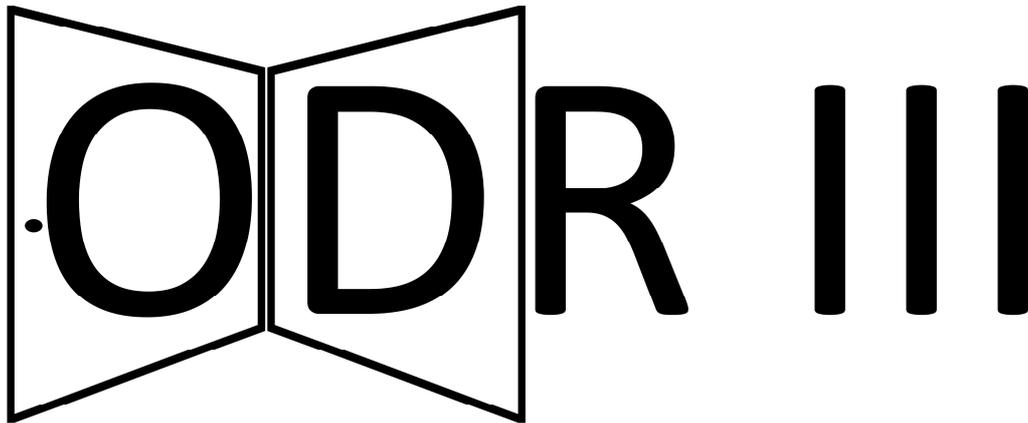
This volume is dedicated  
with gratitude to  
Robert S. Wallerstein (1921-2014), *former President of the IPA*

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ISBN



## Prefaces

Dear Colleagues,

On behalf of the IPA Board, I want to send our sincere congratulations and thanks for this third edition of the Open Door Review, which continues this circulation process of psychoanalytic research.

It is easy to see how this Review will be extremely stimulating not only for professional psychoanalysts, but also for all those who are involved in research organisations, universities and mental health bodies.

The majority of people, many analysts included, are not aware of the tremendous work done year after year by the researchers in our field, and this publication will opportunely provide them with something that is much needed today: the meaningful outcome of empirical research, a parallel dimension which scientifically integrates the better known clinical research.

Furthermore, few people know that the IPA finances many of these research plans, and that each year the IPA spends up to 20% of our total activity budget on funding research.

I want to thank all our prestigious colleagues of the IPA Research Board: Committee Chair, Mark Solms, Co-Chairs Marianne Leuzinger-Bohleber, Ricardo Bernardi, Robert Galatzer-Levy and, as well as Horst Kächele and all those who have contributed to this excellent new edition.

As IPA Members, we are proud and grateful for this remarkable scientific contribution.

It shows once more how the contemporary psychoanalytic community wants to actively keep itself updated and connected with a larger empirical research vision, which can confirm and strengthen its clinical and theoretical achievements and provide evidence on the efficacy of psychoanalysis to the whole scientific community.

So, welcome to this third edition of the Open Door Review!

Stefano Bolognini

*President of the International Psychoanalytical Association*

*July 2015*

In my capacity as Chair of the Research Committee, I would like to add my sincere thanks and congratulations to those of Stefano Bolognini, President of the Psychoanalytical Association, on the occasion of the publication of this Third Edition of the *Open Door Review*. It is a major resource to our field, and its Editors have performed a great service to international psychoanalysis.

In this edition, they have not only provided us with an accessible overview of the current standing of outcome research with psychoanalytical treatments of various kinds, in various clinical populations, but also with an equally readable overview of the current standing of process research -- which is so important for understanding the therapeutic mechanism of psychoanalysis -- and also with a sophisticated introduction to the epistemological and methodological context within which this research was conducted, and with other related material.

In this way, they have struck an ideal balance, between the need for a quick and easy reference guide for practitioners (and for those who must communicate the therapeutic value of psychoanalysis to the wider educated public, who now demand evidence-based support for the claims of any treatment modality, in an increasingly critical and competitive -- sometimes even hostile -- environment) and the need to recognize the real complexities that must be taken into account if we are to obtain a valid picture of what 'outcome' means when the subject of change is something as complex and intangible as the life of the mind.

The editors of this volume have embraced the challenge laid down by the commentators and colleagues who demand simple solutions to problems which are far from simple, but they have also stood their ground. To quote what the great Albert Einstein said in 1933: "Everything [in science] should be made as simple as possible, but not simpler".

Mark Solms

*Chair of the Research Committee of the IPA*

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## Introduction to the Third Edition

The second edition of the Open Door Review published in 2002 review has been a considerable success. That document was produced by a collaborative effort of the Research Committee of the International Psychoanalytic Association (main editor: Peter Fonagy). It covered many of the studies of the outcome of psychoanalytic treatment carried out in Europe and North America over the past decades. The document was intended as a resource to those who wish to further their knowledge of the area. It did not pretend to be much more than a collection of abstracts of work carried out by psychoanalytic researchers. It did 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.

Since then many years have passed without providing an update. Now the Research Committee of the IPA headed now by Mark Solms has commissioned a third edition and invited us to take care of this task. Inspired by the success of the previous versions, we have shouldered this task. Our policy was guided by the idea that the main addressees are the clinicians of psychoanalysis that should be encouraged to sift through the growing bulk of outcome and process studies that have been performed during the last decade. Although the focus of the Open Door Review remains on process and outcome research in psychoanalysis, we would like to pronounce that contemporary psychoanalysis research can not be restricted to these two domains. As Marianne Leuzinger-Bohleber discusses in her introductory chapter: In the hundred years of psychoanalysis not only a plurality of theories has been developed but also a plurality of research procedures, which is an indicator for any mature scientific discipline. Dominique Scarfone elaborates this point of view in his introductory chapter on conceptual research in psychoanalysis referring to the French tradition in psychoanalysis. Ricardo Bernardi summarizes some of the research traditions in South America illustrating that we also have a plurality of different research cultures within the IPA. These contributions are gathered in part 1.

In part 2 Peter Fonagy provides an excellent overview of methodological and epistemological challenges in process and outcome research.

Part 3 presents under a variety of sub-headings psychoanalytic research projects by authors who have followed our invitation. It is obvious, especially the genre of sophisticated outcome studies has become more powerful in its scope and clinical relevance.

Research reports have appeared in prestigious peer-reviewed psychiatric and psychological journals, and advances in measurement and statistical technology have been made. There is no doubt that psychoanalytic research is – due to its specific research subject, unconscious fantasies and processes – more complex and challenging compared to other schools of psychotherapy. It is nevertheless a surprising fact that whenever the effectiveness of the method is fairly and appropriately assessed, it yields effect sizes comparable with other therapeutic approaches. No doubt, the Mental Health institutions in many countries demand to meet the challenge of costs and increasingly undertake cost-benefit and cost effectiveness analyses.

If you look at the sections of the third edition, we hope you will agree with us that a new edition was the only way to go. Considerable progress has been made over the years, and we felt this should be reflected in the review. We decided to summarize outcome and process studies which had been published after 2000 (for earlier studies: see Second Edition). We also include some few examples of systematic clinical research, conceptual research, some clinical case studies and some studies from the growing field of neuropsychoanalysis (part 3,e,f,g,h). We decided not to include the large field of psychoanalytical studies in developmental and prevention research.

Part 4 provides a fairly recent meta-analysis by Leichensring & Klein (2013) that in our view contains a digestible information in an otherwise highly technical field of controversial debates. This report clearly conveys that for serious psychological disorders such as depression and generalized anxiety, longer psychodynamic-psychoanalytic treatments do generate have substantial 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.

Assuming that the relevant readership would be the psychoanalytic clinicians we decided to omit the section on measures as the second edition is still available on IPA's homepage ([http://www.ipa.org.uk/IPA\\_Docs/Open%20Door%202002.pdf](http://www.ipa.org.uk/IPA_Docs/Open%20Door%202002.pdf)).

In part 5 the ODR-3 assembles all the bibliographic references that have been quoted in part 3. Additionally it provides in part 6 an additional reading list that had been assembled by the American Psychoanalytic Association (recommended by J. Clarkin).

For all potential contributors that we missed or who did not submit in time there is the good news that we plan a net-based version of the ODR-3 that will allow to easily add, update or even delete contributions .

As members of the research committee of the IPA 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 IPA administration.

As mark of our gratitude we are pleased to dedicate this volume to the former president of the IPA, Robert S. Wallerstein, who sadly passed away some months ago. He was one of the first presidents of the IPA who consistently and courageously supported research and tried to build bridges between clinicians and researchers.

Marianne Leuzinger-Bohleber & Horst Kächele

*Editors in commission of the Research Committee of the IPA*

July 2015



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# 1. From past to present

# Development of a plurality during the one hundred year old history of research of psychoanalysis<sup>1</sup>

*By Marianne Leuzinger-Bohleber*

## Introduction

What kind of science is psychoanalysis, actually? What did Freud mean when he defined psychoanalysis as a special “science of the unconscious”? As is well-known, before his resolute turn to the natural sciences, the young Freud was particularly interested in philosophy and the humanities. He focused on medical and neurological research in Ernst Brücke’s laboratory at the Institute of Physiology. It was here that he first encountered the kind of strict, positivist understanding of science to which he remained committed throughout his life. However, as we are aware, Freud was to later turn away from contemporary neurology owing to what he considered the methodological limitations of this discipline in research on the psyche. He defined “The Interpretation of Dreams”, the key work of psychoanalysis, as “pure psychology”. Freud’s self-understanding was that of a physician whose methods of empirical observation paralleled those of a natural scientist. As Joel Whitebook (2010) notes, Freud’s aspiration towards precise, “empirical” examination of hypothesis and theories protected him from his own inclination to wild speculation. As a “philosophical physician” Freud was thus able to establish a new “science of the unconscious”.

For the International Psychoanalytical Association (IPA), defining psychoanalysis as an independent, “psychological science of the unconscious” has proved an integral aspect in the history of its success. The fact that Freud considered integrating psychoanalysis into the medical organization of August Forel’s “medical psychology and psychotherapy”, or even into the “order for ethics and culture” as early as 1909, is a well-known fact. Fortunately, on New Year’s Eve 1910, he instead opted to found his own, independent organization, the IPA (see Falzeder, 2010). It was this decision that secured the independence of psychoanalysis as a scientific discipline with its own research methodology and institution, independent of the university system. Freud would later repeatedly emphasize that psychoanalysis merited autonomy as a discipline and was not to be “swallowed by the medical faculty” (Freud, 1926, p. 248), “but rather, as ‘the psychology of the unconscious’ (Tiefenpsychologie) – the discipline of the unconscious –, could become indispensable to all sciences associated with the emergence of human culture and its great institutions of art, religion and social systems...” (Freud, 1926, p. 248)

Over the course of its one-hundred year history the specificity of psychoanalytic science became increasingly defined. Psychoanalysis developed a differentiated, independent method for the examination of its specific object of research, namely, unconscious conflicts and fantasies. International psychoanalysts summarized their insights in countless papers. They acquired such insights by way of thorough-going studies of different groups of patients, and by applying their “specific psychoanalytical research methods” to the study of unconscious fantasies and conflicts by observing free associations, dreams, transference and countertransference reactions as well as transformation processes in the psychoanalytic relationship etc.

Moreover, as is the case with all other contemporary disciplines, it has set its own criteria of quality and truth e.g. the meticulous investigation of the analysand’s conscious as well as unconscious responses to interpretations and their influence on his transformation processes. Several discourses

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<sup>1</sup> This paper is based on the Research Lecture given at centenary celebration of the IPA in London, March 2010 and its elaboration in Leuzinger-Bohleber, in press.

were dedicated to the question as to how such, typically psychoanalytical observations of changes in the psychoanalytical process can best be documented and communicated – no less to render them comprehensible and susceptible to criticism from the outside (for further details see sections 2.1)

The present paper also discusses how the conceptualization of psychoanalysis as a scientific discipline necessitates critical reflection in a fruitful dialogue with other contemporary scientific disciplines (see also Leuzinger-Bohleber, in press).

The paper goes on to argue that it is crucial for psychoanalysis to maintain its specificity as well as the richness of contemporary psychoanalytical research (see 2.).

I focus on the situation in Germany, for the most part in reference to a single concrete research example: the major, ongoing LAC Depression Study at the Sigmund Freud Institute in Frankfurt (see ODR).

## Remarks on the Hundred-Year History of Research in Psychoanalysis

Freud's life-long hope was that following the development of modern natural sciences there would come a time in which the insights of psychoanalysis – as acquired by practitioners through the application of purely psychological, clinical methods of observation in the psychoanalytical situation – would also be “objectively” examined by way of the “hard” methods of natural science. This is a scenario which has today, in many respects become reality in the dialogue with the modern neurosciences. However, forty years ago Jürgen Habermas (1968) introduced an epistemic critique of Freud's aspiration to “objectively” study psychoanalysis by natural scientific methodology. He described the longing for “objectivity” as the “scientistic self-misconstrual” (Sziientistisches Selbstmissverständnis) of psychoanalysis. He characterized psychoanalysis as following an *emancipatory interest in insight*, in contrast to behavioural therapy, which is motivated by a *technical interest*. This distinction met with a positive response by an entire generation in the Western countries, whereas, due to other factors, psychoanalysis reached a height to which it never returned. As a hermeneutic method of individual and social unconscious sources of psychic and psychosomatic suffering, on the whole, psychoanalysis experienced the kind of social acceptance in these years which at times verged on idealization. Although there were always attacks and controversies, as a method of treatment and as a critical theory of culture, psychoanalysis had no need for concern with respect to its legitimacy during this period.

The social acceptance during these decades also impacted upon the understanding of science and research in psychoanalysis (see e.g. Zaretsky, 2004/2006; Makari, 2008, Leuzinger-Bohleber, 2011). In short, during 1970's and 1980's, aside from genuine clinical psychoanalytic research, this, above all, involved hermeneutically oriented and social psychological approaches, the analysis of culture and an interdisciplinary exchange with philosophy, sociology and literary studies, humanities and pedagogy, as well as film and art. Empirical, and especially quantitative research in psychoanalysis and the dialogue with the natural sciences, were considered by many as naïve and unsuited to psychoanalysis, even to the point of being harmful.

As Thomas Kuhn describes in his analysis of the history of science, different paradigms often exist side by side within a scientific discipline. However, one of them usually predominates, namely, that which is best-suited to the *Zeitgeist*. The above-mentioned understanding of psychoanalysis as a critical hermeneutics of the 1970's and 1980's is still vividly represented in many countries and several IPA societies (see e.g. Green, 2003; De Mijolla, 2003; Perron, 2003, 2006; Widlöcher, 2003; Ahumada & Doria-Medina, 2009; Bernardi, 2003 and in this volume; Vinocur de Fischbein, 2009; Duarte Guimaraes Filho, 2009; Scarfone, in this volume). In some countries, particularly in the United States, England, Germany and some of the Nordic countries, the adjustment to an empirical research paradigm has been pushed to the fore over the last decades (see, among others, Fonagy, 2009, and in this volume). In these countries the *Zeitgeist* has changed since the 1970s: in times of “evidence-based medicine” and of medical guidelines, one sometimes has the impression that for psychoanalysis, too,

only one form of research exists, namely, the type of empirical-quantitative psychoanalytic research that conforms to the classical natural sciences. On closer inspection, this is a peculiar reoccurrence of an outdated and problematic notion of “unified science” (Einheitswissenschaft) (see e.g. Hampe, 2003; Leuzinger-Bohleber, Dreher, & Canestri, 2003; Leuzinger-Bohleber, in press), a simplification of the complexities of research in the knowledge societies (see e.g. Weingart, 2002). Instead, considered epistemologically, a plurality of theories, scientific experiences, methods and concepts of investigation now predominate in most contemporary scientific disciplines, including psychoanalysis. As discussed in previous papers, according to our concept of the plurality of sciences originating in the various concepts of experience, by positioning itself in this way, psychoanalysis is by no means isolated but has similar concerns to other contemporary sciences, all of which have sought to explain to the other the special character of their discipline, to initiate dialogue and, at best, to promote interdisciplinary collaboration. The idea of a unified science which, full of enthusiasm and persuasive power was initially declared in German Idealism, and later in a different form, in logical empiricism has turned out to be untenable (see e.g. Leuzinger-Bohleber & Bürgin, 2003, pp. 12-13.)

*‘Like all euphoria, the notion of a philosophical unified science was not a permanent one: it passed. At this point I only wish to state that I am unaware of any serious representative of philosophy of science who still cultivates the notion that a phenomenon such as a unified science exists’ (Hampe, 2000, p. 28).*

The sciences have instead become more subtly diversified. The distinctions between the natural sciences and the humanities as elaborated by Dilthey at the end of the 19th century now no longer serve to sufficiently delineate the diversity of contemporary scientific disciplines. Thus, the impossibility of a unified theoretical concept for all these sciences has become increasingly evident. A theory of science which could equally well apply to mathematics, physics, biology, psychology, sociology, archaeology, history and philology let alone to medicine, jurisprudence and theology does not exist. We are indeed confronted with a state of ‘plurality in the sciences. As summed up by an expert on the philosophy of science, Michael Hampe (2002):

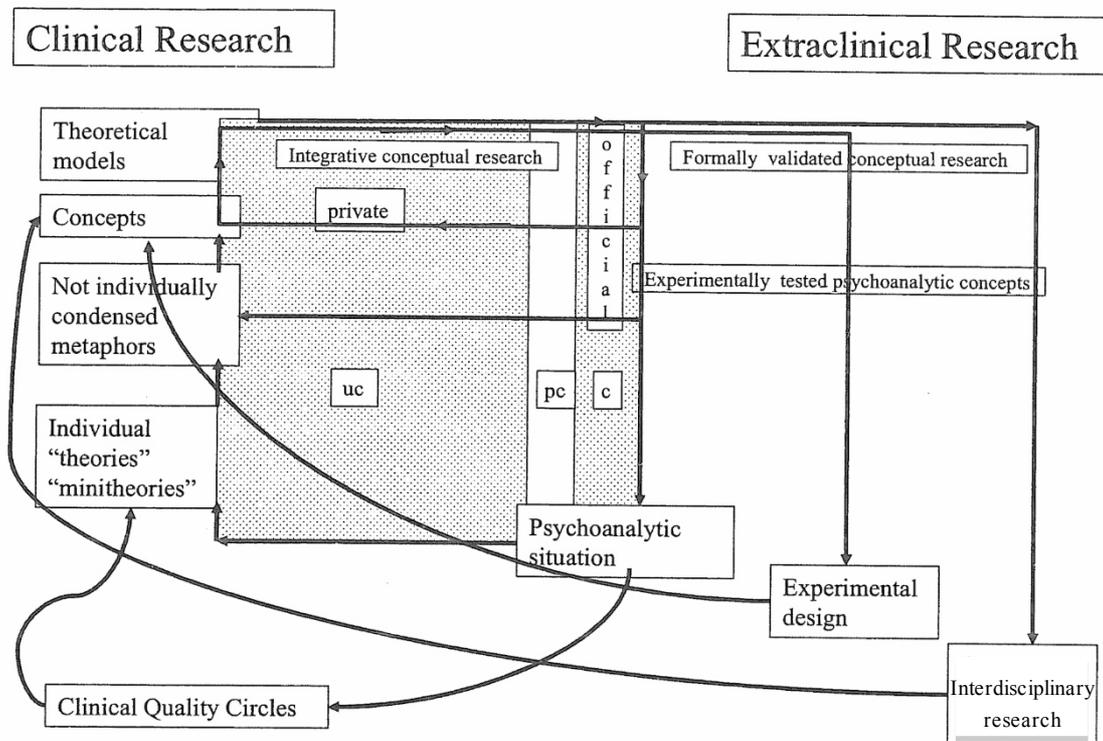
*‘Firstly, plurality in the sciences not only means plurality of subjects, but, secondly, also scientific forms of theory. Thirdly, these different forms of theory produce a pluralism of scientific experience. The plurality of scientific experience is possible by trying to discipline our everyday experience. The quality of experience, its importance with respect to precision, completeness etc. are thus acknowledged values. In the individual sciences the pluralism of these different epistemic values (‘Erkenntniswerte’) is realized in different ways, and in each science special methods were developed in order to ensure that the precision, completeness, level of contrast etc. as uniquely defined by each science could be developed step by step. Therefore, above all else, plurality in the sciences means a plurality of theories, a plurality of experience, and a plurality of epistemic values (‘Erkenntniswerte’) and, lastly, a plurality of methods’ (p. 33).*

In keeping with challenging epistemic considerations, it would seem appropriate to describe the distinctive feature of psychoanalysis as a “specific scientific discipline of the unconscious” (spezifische Wissenschaft des Unbewussten) – a discipline which, over the foregoing 100 years of its history, has developed a range of highly advanced research methods for investigating the specific object of its research, namely, unconscious conflicts and fantasies. Hence, as is the case with many other scientific disciplines, contemporary psychoanalysis comprises a plurality of theories, methods of clinical treatments as well as a plurality of research. These will be discussed below.

I would now like to provide a brief outline of this point by way of a diagram of clinical and extra-clinical research in psychoanalysis, which I have developed in another paper. To avoid floundering in abstractions, I refer in my plea for the creative use of a broad spectrum of possibilities for psychoanalytic research, to current research projects of the Sigmund-Freud-Institute in Frankfurt

a.M.<sup>2</sup>, a research institute exclusively for psychoanalysis, in which we attempt to encounter the actual zeitgeist without uncritically submit ourselves to it and without renouncing the autonomy and specificity of psychoanalysis as a scientific discipline.

## Clinical and Extra-Clinical Research in Psychoanalysis



Today we can differentiate between two different groups of psychoanalytic research, the *clinical* and the *extra-clinical*. By *clinical research* is meant genuine psychoanalytic research in the psychoanalytic situation itself. Ulrich Moser (2009) describes this as *on-line research* whereas, as outlined below, the *extra-clinical research* (*the off-line research*) occurs after the psychoanalytic sessions and embraces a variety of research strategies.

### Clinical research in psychoanalysis

Let us first turn to *clinical research*: Clinical research takes place in the intimacy of the psychoanalytic situation. It may be described as a circular process of discovery whereby, together with the patient, idiosyncratic observations of unconscious fantasies and conflicts are successively visualized, symbolized and finally put into words at different levels of abstraction; this represents an understanding that moulds our processes of perception in subsequent clinical situations, even though we enter into each new session with the basic, genuine psychoanalytic attitude described as “not knowing”. The circular processes of discovery initially occur above all unconsciously and in the realm of implicit private theories. Here, only a small part is accessible to conscious reflection by the psychoanalyst (see EPF Working Party on Theoretical Issues, 2006, 2012; Project Group for Clinical Observation of the IPA, Altmann de Litvan, 2014) (see summaries in this volume).

The insights gained in this clinical research are presented for critical discussion in the psychoanalytic community and beyond. In agreement with many practicing analysts, clinical research continues to be

<sup>2</sup> See [www.sigmund-freud-institut.de](http://www.sigmund-freud-institut.de)

the central core of psychoanalytic research in general, based as it is on the characteristically psychoanalytic idea of experience and linked to epistemic values (Erkenntniswerte) (compare Toulmin, 1977/83; Hampe, 2004, 2008). Clinical, psychoanalytic research pivots on understanding the unconscious construction of meaning, on personal and biographical singularity. It may thus be characterized as critical hermeneutics.

The professionalism of the psychoanalyst adopts an attitude of free-floating attention (gleichschwebenden Aufmerksamkeit) in his own counter-transference of the scenic observation of the patient's "embodied enactments" (see also Argelander, 1967; Lorenzer, 1974/85; Leuzinger-Bohleber & Pfeifer 2002; Leuzinger-Bohleber, Henningsen, & Pfeifer, 2008), Freudian slips, dreams etc. for the successive understanding of the actual unconscious psychodynamic of the analysand. The typical psychoanalytic process of searching for "unconscious truths" can only be carried out with the analysand, and is regarded as one of the distinctive characteristics of psychoanalysis – for example, as opposed to the top-down procedure of behaviour therapy. Due to this fundamental position, namely, that psychoanalysts can only "test the truth" of their understanding of psychodynamic processes together with the patient, Jonathan Lear (1995) impressively described psychoanalysis as the most democratic of current therapeutic procedures. Furthermore, the characteristic "criterion of truth" of psychoanalytic interpretation is that the "truth" of a certain interpretation of unconscious fantasies or conflicts is something which can only be decided *together* with the patient, i.e. by the common observation of his (unconscious and conscious) reactions to an interpretation.

As is generally known, we owe our specific psychoanalytic, clinical-empirical method of research, the intensive and detailed "field observations" with single patients in the analytic situation, for the most part, those insights acquired over the foregoing 100 years of scientific history – for example the genesis and treatment of chronically depressed patients. Christina von Braun (2010) also sees a unique opportunity in the clinical research of psychoanalysis to recognize and critically reflect on the deeper cultural changes brought about by the ubiquitous exploitative mentality of global and "emotional capitalism" (Illouz, 2006) on the unconscious of modern man in the analytic relationship – something which is not only highly relevant for the affected individual, but also for an analysis of culture as such.

Let there be no mistake, Peter Fonagy is right when he points out that not every clinician is automatically a researcher (see his contribution in this volume). A methodologically systematic procedure and a self-critical "basic clinical research attitude" (see Scarfone, in this volume; Bernardi, in this volume) is a precondition; a gain in knowledge in this form is not only a professional skill but also a clinical science. Psychoanalysis has at its disposal, probably more than every other clinical discipline, a differentiated culture of intervision and supervision – closely modelled on psychoanalytic practice – in which the clinical processes of research and greater insight can be critically discussed. There is, however, much room for improvement. Many problems are well known, for example, the chance selection of clinical case reports describing only theoretical concepts as opposed to critically developing them.

We are in urgent need of good clinical research, not only in order to maintain our standing in the world of psychotherapy, but also to continually develop our skills in professional treatment (compare Boesky, 2002, 2005; Chiesa, 2005; Colombo & Michels, 2007; Eagle, 1994; Haynal, 1993; Knoblauch, 2005; Lief, 1992; Mayer, 1996). This is one of the goals of the IPA Project Committee for Clinical Observation (Chair: Marina Altmann), but also an IPA Clinical Research Committee (Chair: David Taylor) so as to secure and improve the quality of clinical research in the IPA.

Thus, much like the EPF working parties, or the IPA in the LAC Depression Study, we are developing *our own form of clinical research*: we discuss the treatment sessions that have been systematically documented prior to our discussion in weekly "clinical conferences". Based on this joint clinical research, the elaboration of "expert-validated" narrative case reports are the most important results of this study. These case studies provide psychoanalytic insights into the specific psychodynamics of

chronic depression, its complex individual and cultural determinants as well as the details of treatment, to the psychoanalytic and non-psychoanalytic community.

The method of *expert-validation* was developed in the DPV Follow-Up Study. It is applied, in modified form, in the LAC Depression Study and in the Three Level Model of Clinical Observation, as has been developed by the Project Group for Clinical Observation since 2009 (see contribution of Leuzinger-Bohleber, 2014; Altmann de Litvan, 2014, summaries in the ODR).

## Psychoanalytic Conceptual Research

The new forms of clinical research outlined in the above invariably constitute part of creative and original research on concepts – a field of research as old as psychoanalysis itself. The creative development and enhancement of concepts has always distinguished the innovative minds of psychoanalysis, and thus makes our discipline particularly attractive to intellectuals, writers, artists and researchers in other disciplines.

A new characterization of psychoanalytic conceptual research was elaborated by Joseph Sandler and Anna Ursula Dreher during the 1990's, hence distinguishing it from other forms of psychoanalytic research. They postulated that concept research was to be considered as an independent form of psychoanalytical research, which they substantiated by way of comprehensive examples, such as by specifying the concept of “trauma”. In the Research Subcommittee for Conceptual Research initiated by former IPA President Daniel Widlöcher in 2002, the object of which was to erect bridges between the conceptual traditions within the different IPA regions, we attempted to further delineate and differentiate the research on concepts, as well as to clarify quality criteria both for this aspect of psychoanalytic research in particular and other relevant epistemological questions (cf. figure 1) (see e.g. Leuzinger-Bohleber, Dreher, & Canestri, 2003; Leuzinger-Bohleber & Fischmann, 2008, Dreher in the ODR).

Based primarily on the French tradition (e.g. Laplanche's work), Scarfone (in this volume) summarizes another form of conceptual research. He also mentions the conceptual research of the Project Committee for Conceptual Integration (Chair: Werner Bohleber; see e.g. Bohleber et al., 2013; Bohleber, Jiménez, Scarfone, Varvin, & Zysman, in press and in the ODR).

Conceptual research on the unconscious psychodynamics of chronic depression is one of the main objectives of the LAC Depression Study. All analysts prepared to engage in the study had been trained by David Taylor in the “Tavistock Manual for Treating Depression”. In several workshops with him and with Hugo Bleichmar, another leading psychoanalytic expert in depression, the participating psychoanalysts discussed their clinical observations in detail and tried to conceptualize their clinical findings. To mention just one example: Rosemarie Kennel applied the concept of psychic retreat, as developed by John Steiner, to one of her psychoanalytic treatments and published a conceptual paper (Kennel, 2013).

## Extra-clinical empirical studies: Psychoanalytic psychotherapy research, an example

In the next step, the results of the clinical-psychoanalytic and conceptual research thus may become the subject of extra-clinical studies (see figure 1). We distinguish between empirical, experimental and interdisciplinary studies.

As an example of extra-clinical empirical studies, I would like to shortly discuss psychoanalytic psychotherapy research because it is indispensable in the knowledge-society for political and public reasons, to prove the effectiveness of psychoanalytic treatments by the criteria of evidence-based medicine in the Mental Health Systems of many Western countries. This is one reason why outcome research is the main focus of the Open Door Review.

Robert S. Wallerstein (2001) traces these attempts back to their beginnings in 1917 and defines different generations of psychotherapy researchers. He mentions above all a number of American studies, that I – without making a claim to be exhaustive – will supplement with some European studies.

**1. Generation (1917-1968):** for the most part, retrospective studies that verified – with unspecific criteria – the successfulness of most of the psychoanalytic treatments. (Coriat, 1917; Fenichel, 1930, Jones, 1936; Alexander, 1937; Knight, 1941; Hamburg et al. 1967; Feldman, 1968).

**2. Generation (1959 -....):** in which two different groups of studies were carried out:

a) *Prospective, aggregated comparisons of different, exactly defined groups of psychoanalytic treatment.* These studies relied on more sophisticated research methods and operationalized, for example, the criteria of success for the expected success of the therapy. Also they could verify that approximately 80% of all psychoanalytic treatments were successful. (Knapp, Levin, McCarter, Wermer, Zetzel, 1960; Shashin, Eldred and van Amerongen, 1975; Bachrach, Weber & Solomon, 1985; Erle & Goldberg, 1984).

b) *Individual studies that resulted from a methodological uneasiness that individual differences between the patients should not be mixed with group examinations, but to place the main focus on the individual consideration of the single treatment of different patients, as is fitting in psychoanalytic procedure, in which it always has to do with the understanding of unconscious structures of meaning.* For this reason they used, for example, in their interviews some careful psychoanalytic methods, such as psychoanalytic follow-up interviews. (Pfeffer, 1963; Norman, Blacker, Oremland & Barrett, 1976, Schlessinger, 1980, later follow-up studies at the Anna Freud Center by Target and Fonagy, 1994; DPV Follow-Up-Study by Leuzinger-Bohleber, Stuhr, Rürger and Beutel, 2003). These studies verified not only the effectiveness of psychoanalytic therapy, but also developed a number of unexpected, clinically interesting questions, for example, that with reference to the reduction of symptoms and to other therapy goals, some treatments proved to be effective but that these patients had not gone through a psychoanalytic process in a narrower sense.

**3. Generation (1945-1986):**

*In these systematic and formal psychoanalytic studies of psychotherapy an examination of results and of the process were combined, i.e. statistical comparisons were made between the groups but in combination with systematic single case studies, that, for example, followed the fates of single patients over a longer period of time.* (Bachrach, Galatzer-Levy, Skolnikoff & Waldron, 1991; Kantrowitz, 1986). An example of this 3rd Generation of psychoanalytic psychotherapy research is exemplified by the Psychotherapy Research Project of the Menninger Foundation (Wallerstein, Robbins, Sargent u. Luborsky, 1956) that led to a wealth of insights on the results of psychoanalytic and supportive psychoanalytic therapies and on details concerning treatment techniques. Impressive is, for example, the careful longitudinal study of 42 patients over the course of several decades that Wallerstein published with the moving title *Forty-two Lives in Treatment* (Wallerstein, 1986).

**The current 4. generation (1970...)** combines not only research of results and therapeutic processes but, thanks to new techniques (video/audio recordings), links microanalysis of therapeutic processes with research on results (beginning with early analysis of tape recordings by Earl Zinn, see Carmichael, 1956; Dahl, Kächele & Thomä, 1988; Strupp, Schacht & Henry, 1988; Beenen, 1997, Leuzinger-Bohleber, 1987, 1989; Grande, Rudolf & Oberbracht, 1997; Huber et al., 2012; Sandell, 1997; Leuzinger-Bohleber, Rürger, Stuhr, Beutel, 2003, Busch, Milrod & Sandberg, 2005, Beutel et al.,

2012; Leuzinger-Bohleber, in press b; compare also first two edition of the Open Door Review by Fonagy et al., 1999 and his chapter in this volume, or his excellent overview, 2009; as well as new studies of long-term therapies summarized by Leichsenring & Rabung, 2008; see his metaanalysis in this volume).

Unfortunately it is little-known, above all, by clinicians of the IPA, how many psychoanalytic research groups are currently involved in extra-clinical studies. Fonagy (2009) spoke in a comprehensive survey of the worldwide “psychotherapy bee-keepers” that have verified with their industrious bee colonies the effectiveness of psychoanalytic short-term therapies (compare further overviews, e.g. Emde & Fonagy (1997); Fonagy, 2001; Galatzer-Levy, 1997; Hauser, 2002; Holt, 2003; Jones, 1993; Kächele (2009), Kernberg (2006); Leichsenring & Rabung (2008); Perron (2006), Safran (1991); Schachter & Luborsky, 1998; Schlessinger, 2008; Stern, 2008; Wallerstein, 2001, and this Third Edition of the Open Door Review).

Careful extra-clinical research requires enormous expenditures that can only be carried out in a research network that is correspondingly endowed and supported by a constant process of reflection of the accompanying dependencies – also among the generations of involved researchers.

The LAC Study is an attempt to meet contemporary research criteria in psychotherapy in an attempt to “prove” the outcomes of psychoanalysis and psychoanalytic, long-term therapies, and thus convince insurance companies in Germany to finance these kinds of treatments for chronically depressed patients (see summary in the ODR).

## Experimental Psychoanalytic Studies

That it is impossible to test psychoanalytic processes directly in an experimental design, e.g. to study the brain of psychoanalysts and their patients during the psychoanalytic sessions in a randomized control trial, is self-evident. However, in recent decades different research groups have been successfully undertaking experimental examinations of single psychoanalytic concepts. These have ranged from the preconscious and the unconscious processing of information in memory and in dreams, to mention just a few: the workgroup of Howard Shevrin and his group (see e.g. Shevrin, 2000); Steven Ellman and his group in NY (see e.g. Ellman & Antrobus, 1991; Ellman & Weinstein, 1991; Ellman, 2010), Wolfgang Leuschner, Stephan, Hau, Tamara Fischmann at the SFI (Hau, 2008) the concept of embodied memory, by Pfeifer and his research group in Zurich (Leuzinger-Bohleber & Pfeifer, 2002; Leuzinger-Bohleber, in press) as well as other studies of facial interaction were carried out with the aid of the FACs from Rainer in Saarbrücken (e.g. Krause, 1997).

In the Frankfurt EEG and FmRI Study (FRED Studie), we examined part of an example of chronically depressive patients of the LAC Study, also by way of methods culled from the neurosciences (EEG and FmRI). This was undertaken so as to test whether changes in psychoanalytic, long-term treatments can also be proven with the aid of such methods (cf. Fischmann, Russ, Bohleber, 2013, summary in this volume)

## Interdisciplinary Research (cf. figure 1).

We have discussed the interdisciplinary dialogue with the neurosciences and Embodied Cognitive Science in several publications and have summarized clinical, conceptual and empirical studies in this field (see e.g. Leuzinger-Bohleber, in press). Whereas, these interdisciplinary studies are fascinating, the exclusive research projects for the acceptance of psychoanalysis in the modern world of science are not.

Creative exchange with attachment research and empirical developmental research, for example, comprise further important fields in interdisciplinary research. No less significant is the collaborative interdisciplinary research with literature and cultural studies, with social psychology, philosophy, the media- and communication sciences as well as ethno-psychoanalysis. Psychoanalysis as a specific

treatment and research method may frequently take on several socially relevant themes in order to communicate the indispensable nature of its research results to the scientific community and to the general public. For example, such topics may cover the field of early prevention, ADHS, migration, youth violence, right-wing radicalism, nationalism and Antisemitism, and the return of fundamentalism, religion and violence, as well as the short- and long-term influence of new media and technologies on processes of psychic development and of modern conflicts in the realms of sexuality and object relations.

## Summary

To summarize just a few points for further discussions:

- a) Already Freud was hoping, that psychoanalysis by means of “objective research results” could obtain the acceptance in the scientific community in medicine and natural sciences. On the other hand it was only through the insistence on its own autonomy and specificity – as a method and institution – that psychoanalysis as a specific scientific discipline investigating unconscious psychic processes could secure its survival and its productive unfolding in the last 100 years.
- b) In the first century of its history psychoanalysis developed a highly sophisticated method of research for the investigation of its own specific research object, of unconscious fantasies and conflicts. The enormous development of psychoanalysis during this first centenary of the IPA has led to a plurality of theories, of psychoanalytical treatments, of epistemological positions as well as to a plurality of psychoanalytical research.
- c) Contemporary psychoanalytic research takes place in a field of tension. On the one pole exists the danger of retreating to the psychoanalytic ivory tower and refuting the dialogue with the non psychoanalytic community - on the other pole the over-adaptation to a, for psychoanalysis inadequate understanding of science and therefore a loss of identity and independence. This field of tension cannot be resolved but can only be critically reflected upon and productively shaped again and again in an interdisciplinary and intergenerational dialogue. This critical reflection may also be seen as a safeguard against submission to the dominating “Zeitgeist”. As it is well known: the gold of contemporary science may well be the iron of the future.
- d) The future of psychoanalysis will flourish if innovative and creative insights can be found in its rich spectrum of different fields of research in the clinical, conceptual, empirical, experimental and interdisciplinary research and be transferred to the scientific and non-scientific community.
- e) In today’s “knowledge-societies” – in which scientific experts compete at all levels for authenticity and credibility – it has become a question of survival, but also a new chance for psychoanalysis to maintain its standing. Therefore it has to assert itself as an specific, irreplaceable, effective and productive clinical method of treatment and a theory of mind and culture. Through its specific research method, the developing of unique and effective forms of short-term and long-term treatments, by interesting and innovative explanations for the complex phenomenon of individuals and groups as well as of society, psychoanalysis may even increase its public attractiveness as a “specific science of the unconscious”. The “plurality of research” opens many new windows for psychoanalysis towards many other contemporary scientific disciplines which can be productively used for an innovative future of psychoanalysis as a clinical practice and as a science.

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# Conceptual research in psychoanalysis

*By Dominique Scarfone*

Psychoanalysis is not an experimental type of science, yet it is based on careful observation of psychic facts carried in the course of clinical practice. Psychoanalytic hypotheses are then empirically tested through the collaborative work of the analyst-patient team. The main difference with experimental research is probably that each analytic “team” is unique and intimately involved in the processes at study (observation is not independent of the observer), therefore not really allowing for reproducible results *stricto sensu*: what works with one analytic dyad does not necessarily so with another; secondly, the nature and duration of psychoanalytic treatment impedes the constitution of cohorts large enough for specific hypotheses to be *prospectively* tested. Moreover, confidentiality is not an external constraint but an intrinsic condition for the deployment of analytically usable material, which also limits reproducibility.

In spite of these limitations, there is no dearth of psychoanalytic theories and concepts, resulting in the often deplored “Babel” in the psychoanalytic domain. Jean Laplanche, for one, suggested that the contemporary psychoanalytic conceptual field resembles the Ptolemaic astronomical system, where for every new observation a new “epicycle” is added to our theoretical model, rather than examining the eventual need for a “Copernican revolution” added to our discipline. Laplanche (1987) went as far as proposing his own version of a Copernican turn in psychoanalysis, but we shall not discuss his proposal here. We will, instead, examine the method that he followed in his struggle in our midst against the spirit of Ptolemy, and which inspires the sort of conceptual research that I try to carry with my graduate students.

## ***Laplanche’s method of conceptual research***

Laplanche’s research started with the delimitation of the psychoanalytic domain of study. For him it consists of four main fields of research : 1-Psychoanalytic treatment proper; 2- *Extra-muros* (a.k.a. “applied”) psychoanalysis; 3- History (mainly the history of psychoanalysis); 4- *psychoanalytic theory*.

The fourth element in this list is the one concerned with conceptual research proper. In retrospect, it is surprising that before Laplanche very few theoreticians of psychoanalysis, if any, had considered the possibility of applying the psychoanalytic method of investigation to Freud’s theory itself. Laplanche based his work in this field on the Freudian notion that the unconscious is a force affecting human thinking and discourse, eventually interfering with the establishment of adequate knowledge. Now, if this is true of any human thought, feeling and discourse, then it applies just as well to Freud’s theory. It is not, however, a matter of psychoanalyzing Freud the man, but to consider theory itself as subjected to phenomena not unlike slips, negation, denial, rationalizing, reaction formation etc.

## ***The reliability assumption***

One important premise is that Laplanche’s method rests on the assumption that Freud’s thinking is *reliable*. That is: not that Freud was always right, but that he was relentlessly on the trail of the unconscious, tracking its various effects and manifestations. Such consistency in his effort made it so, according to Laplanche, that when Freud went astray in one part of his theorizing, this was somehow compensated with new thinking in another part. Both the parts may of course present problems, but the phenomenon as a whole is a good indicator of where lies the deeper problem in need of further research and reflection.

A good example of this is Freud's introduction of a "death drive" in 1919, a controversial and problematic concept if there ever was one. For Laplanche, the seemingly sudden emergence of a totally new conception of the drives was in need of an explanation, to be found in what had been developed by Freud in the previous years. Indeed, based on the reliability assumption mentioned above, Laplanche posited that a change must have occurred somewhere in the preceding formulations, requiring that new concepts make up for the loss or the erasure entailed by that change.

Laplanche's study has shown that Freud's need for the concept of a death drive indeed resulted from the introduction of narcissism from 1910 on. Narcissism had entailed a sort of conceptual "taming" of the theretofore "demonic" sexual drive, to the point where sexuality was now put on the same side as self-preservation instincts to the point where sexuality was now put on the same side as self-preservation instincts, under the larger heading of "life instincts. Freud's consistency in his positing the strangeness of the unconscious "thing" required, however, that the demonic aspect be relocated elsewhere in the theory. This was, according to Laplanche, the reason for the introduction of a death drive, in charge of the turbulence of the drives that had been lost of view. An additional historical argument was brought by Laplanche in support of this view. It was discovered in the Minutes of the Vienna Society of the year 1910, where "life instincts" were mentioned nine years before *Beyond the pleasure principle*, except that they were then situated as the opposite of the sexual drives suggesting that the placeholder for the demonic sexual drives and the death drive was exactly the same.

From this example we can see that Laplanche's method of theoretical/conceptual research requires 1- an extended knowledge of the Freudian theory; 2- an appreciation of the entire structure of the theory so as to detect the equilibria that prevail and which will eventually call for corrective measures whenever a new idea of concept disrupts those equilibria; 3- an epistemological study of the concepts themselves.

### ***Working on post-freudian concepts and theories***

Laplanche's method can obviously be applied not just to Freud but also to any other "consistent" psychoanalytic theoretician. Most importantly for our present day situation, it can apply to the study of the impact that post-Freudian concepts have on the Freudian conceptual body taken as a whole. This puts on us an even greater pressure for first carefully examining the elaborate set of concepts that was Freud's legacy in order to carefully monitor exactly what was added over the years by important post-Freudian authors and how their contributions relate to the original body.

Here is an example. In the late 1990's, while looking for a way of examining virtual reality from a psychoanalytic point of view, my student of the time Marie Leclaire and I were struck that in the vast majority of articles related to "reality testing". The concept was taken for granted and could be summarized as meaning: "Reality testing is what is lacking in psychosis", which is a rather poor definition for a concept of such importance. Going back to the origins we were struck by the different definitions Freud had given of "reality testing", as highlighted by Laplanche & Pontalis in *The Language of Psychoanalysis*. So, we undertook the task of re-reading Freud on the subject and thereby were able to find that the concept went back to the very beginnings of psychoanalysis and that it entailed in fact precise references to two different kinds of mnemonic traces as well as to a more detailed sequence of mechanisms than was usually assumed. We were thus able to document an "actuality test" as a first step towards a "reality test". (Leclaire & Scarfone, 2000).

Recent work in the IPA's Conceptual Integration Project Group (CIPG) has taught me many important things about how to examine concepts and their different meanings according to the various theoretical trends and "schools of thought" (Bohleber et al., 2013). The CIPG applied its method to single concepts, but I now think it useful to use it in comparing two or more concepts critically. Hinshelwood (2008) provided a recent example of such comparative study, though his specific method was not the same. His study examined splitting and repression and the result, in my view, well illustrates the interest of conducting comparative work. I believe that combining the methodology developed by the CIPG in the study of single concepts with a comparative method loosely inspired from Hinshelwood one can contribute to the effort of streamlining, so to speak, the conceptual "Babel" of psychoanalysis.

## ***The parsimony principle***

A deliberate strategic choice is implied here, which is to work from the premise that the Freudian conceptual body is still the fertile ground from which post-Freudian concepts grow. While these may employ a different vocabulary, it begs the question whether the introduction of a new term truly reflects the introduction of a new concept and is not a mere rebranding. A *parsimony principle*, attributable to William of Ockham (Fourteenth Century), but also to William James' philosophical pragmatism, is necessary in this domain. The rule is that new concepts should be introduced only if they cover new ground by referring to some unique fact or process not already invoked by existing notions. In the physical sciences this rule is more easily obeyed than in our field since, in psychoanalysis, we lack the "crucial experiment" that demonstrates—or disconfirms—the actual uniqueness of the concept, let alone the existence of the concept's referent. The easiness with which new ideas and expressions are brought to our attention in psychoanalysis certainly reflects the liveliness of the field, but it can also become problematic when expressions and ideas do not really add to our actual knowledge but simply reformulate older ideas in a new guise. Then again, this could still be a minor problem, were it not that such strategy—even when it is not intentional—results in a lack of genuine discussion among psychoanalysts and in the creation of ever more divergent theories and "schools" within psychoanalysis.

One example could be the use of "dissociation" as a replacement for "repression" by a number of contemporary authors. In a research conducted by one of my students (paper in preparation), a close examination of the history of the two concepts, and more importantly of their past and present usage, shows that it is in fact quite difficult to set them apart, especially when both are looked at as process or mechanism. A close reading of Freud and Janet, for instance, shows how the two concepts, though different in some respect, are not really as different as modern theoreticians say they are. If a well documented conceptual debate could be carried around these two concepts, it could possibly diminish the theoretical distance between different "schools".

## ***Concepts and theories***

Not surprisingly, the close study of any psychoanalytic concept immediately raises issues about other concepts belonging to the same conceptual cluster—think here, for example, of the cluster formed by primal and secondary repression, splitting (of the Ego, of the object), dissociation, suppression, denial, disavowal, negation etc.—so that conceptual research is, in a way, always examining the theory as a whole. Therefore, what Laplanche had identified in Freud's theorizing (that change in one part of the theory requires change in another part) remains true when we engage in research concerning contemporary issues. Thus, for instance, if there is indeed an —albeit partial—overlap between repression and dissociation, then we may wish to look for some underlying, more "primitive" formulation that could account for the clinical phenomena encompassed by the two concepts. This, in turn, may question other large areas or clusters within the theory as a whole. For instance, one could ask how the more basic concept or "common denominator" behind dissociation and repression resonates with other common denominators in the remaining conceptual clusters, and so on. Lacking, as we saw, the "crucial experiment" and being observer-dependent, psychoanalytic practice cannot be expected to demonstrate the validity of its concepts in the way, for instance, the Large Hadron Collider recently confirmed the existence of the Higgs Boson. Our concepts and theories are supported by their potential refutability, their internal coherence, their compatibility with other concepts within existing conceptual clusters, their heuristic value and clinical usefulness. Indirect support can also be provided by their eventual resonance with concepts belonging to the neighbouring social and biological sciences. The task is therefore to identify the concepts and theories that seem to rest on more shaky grounds and submit them to the test of seeing if and how much they meet the above mentioned criteria. In this way, conceptual research constantly "puts to the question" psychoanalytic theory as a whole and may thus ensure its vitality, its closer correspondence to the facts unearthed by psychoanalytic practice and its unique contribution, alongside other disciplines, to the task of understanding the human condition.

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# Psychoanalytic Research in Latin America: Challenges

*By Ricardo Bernardi*

During the last decades there has been in Latin America an increasing interest in research in psychoanalysis and, at the same time, passionate controversies about the validity and usefulness of this kind of research for psychoanalysts. Both the way in which clinicians have become interested in research as well as the objections that have been posed are partly similar to those which took place in other regions but they also present characteristics that respond to the peculiarities of Latin American tradition, which helps to understand the difficulties and crises of the marriage between research and psychoanalysis.

Latin American psychoanalysis is increasingly pluralistic regarding its theoretical and technical orientations (Freudian, Kleinian, Freud-Lacanian, Bionian, Winnicottian, etc.). These diverse approaches coexist in the societies and also in the analysts' minds, in their implicit theories, and in their operative models. Latin America has always been open to external influences from Europe and North America, and local traditions have been strongly influenced by new ideas coming from overseas. These external influences have sometimes led in the history of psychoanalytic ideas to very marked shifts, some kind of "geological" gaps in the dominant theoretical orientations. The theoretical landscape presented marked changes without a clear discussion of the reasons for it. For example, the hegemonic predominance of Kleinian thought in Argentina and Uruguay before 1970, later gave place to a pluralism with an increasing influence of French thought, and especially Lacanian, in the following years up to today (Bernardi, 2002).

The interest in research did not follow this pattern. It has never been a dominant trend; it is shared by analysts with diverse theoretical orientations; and it has been present from the very beginnings of Latin American psychoanalysis. Some pioneers, like José Bleger or David Liberman, have had a keen interest in combining different methodologies to complement classical psychoanalytic inquiry. Liberman started recording patients and analysed the tapes with diverse approaches as early as the 1960s and 1970s. However, this trend did not become widely accepted and in the following decades the mainstream favoured a strongly speculative metapsychological thought. The attempts to complement this kind of thought with empirical research of different kinds were often resisted. These resistances are present in all Latin American region, from Mexico up to Chile. Ramonet, Cuevas, Lartigue, Mendoza and López Garza state that in Mexico, psychoanalysis has on one side to face the scientific community's claim for a more rigorous proof of its effectivity, and, on the other side, the resistance of the analyst to this kind of empirical studies (Ramonet, S., Cuevas, P., Lartigue, T., Mendoza, J., & López Garza, D., 2005).

Sometimes there is an overt aggression towards the ideas that come from the empirical research field, such as the one narrated by Juan Pablo Jiménez in FEPAL Latin American congress, in 1990. When he proposed the complementation of psychoanalytical clinical knowledge with other methodologies and systematic research, he felt surprised by the hostile answer from the audience (Jiménez, J.P., 2008). However, this rejection was not unanimous. Analysts from different parts of Latin America were also interested in the research advances and some societies created research groups. This step towards a wider pluralism, that includes research contributions, was successful in many places and in several psychoanalytical societies there is a sustained interest in discussing diverse kinds of research. The IPA activities during the last decades favourably influenced this direction.

When Horacio Etchegoyen was President, the IPA supported an Argentinian proposal to develop a multicentric study in several countries of Latin America, in order to study process and outcomes of

analyses in progress, with the assistance of Horst Kächele. Although this study had a short life, due to financial difficulties and lack of interest from analysts to participate in it-by answering the questionnaires that were part of the research - it showed that this kind of studies was feasible.

Less ambitious projects were successfully done in different places of the region and, especially, strengthening what Marta Nieto (unpublished) called a “research attitude” of analysts. This attitude leads to focus to the degree of adequacy of theoretical ideas to clinical facts, favouring the suspicion when discrepancies occur. In a similar direction, Juan Pablo Jiménez noted the positive effect of research, not only through its specific contributions, but also in promoting the need of a greater clarification of clinical concepts in relation to the metapsychological assumptions of ideological type (Jiménez, 2007). In the field of clinical research, H. Etchegoyen underlines the role of the testing of interpretation.(Etchegoyen, 2001, 2002). How interpretations changed through time in a given psychoanalytic society was also studied (Bernardi et al., 1997), as well as what kind of evidence leads analysts to change their theoretical and technical models (Bernardi, 2003). There are studies about the characteristics of clinical inference (Leibovich de Duarte, 2010). Papers like the one by Ramonet et al. sought to establish bridges between clinical practice and research (Ramonet et al., 2005). Other research fields were explored, especially regarding child development (Altmann de Litvan, , 2007; Schejtman, et al., 2014); underlying structures of mother-infant interaction at brief psychotherapeutic processes (Altmann de Litvan, 2015); depression (Botto., Acuña & Jiménez, 2014); the efficiency of psychoanalysis and psychotherapy (Mantilla Lagos & Sologuren De La Fuente, 2006); the relation between frequency and analytic process(Altmann et al., 2002).

These examples do not expect to be a systematic revision but only a fragmentary illustration of some papers written in the psychoanalytic research field from different Latin American countries. There is also a variety of papers related to conceptual research and to discussions of epistemological nature about the role of research in psychoanalysis which I do not mention here due to space reasons.

The creation of an exchange net among analysts interested in research in Latin America was strengthened by the activities organized by the IPA Research Committee and the Society for Psychotherapy Research (SPR) in the region. The Research Training Programme (RTP), developed by the IPA Research Committee, chaired by Peter Fonagy, allowed researchers from different countries to share and compare their research projects, to receive counselling from a faculty of experts, and to later keep an exchange among them through an electronic e-mail list ([ipa.researchtraining@lists.uni-ulm.de](mailto:ipa.researchtraining@lists.uni-ulm.de)). It is the opinion of those who participated in this program that the RTP experience left an indelible mark that significantly enriched their vision of research and also of psychoanalysis. This was also helped by the possibility to receive IPA grants for research projects, managed by the research committee. This has been an important incentive for a greater development of research in Latin America.

Another important factor that strengthened the net of analysts interested in research was the creation of the South American Chapter of the Society for Psychotherapy Research, which took place in Mendoza, Argentina, in year 1992, fostered by Horst Kächele and Ken Howard. Juan Pablo Jiménez was the first Latin American Vice-President of the SPR, which helped psychoanalyst researchers to have a fluent dialogue among themselves and with psychotherapists from other approaches. Universities have also a crucial role facilitating research, e.g. through research grants and doctoral theses, but unfortunately the presence of analysts in universities has decreased in the last years.

Comments about psychotherapy research by Guillermo de la Parra, Past President of the SPR, are also valid for psychoanalysis (De la Parra, 2013): “In short, Latin America’s production is slowly growing at an international level, although it is still small in scale” (p. 612). He states that difficulties and weakness of research in Latin America are linked to the lack of research culture, lack of training, scarcity of resources and the little time to devote to research and the need of English translation (p. 618).

Although the number of scientific papers is scarce, the effects of research on psychoanalytic thinking are meaningful and promote new orientations for psychoanalytic thinking. These effects can be seen in the conceptual, clinical and interdisciplinary fields.

Research questions force us to clarify theoretical terms. This, in turn, forwards the discussion of epistemological questions about evidence and truth in psychoanalysis. Sometimes psychoanalytic theories are considered as a priori unquestionable truths. Instead, a research attitude promotes their consideration as alternative hypotheses and underline the need to observe their consequences in the clinical and extra-clinical field. For example, what kind of approach benefits what kind of patients, and how? This kind of questions favour a clinically-guided metapsychological reflection that complements the speculation starting from only theoretical and historical psychoanalytic principles.

We can only expect that a small number of analysts devote a great part of their time to research, which is favoured by their belonging to a university. However, the benefits of the “research attitude” mentioned above are spread to a greater number of analysts’ thinking. It tends to favour psychoanalysis not to enclose in a discourse of demonstrative kind, while assuming certain unchangeable truths, by confronting them at different levels, favouring a reflective, critical thought. Current controversies about research in the different regions shed light on many of these problems in different fields. They allow a better confrontation and debate of theoretical ideas (Bernardi, R., in press). It also stimulates the development of clinical research.

The present interest in Clinical Working Parties and Working groups is a proof of the interest in clinical research. The Clinical Observation Committee, chaired by Marina Altmann, has elaborated a clinical observation model (Three Level Model for Observing Patient Transformations), and many clinical observation groups have applied it to the observation of clinical materials. The 3-LM opens bridges with other kind of research about what benefits do patients obtain from psychoanalysis, and facilitates to study the predictive and clinical validity of clinical judgements comparing them with other assessment methodologies.

Finally, I’d like to remark that research has a key role in the opening of psychoanalysis to the dialogue with other disciplines and with other cultures from our time, thus enabling knowledge triangulation and search of consilience. Current studies in neuropsychology are an example of this crossed fertilisation among different fields.

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## 2. Epistemological and methodological issues on process and outcome research

# Research issues in psychoanalysis

By Peter Fonagy

## Foreword

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.<sup>3</sup> 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 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 20<sup>th</sup> 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 (2001), in his incisive and erudite analysis of epistemology in the 2nd edition of the *ODR*, draws attention to this in his discussion of the advantages and disadvantages of

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<sup>3</sup> 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.

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/or 1992).

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 & Zolse, 1998), the potential for early diagnosis via brain imaging of neurosurgically treatable lesions (Videbeck, 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 (2001). 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 21<sup>st</sup> 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 (2001) 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 (2001) 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, Schefflin, & 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 et al. (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 (2001) 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 20<sup>th</sup> 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 (Rousillon, 1998). 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.

# Methodological considerations in evaluating the outcome of psychoanalysis

*by Peter Fonagy*

## **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 (2001) 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, 1993). 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 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, in press; 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 (1988), 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

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# 3. Description of Studies

Naturalistic studies, pre-post studies, quasi-experimental studies

# Adelphi University: Psychodynamic Psychotherapy Process and Outcome Research Team

Hilsenroth, M. (2007). A programmatic study of short-term psychodynamic psychotherapy: Assessment, process, outcome and training. *Psychotherapy Research, 17*, 31-45.

Hilsenroth, M.J., Cromer, T., & Ackerman, S. (2012). How to make practical use of therapeutic alliance research in your clinical work. In Levy, R. A., Ablon, J. S., & Kächele, H (Eds.). *Psychodynamic Psychotherapy Research: Evidence-Based Practice and Practice-Based Evidence*. (pp. 361-380). New York: Humana Press.

Kuutmann, K., & Hilsenroth, M. (2012), Exploring in-session focus on the patient-therapist relationship: Patient characteristics, process and outcome. *Clinical Psychology & Psychotherapy, 19*, 187-202.

## Goals

The goals of this ongoing treatment program incorporate an evaluation of interrelated issues regarding psychological assessment, psychotherapy process, treatment outcome and clinical training (see Hilsenroth, 2007 for full description).

## 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. The participants utilized in this program are patients admitted for individual psychotherapy at a university-based, community outpatient psychological clinic. Patients are accepted into treatment regardless of disorder or comorbidity and assigned to treatment clinicians in an ecologically valid manner.

## Method

Patient characteristics, psychotherapy process, technique and treatment outcomes are all evaluated from three perspectives including: patient self-report, therapist ratings, and independent raters using videotape. These measures are administered longitudinally: prior to beginning treatment, at different (standardized) points during the treatment, and at the termination of treatment. Treatment consists of once or twice weekly, videotaped sessions of Psychodynamic Psychotherapy.

## Therapists

In this program treatment manuals are utilized for intensive training in technique. However, these manuals are used to aid, inform, and guide the treatment rather than to prescribe it. Thus, therapists are encouraged to provide the interventions in an optimally responsive manner. Advanced graduate students enrolled in an American Psychological Association approved Clinical Psychology Ph.D. program provide therapy in this project. Each therapist receives weekly supervision in both individual and group format that focuses heavily on the review of videotaped case material and technical interventions.

## Evaluation

This research program integrates the rigor of assessment and technique training components of an efficacy model within an effectiveness design to examine clinical processes and outcomes of Psychodynamic psychotherapy from multiple perspectives. Incorporation of these efficacy features in

a naturalistic treatment setting allows for the examination of therapy process that is more generalizable to applied clinical practice.

Additionally, this program is distinctive in that it was one of the first to examine the effects of a psychological assessment process itself on the ensuing treatment. Limitations include the absence of a control group and the use of graduate clinicians as therapists.

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# Changes in symptoms and interpersonal problems during the first 2 years of long-term psychoanalytic psychotherapy and psychoanalysis

Berghout, C. C., Zevalkink, J., Katzko, M. W., & de Jong, J. (2012). Changes in symptoms and interpersonal problems during the first 2 years of long-term psychoanalytic psychotherapy and psychoanalysis. *Psychology and Psychotherapy, 85*(2), 203-219.

## Objectives

Longitudinal measurements can provide important information regarding variations in developmental trajectories of patients in long-term treatment. The present study investigated changes in general symptoms, depression, anxiety, and interpersonal problems during the first 2 years of long-term psychoanalytic psychotherapy (PP) and psychoanalysis (PA). It was expected that interpersonal problems would diminish more slowly compared to symptomatic dysfunction.

## Design

An accelerated longitudinal design with five consecutive measurement points across two cohorts of patients was used.

## Methods

Changes on the Symptom Checklist-90-R (SCL-90-R), Beck Depression Inventory-II (BDI-II), State-Trait Anxiety Inventory (STAI), and Inventory of Interpersonal Problems-64 (IIP-64) were investigated during the first 2 years of long-term PP (n = 73) and PA (n = 40). Linear regression analysis was performed to model the different courses of improvement.

## Results

After 2 years of treatment, patients in both groups still presented moderate to high levels of symptoms and interpersonal problems compared to non-clinical populations. As expected, interpersonal problems changed less rapidly. PP patients changed both with regard to symptomatic and interpersonal problems, whereas the only significant change in the PA group was on one of the symptomatic subscales. Slopes in the PA group and in PP group did not differ significantly from each other, except for the IIP-64 scale intrusive, with PP patients showing significantly more improvement than PA patients. The height of intake values of the outcome variables appeared to predict the speed of symptomatic recovery.

## Conclusions

Symptoms and interpersonal problems did not decrease notably within the first 2 years of psychoanalytic treatment. This is consistent with the idea that significant change takes time for patients with chronic mental disorders and personality pathology. In regular practice, it is advisable to monitor changes routinely in order to identify slow responders more quickly and change the treatment plan, if necessary.

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# The Munich Attachment- and Effectiveness Project (MBWP)

Erhardt, I., Mertens, W., Benecke, C., Zehetleitner, M., & Hörz, S. (2010). Klinische Praxis und formalisierte Diagnostik: Lässt sich der Bericht für den Gutachter mit einem OPD-Rating vergleichen? {Clinical practice and formalized diagnostics: Can one compare both?} *Psychotherapie & Sozialwissenschaft*, 12(1), 79-106.

Hörz, S., Träger, M., Siegl, G., & Mertens, W. (2011). Einsatz der OPD in der Psychotherapieforschung {Implementation of OPD in psychotherapy research}. *Psychotherapie in Psychiatrie, Psychotherapeutischer Medizin und Klinischer Psychologie*, 16, 41-54.

Hörz-Sagstetter, S., Mertens, W., Isphording, S., Buchheim, A., & Taubner, S. (2015). Changes of Reflective Functioning during psychoanalytic psychotherapies. *Journal of the American Psychoanalytic Association*, in press.

Mertens, W. (2009). Ein jedes Leben ist anders - Plädoyer für eine stärkere Feinauflösung in der Psychotherapieforschung {Each life is different - A plea for more fine-tuned psychotherapy research}. In G. Jüttemann (Ed.), *Komparative Kasuistik - Die psychologische Analyse spezifischer Entwicklungsphänomene* (pp. 131-139). Lengerich: Pabst.

## Goals

The Munich Attachment- and Effectiveness Project (MBWP) is a naturalistic prospective psychotherapy study examining process and outcome of psychoanalytic psychotherapies.

## Method

At baseline, the Operationalized Psychodynamic Diagnostics (OPD-2, OPD Taskforce, 2008) were applied. Then, using the Heidelberg Structural Change Scale (HSCS, Rudolf et al. 2000), five therapeutic foci were chosen, reflecting difficulties in relationship patterns (one focus), psychodynamic conflicts (one to three foci) and impairments in personality structure (one to three foci) (e.g. Hörz et al. 2011). For attachment classification the "Adult Attachment Interview" (AAI) and the "Adult Attachment Projective" (AAP) were employed and the "Reflective Functioning Scale" (RF) was applied to the AAI for the assessment of Reflective Functioning. Furthermore, at baseline and at follow-up, a number of self-reports were used: "Gießen-Test", "Narzißmus-Inventar", "Bielefelder Fragebogen zur Klientenerwartung" (BFKE) and "Symptom-Check-List" (SCL-90).

The 20 psychoanalysts recorded several sessions on audiotape at up to five points in time (three to five sessions around baseline, around the 80th session, the 160th session, the 240th session and the 300rd session).

The study was set up following a quasi-experimental design: -half of the psychotherapists (N=10) received an introduction to attachment research applied to the results from their patient's AAI and AAP (two 90 minute sessions per patient, overall 20 sessions). The other ten psychotherapists were introduced to a dream coding method (Moser & Zeppelin, 1996) and spent 20 sessions discussing the application of this method to the initial dreams of their patients and relating these to the psychodynamic impressions emerging from the first therapy sessions. One of our hypotheses examines the question if in the first group this sensitization for questions relating to attachment research could enhance the understanding of separation traumas during treatment and hence lead to a change of the attachment classification.

However, the main focus of this study is on researching microprocesses and interactions (across the mentioned points in time as well as a follow-up assessment one year after treatment). The following instruments were employed: the plan formulation method (PFM) to assess the patient's unconscious therapy goals, his or her pathogenic beliefs, test situations as well as plan compatibility of therapist interventions; the psychotherapy process Q-Sort (PQS) to obtain the most and least characteristic

items regarding patients' behaviors and experiences, therapists' interventions and features of the interaction. In several cases, the Structural Analysis of Social Behavior (SASB), Core Conflictual Relationship Theme (CCRT) or Verbal Elaboration of Affect Scale (GEVA) were employed. We used AAP, AAI, RF, HSCS and self-report measures as outcome measures. The focus of this research project is set on intensive single case studies combining the mentioned process and outcome instruments at various points in time.

A number of research questions emerge from the MBWP. Combining process research, broadened and differentiated using single cases, and outcome findings at different points in time, the following questions regarding process and outcome can be considered relevant:

How good is the concordance between the analysts' descriptions for the peer reports system for psychotherapy and interview ratings based on the Operationalized Psychodynamic Diagnostic System (OPD-2) (Erhardt et al., 2010)? What correspondence between AAI and AAP assessments in this clinical sample can be found (Hörz et al. in prep.)? Which attachment classification can be found in a patient who takes a good course on the HSCS compared to a patient with a poor course on this scale? How does a patient with secure attachment classification (AAI, AAP) change over time in comparison to a patient with insecure attachment classification or unresolved trauma? What influence do analyst's plan compatibility in the sessions have on the treatment outcome? What are the interrelations between PQS findings and therapy outcome? How much do RF and HSCS results correspond? At which point in time do decisive changes in HSCS take place? Can hints for these changes be found in other instruments, e.g. the Narzissmus-Inventar? Can further changes be found between the end of treatment and follow-up assessment?

Another goal of this project is to encourage the discourse about which research methods could be taught in future psychoanalytic training curricula to reduce the gap between scientists and practitioners. Which of the methods are too cumbersome and need too much training, which of the methods can be improved?

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# The Frankfurt-Hamburg Long Term Therapy Study

Brockmann, J., Schlüter, T., & Eckert, J. (2006). Langzeitwirkungen psychoanalytischer und verhaltenstherapeutischer Langzeitpsychotherapien. Eine vergleichende Studie aus der Praxis niedergelassener Psychotherapeuten {Long-term effects of long-term psychoanalytic and long-term behavior therapy. - A comparative study from general practices of psychotherapists}. *Psychotherapeut*, 51, 15–25.

Jakobsen, T., Rudolf, G., Brockmann, J., Eckert, J., Huber, D., Klug, G., . . . Leichsenring, F. (2007). Ergebnisse analytischer Langzeitpsychotherapie bei spezifischen psychischen Störungen: Verbesserungen in der Symptomatik und in interpersonellen Beziehungen {Results of psychoanalytic long-term therapy in specific diagnostic groups: Improvement in symptoms and interpersonal relationships}. *Zeitschrift für Psychosomatische Medizin und Psychotherapie*, 53, 87-110.

Salzer, S., Leibing, E., Jakobsen, T., Rudolf, G., Brockmann, J., Eckert, J., . . . Leichsenring, F. (2010). Patterns of interpersonal problems and their improvement in depressive and anxious patients treated with psychoanalytic therapy. *Bulletin of the Menninger Clinic*, 74(4), 283-300.

## Brief Summary

The prospective study compares 31 patients in long-term behavior therapy (CBT) with 31 patients in long-term psychoanalytic therapy (PA). A naturalistic design was applied within the German health system. All patients underwent a diagnostic interview (SCID) by an external interviewer. Only patients who fulfilled the DSM III-R criteria for a depression or an anxiety disorder were included in the study. Although the diagnosis of the patients undergoing long-term CBT and long-term PA were comparable, we found that they differed in various ways. (We did not randomise the patients.)

The differences arose in a number of characteristics. PA-patients were higher educated, use less psychotropic medication and had a lower strain of symptoms (SCL-90-R GSI: PA= 0.9 vs. BT=1.5. PA-patients also differed in the access to psychotherapy. They introduced themselves more to therapy (vs. recommended by professionals). The average duration of long-term CBT was 2.4 years and 64 sessions. The average duration of long-term PA was 3.6 years and 209 sessions. Symptoms (SCL-90-R) and interpersonal problems (IIP) were examined at the beginning, after 1 year, 2.5 years and 3.5 years and after 7 years.

Both groups showed significant degrees of improvement within the first 3.5 years and remained stabilized in the following 3.5 years regarding the symptomatic aspects. Focussing on the interpersonal problems, group PA showed further improvement after the 3.5 years period. The CBT group however couldn't show any further improvement after 3.5 years but they stabilized.

After 3.5 years B -patients had a symptom strain GSI = 0.8 (SCL-90-R) with nearly the same results after 7 years. In other words: CBT patients ended up with a symptom strain with which PA-patients started therapy.

Consume of psychotropic medication was different after 7 years (11% of the PA-patients and 23% of the CBT patients). CBT patients had seen the continuing medication not as a failure of therapy.

Relapses (defined as statistic significant changes at 3.5 years that did not longer exist after 7 years) were low (both 19%) compared to short time therapy relapse rates for patients with depression.

31% of the PA patients and 12 % of the CBT patients have looked for further therapy. The difference between the groups is significant. We did not ask for the reasons why and what kind of therapy they had chosen.

Data of the study were used in other studies (Salzer et al. 2010, Jakobsen et al. 2007)

## **Conclusions**

These results point out why comparison studies concerning the matter of therapy using parallelized samples cannot always match up to reality.

Most patients did profit from therapy and felt satisfied by the therapy, but the profit was different.

Different people choose or are recommended by professionals to different treatments. Treatment theory matters (Fonagy & Allison 2014).

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# The Heidelberg Berlin Study: Psychodynamic change in two forms of long term psychoanalytic therapy

Grande, T., Dilg, R., Jakobsen, Th., Keller, W., Krawietz, B., Langer, M., Oberbracht, C., Stehle, S., Stennes, M., & Rudolf, G. (2006): Differential effects of two forms of psychoanalytic therapy: Results of the Heidelberg-Berlin Study. *Psychotherapy Research* 16, 470-485

Grande, T., Dilg, R., Jakobsen, Th., Keller, W., Krawietz, B., Langer, M., Oberbracht, C., Stehle, S., Stennes, M., & Rudolf, G. (2009): Structural change as a predictor of long-term follow-up outcome. *Psychotherapy Research*, 19, 344-357.

Leising, D., Rudolf, G., Stadler, K., Jakobsen, Th., Oberbracht, C., & Grande, T. (2003): Do interpersonal behavior and emotional experience change in the course of successful longterm psychoanalytic therapies? *Psychotherapy Research* 13, 461-474.

Rudolf, G., Grande, T., & Oberbracht, C. (2000). Die Heidelberger Umstrukturierungsskala. Ein Modell der Veränderung in psychoanalytischen Therapien und seine Operationalisierung in einer Schätzskala {The Heidelberg Structural Change Scale. A model of change in psychoanalytic therapies and its operationalisation in a rating scale}. *Psychotherapeut*, 45, 237-246.

In this multicenter study process and outcome of two forms of long-term therapies (psychoanalytic and psychodynamic) have been studied. There were three main points of interest: to describe the clinical outcome of psychoanalytic long term therapies; studying psychodynamic nature of change in longer and shorter therapies; identifying predictors for follow-up developments.

Patients have been assigned and treated by experienced psychoanalytic practitioners and have been interviewed and videotaped by members of the study group. Clinical, social and psychodynamic data (rated in the OPD system) were collected by therapists, the study group and patients self reports every three months, respectively six months during the long term therapy and follow-up one and three years after. Those groups were matched in social demographic data and clinical severity.

## Results

No difference in global outcome rates between longer psychoanalytic and shorter psychodynamic therapies was found, but the level of structural psychodynamic change (as measured by the Heidelberg Structural Change Scale (HSC) (see Rudolf, 2000) was higher in longer therapies. Structural change at the end of therapy was the best predictor for longterm follow-up development of the patients. The HSC was found to be especially useful for psychodynamic training and quality assessment.

## Evaluation

The main interest was to evaluate longer and shorter psychoanalytic therapies under naturalistic conditions. In the videotaped interviews the change of focal psychodynamic aspects (“structural change”) were rated by blind raters. Thus the perspective of patients self reports, therapist ratings and the ratings of the independent study group could be compared. For some questions data of this study have been put together with other German studies run in this time (see Jacobsen et al. 2007).

In consequence of the fact that initial level of patients structural integration (due to OPD) correlated with therapy outcome in the following years we developed a modified psychodynamic therapy for patients with low structural level (Rudolf 2004, 2006, 2013).

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## Stuttgart TRANS-OP study

The Puschner, B., Kraft, S., & Bauer, S. (2004). Interpersonal problems and outcome in outpatient psychotherapy: Findings from a long-term longitudinal study in Germany. *Journal of Personality Assessment*, 83(3), 223-234.

Puschner, B., Kraft, S., Kächele, H., & Kordy, H. (2007). Course of improvement during two years in psychoanalytic and psychodynamic outpatient psychotherapy. *Psychology and Psychotherapy*, 80, 51-68.

Puschner, B., Wolf, M., & Bauer, S. F. (2008). Helping alliance and outcome in psychotherapy: What predicts what in routine outpatient treatment? *Psychotherapy Research*, 18(2), 167-178.

### Objective

To assess and predict level and course of symptomatic improvement in psychoanalytic (PA) and psychodynamic psychotherapy (PD).

### Material and Methods

In a comprehensive longitudinal study, course of improvement of 116 patients in PA and of 357 patients PD was tracked over a period of two years and analyzed via hierarchical linear models.

### Results

At baseline, over 90% of the patients reported considerable psychological, physical, or interpersonal distress. In both forms of treatment, course of improvement was best fitted by a linear model as compared to a logarithmic one. Symptom distress decreased notably within two years, with an especially sharp decline already before the beginning of treatment. No significant differences between forms of treatment as to level or pace of symptom improvement could be observed. Prediction of speed of improvement was poor, with initial symptom distress showing the strongest influence, while initial helping alliance had no predictive value. When comparing patients who finished their treatment within the two-year observation period to those with still ongoing treatments, the former showed quicker symptom improvement.

### Discussion

Implications for psychotherapy provision are pertinent for issues of allocation of resources.

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# Implementing panic-focused psychodynamic psychotherapy into clinical practice.

Beutel, M., Scheurich, V., Knebel, A., Michal, M., Wiltink, J., Graf-Morgenstern, M., . . . Subic-Wrana, C. (2013). Implementing panic-focused psychodynamic psychotherapy into clinical practice. *Canadian Journal of Psychiatry*, 58(6), 326-334.

## Objective

To determine the effectiveness of manualized panic-focused psychodynamic psychotherapy (PFPP) in routine care in Germany.

## Method

German psychoanalysts were trained according to the PFPP manual. Fifty-four consecutive outpatients with panic disorder (with or without agoraphobia) were randomly assigned in a 2:1 ratio to PFPP or cognitive-behavioural therapy (CBT) plus exposure therapy. Subjects (female 57.4%; mean age 36.2 years) had high rates of psychiatric (68.5%) and somatic (64.8%) comorbidity, and previous psychiatric treatments (57.4%). Assessments were performed pre- and posttreatment and at 6-month follow-up. The primary outcome measure was the Panic Disorder Severity Scale.

## Results

Both treatments were highly effective. In patients randomized to PFPP, remission was achieved in 44.4% at termination and by 50% at follow-up (CBT 61.1% and 55.6%, respectively). No significant differences were found. Emotional awareness, a posited moderator of good outcome in psychotherapies, was significantly higher in the CBT group at baseline. It was found to be a strong moderator of treatment effectiveness in both treatments. After adjusting for initial Levels of Emotional Awareness Scale (LEAS) scores, effect sizes (ESs) for the primary outcome were Cohen  $d = 1.28$ , from pre- to posttreatment, and  $d = 1.03$ , from pretreatment to follow-up, for PFPP, and  $d = 1.81$  and  $1.28$  for CBT, respectively.

## Conclusions

PFPP was implemented effectively into clinical practice by psychoanalysts in the community in a sample with severe mental illness with large ESs. Assessment of LEAS may facilitate the identification of patients suitable for short-term psychotherapy. (Clinical Trial Registration Number: German Clinical Trials Register, DRKS00000245; Universal Trial Number, U1111-1112-4245).

## Contact

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# Milan study on facilitated psychoanalytic treatment for adults in collaboration with mental health services

Link: IPA Research Database: <http://www.ipa.org.uk>

## Objectives

The Research project, granted by IPA, was planned by the Study Group for the Adult Facilitated Clinical Service of the Center of Psychoanalysis of Milan, composed of twenty analysts, where treatments are carried out in collaboration with Mental Health Services to favorable economic conditions, with the aim to investigate the subjective changes in patients and the transference-countertransference dynamics, which is recognized to be essential for successful treatment. A main objective is to see whether the economic variables and provenance from public services have an impact on the therapeutic relationship and to verify the potential of the psychoanalytic approach in treatment of severe psychological distress enhancing collaboration with Mental Health Services, taking into account the current socio-economic difficulties. Research questions are: 1. if and to what extent the variables 'money' and 'coming from public services' may influence the therapeutic relationship; 2. which variables are significant; 3. whether psychoanalytic approach can be a valuable instrument enabling severe patients in specific conditions to acquire more appropriate relational and representational capacity, and to improve emotional balance.

## Sample

We have planned to apply the survey on a sample of 20 subjects minimum, selected through contact with mental health services and treated in facilitated psychoanalytic care, comparing them with a control group of equal number of patients treated under the same therapeutic conditions, except for the economic ones. Frequency and setting are kept the same in both groups; the focus is on the evolution of the patient-analyst relationship.

## Instruments

Three tools were chosen for the survey: 1) a form aimed to collect information at the beginning of therapy on objective and subjective data relating to patient (a special tab to collect initial data and Core-OM); 2) administration of OPD (Operationalized Psychodynamic Diagnosis), SCL-90-R (Symptoms Check List- 90-Revised) and the Feeling Word Checklist – 58, to obtain psychodynamic and relational data from patient and analyst; 3) a form for the collection of dreams at beginning and during therapy, according to pre-established steps, to identify the representational ways of the subject.

## Current state of research

The development of the study required a first step of preparation, in which have been analyzed in depth the objectives and research instruments, and addressed difficulties related to the carrying out of research in clinical psychoanalysis, achieving the homogeneity of the group; were established the procedures and instruments for conducting the survey, and for selection of patients. A dedicated team was set up in collaboration with the University of Milan, Bicocca, to deal with the research development and to monitor the implementation of the study, according to ethical and clinical issues. Therapists who endorsed the research have been trained in OPD applications and to other instruments' usage. Collection of cases and their monitoring are currently underway.

## **Evaluation**

Since the research is still in progress, we can not produce at the time reliable evaluations on results; however, the preparation and launching of the project have raised interesting issues on conducting research in psychoanalytic without interfering with the natural course of care and the achievement of its objectives. During the research will try to answer these questions.

## **Contact**

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# The DPV Follow-Up Study

Leuzinger-Bohleber, M., Rüger, B., Stuhr, U., & Beutel, M. (2002). "Forschung und Heilen" in der Psychoanalyse. Ergebnisse und Berichte aus Forschung und Praxis {"Research and Healing" in Psychoanalysis. Results and Reports from Research and Practice}. Stuttgart: Kohlhammer.

Leuzinger-Bohleber, M.; Stuhr, U.; Rüger, B., & Beutel, M. (2003): How to study the 'quality of psychoanalytic treatments' and their long-term effects on patient's well-being. A representative, multi-perspective follow-up study. *International Journal of Psychoanalysis*, 84, 263-290

## Brief Summary

In the so-called "DPV Katamnesestudie" [Outcome study of psychoanalyses and psychoanalytic psychotherapies of the German Psychoanalytic Association], we investigated a representative sample of all the patients who had terminated their psychoanalyses and psychoanalytic long-term psychotherapies with members of the DPV between 1990 and 1993 ( $n = 402$  patients). We applied a large variety of different instruments, questionnaires, psychological tests, analyses of "objective data" from the health insurance companies, and intensive psychoanalytic follow-up interviews. The study led to important results: for example, around 80% of all the treatments showed—on average six years after termination—a good outcome according to the evaluations of the former patients, their analysts, independent analysts, and nonanalysts, as well as "objective information" concerning mental health data (significant reduction of costs by a significant reduction of days off work, days spent in hospitals, etc.; see Leuzinger-Bohleber, Rüger, Stuhr, & Beutel, 2002, 2003).

But the most important, often unexpected insights were gained through the 200 intensive, psychoanalytic follow-up interviews with the former patients and with their former psychoanalysts by independent psychoanalytic interviewers. The interviews were mostly tape-recorded or, if patient or analyst did not consent, carefully documented directly after the interview. This documentation proved to be a unique and rich source for psychoanalytic and non-psychoanalytic insights (particularly concerning the tragic findings of the 4% of the psychoanalyses with negative outcomes). The richness of the interview material confronted us with the methodological challenge of how to summarise and communicate the complexity of the conscious and unconscious discoveries of these interviews in a critical way that would be transparent, reliable, and acceptable by members of the psychoanalytic, as well as the non-psychoanalytic, community. In this context, we developed the so-called *psychoanalytic expert validation*, which proved to be a very helpful and convincing method to summarise the psychoanalytic findings of the follow-up interviews (see ODR: Psychoanalytical Expert Validation).

To mention just one of the unexpected findings: 62% of all the interviewed patients had been severely traumatized children of World War II. Treating children of the perpetrators and the „normal“ German population had been a taboo in Germany for a long time. The unexpected findings of the DPV Outcome Study evoked a broad discussion of this topic within and outside the psychoanalytical community (see e.g. publications by Hartmut Radebold and his team)

## Evaluation

The DPV Outcome Study was the first study investigating the outcomes of psychoanalyses and psychoanalytical therapies by the members of a large psychoanalytical society. Therefore - at the time of the conceptualization of the study -, only a retrospective design was accepted by the clinicians. Many of them feared that a prospective study could have negative influences on the psychoanalytical process. –

Because the study was discussed in each assembly of the membership (in all the annual conferences) it evoked interesting and challenging methodological and epistemological controversies in the DPV. This led to the positive result that many of the analysts became very much interested in empirical research. This is one reason why many of them were now willing to engage in a prospective, randomized outcome study, the *LAC Depression Study* (starting in 2005). (see summary in this volume)

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# Patterns of inner change and their relation with patient characteristics and outcome in a psychoanalytic hospitalization-based treatment for personality disordered patients

Vermote, R., Lowyck, B., Luyten, P., Verhaest, Y., Vertommen, H., Vandeneede, B., Corveleyn, J., & Peuskens, J. (2011). Patterns of inner change and their relation with patient characteristics and outcome in a psychoanalytic hospitalization-based treatment for personality disordered patients. *Clinical Psychology and Psychotherapy*, 18 (4), 303-13.

Blatt, S. J. (2004). *Experience of Depression: Theoretical, Clinical and Research Perspectives*. Washington, DC: American Psychological Association.

Blatt, S. J. (2008). *Polarities of Experiences: Relatedness and Self-Definition in Personality Development, Psychopathology and the Therapeutic Process*. Washington, DC: American Psychological Association.

## Brief Summary

The efficacy and effectiveness of psychodynamic treatments for personality disorders (PDs), and for borderline patients in particular, have been demonstrated in a number of randomized controlled trials as well as in naturalistic pre–post studies. In particular, these treatments have been shown to lead to clinically significant improvements in symptom levels, interpersonal functioning and global adjustment. Yet, the fundamental premise of psychoanalytic theories of PD is that besides improvement in symptoms, long-term psychodynamic treatment also results in changes in personality structure or organization. The concept of personality organization (PO) refers to the underlying organization of structural–dynamic components of personality and has been operationalized from different theoretical perspectives in terms of (a) the developmental level of representations of self and others; (b) the capacity for reality testing and maturity of defenses; (c) the background of safety or ‘felt security’; as well as, more recently, (d) the capacity for mentalization operationalized both in terms of reflective functioning and the Bion-Grid Scale. Although changes in PO are supposed to constitute a core mechanism of change in psychodynamic treatment for PD, today only a handful of studies have empirically investigated this assumption.

Based on this, the first aim of this study was to replicate and extend existing research in this area by simultaneously assessing changes in PO using four different measures reflecting different aspects of PO, namely (a) the developmental level of representations of self and others as measured with the DR-S; (b) mentalization as assessed by the Reflective Functioning Scale (RFS) and the GRID; and finally, (c) levels of felt safety as measured with the Felt Safety Scale (FSS). All scales are scored on the Object Relations Inventory (ORI). The second aim of this study was to investigate whether the 44 patients in a psychoanalytic hospitalization-based treatment for PD show different trajectories of change in PO and whether these different trajectories were associated with different pre-treatment characteristics. In particular, several studies have provided considerable evidence suggesting that anaclitic and introjective personality features (Blatt, 2004) are associated not only with different responses to treatments but also with different changes in terms of PO. In this context, Blatt (2004, 2008) has proposed that anaclitic patients are characterized by a distorted preoccupation with relationship issues, such as trust and intimacy, at the expense of self-development, as for instance expressed in dependent, histrionic and borderline personality features. Introjective patients are primarily preoccupied with intense and distorted attempts at establishing and maintaining a sense of self, including feelings of autonomy, self-control and self-worth, at the expense of developing interpersonal relationships, as in schizoid, schizotypic, paranoid, narcissistic, antisocial, avoidant, self-defeating and obsessive–compulsive PDs and features.

The last aim of this study was to investigate whether different clusters of patients were differentially related to outcome. Indeed, some studies have suggested that patients with PDs not only show different trajectories of change during treatment, but that these different trajectories are also associated with different outcomes. For instance, that introjective patients changed primarily in higher levels of thought disorder, whereas anaclitic patients changed more in the more pathological forms of thought disorder. To the best of our knowledge, this is the first study to directly investigate possible associations between different trajectories of change and outcome in the psychoanalytic treatment of PDs.

In line with findings of earlier studies, the results of this study showed that the psychoanalytic hospitalization-based treatment for PDs is indeed associated with changes in different aspects of PO, including representations of self and others, mentalization and felt safety. In addition, this study extends previous studies in that two different clusters of patients could be identified, which showed a distinct pattern of change in PO during and after treatment. On one hand, one cluster consisted of patients who showed a more fluctuating and thus less stable pattern of changes in PO during treatment and at follow-up. The other cluster consisted of patients showing more consistent improvement in PO both during and after treatment. Importantly, further analyses showed that these two clusters showed substantial differences in terms of pre-treatment personality features as assessed by the SCID-II. More specifically, results showed that the more fluctuating cluster seemed to be mainly characterized by anaclitic features as described by Blatt (2004, 2008), as was shown in higher scores on dependent, borderline, avoidant and depressive characteristics compared with patients from the stable cluster. Patients from the more stable cluster, in turn, tended to have higher scores on SCID-II narcissistic PD features, which is in line with Blatt's suggestion that higher level personality disordered patients with introjective features are mainly characterized by narcissistic characteristics (Blatt, 2004, 2008).

## Evaluation

This study including a longitudinal, multi-wave design as well as multi-trait, multi-method approach lends further support to the assumption that psychoanalytic hospitalization-based treatment of PD is associated with changes in PO. Finally, results of this study also suggest that different types of patients may differentially respond to different treatment factors, adding to the growing evidence for the importance of considering patient–treatment interactions in psycho-therapy research towards PO.

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# Naturalistic outcomes of evidence-based therapies for borderline personality disorder at a university clinic: A quasi randomized trial

Gregory, R.J., Chlebowski, S., Kang, D., Remen, A.L., Soderberg, M.G., Stepkovich J., & Virk, S. (2008): A controlled trial of psychodynamic psychotherapy for co-occurring borderline personality disorder and alcohol use disorder. *Psychotherapy: Theory, Research, Practice, Training*, 45, 28-41.

Gregory, R.J., Delucia-Deranja, E. & Mogle, J.A. (2010): Dynamic deconstructive psychotherapy versus optimized community care for borderline personality disorder and alcohol use disorders: 30-month follow-up. *Journal of Nervous and Mental Disease*, 198, 292-298.

## Brief Summary

Both Dialectical Behavior Therapy (DBT) and Dynamic Deconstructive Psychotherapy (DDP) are listed in the National Registry of Evidence-based Programs and Practices based on independent reviews of their performance in randomized controlled trials for borderline personality disorder. However, little is known about their effectiveness in real-world settings. DDP is a newer treatment with demonstrated efficacy, but has been less extensively applied than DBT. In a twelve month-controlled trial, thirty subjects with Borderline Personality Disorder (BPD) and co-occurring active alcohol use disorders were randomized to either DDP or optimized community care. Almost half the subjects also met criteria for antisocial personality disorder (Gregory et al. 2008). Following twelve-months of active treatment with DDP, they were then evaluated after an additional eighteen months of naturalistic care in the community. As applied in treating this low-functioning and highly comorbid BPD population, DDP demonstrated relatively good retention rates and large between-group treatment effects for core symptoms of BPD, depression, parasuicide behavior, alcohol misuse, recreational drug use, inpatient care, and perceived social support (Gregory, Delucia-Deranja, and Mogle, 2010). Although both, DDP and DBT activate autobiographical memory by reviewing specific emotionally charged incidents and behaviors, the therapist stance differs substantially. Whereas the DDP therapist tries to be nondirective and exploratory, thereby supporting individuation, the DBT therapist tries to be validating, directive, educative and pragmatic.

The present study attempts to fill a gap in the literature by using a quasi-randomized design comparing naturalistic twelve-month outcomes of two manual-based treatments for BPD-DBT and DDP-in the real-world setting of a university clinic. A third group of patients, treated with unstructured eclectic individual psychotherapy, served as a control. This study is the first to compare two manual-based treatments for BPD in a real-world setting.

## Evaluation

Clients receiving DDP or comprehensive DBT demonstrated significant improvement in symptoms of BPD over time in the intent-to-treat sample, but those receiving TAU did not. Moreover, both of the manual-based treatments achieved significantly greater improvement in symptoms of depression and disability than was found in those receiving TAU. Symptoms of BPD, as assessed by the BEST, improved to a significantly greater degree for clients treated with DDP as compared to DBT demonstrated significantly greater improvement in depressive symptoms, disability and non-suicidal self-injury than DBT.

A possible explanation for the differences in outcome between DDP and DBT is that CEBI is a specialized tertiary care program that attracts a particularly refractory and comorbid subgroup of BPD clients who have not been preselected for willingness to participate in a research study. In the treatment of severely impaired BPD clients with active co-occurring alcohol use disorders, DDP has demonstrated strongly positive outcomes and relatively good retention (Gregory et al. 2008).

Both DBT and DDP can be effective for borderline personality disorder in the real-world setting of a tertiary care clinic. However, DDP may lead to greater improvement in symptoms and functioning than DBT in this setting.

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# Prediction of medium-term outcome in Cluster B personality disorder following residential and outpatient psychosocial treatment

## Summary

There is a paucity of research concerning the identification of individual characteristics predictive of outcome in the treatment of personality disorders as there are only a handful of reports that have attempted to identify patients' clinical characteristics predictive of treatment outcome.

In this study, we carried out a predictor analysis of a relative homogeneous group of hospitalized patients (n=73) with a standardized diagnosis of cluster b personality disorder (borderline, histrionic and narcissistic), and we attempted to locate the presence of significant predictive factors that influenced positive and negative medium-term outcome. These patients were admitted to two different psychoanalytically-oriented psychosocial programs for personality disorder: (a) long-term inpatient treatment, and (b) a step-down program. Because of the high co-morbidity of diagnosis in the sample, we also set out to evaluate whether specific combinations of diagnostic categories within Axis-I and Axis-II were significantly associated with outcome 24-month after intake in the dimensions of severity of symptoms presentation (SCL-90-R-GSI), social adjustment (SAS) and global assessment of functioning (GAS). In addition, we explored predictors of outcome specific to each treatment in order to refine clinical recommendations for selection for specific programs.

The stepwise logistic regression analysis with improvement status as the dependent variable revealed that the model including self-mutilation the year prior to intake, avoidant PD, intake GAS scores, age at intake and length of treatment was predictive of improvement at 24 months. Cluster B patients with no previous self-mutilation, who did not have a co-morbid avoidant PD, with higher GAS intake scores, longer treatment exposure and younger age were more likely to improve. Absence of self-mutilation and co-morbid avoidant PD improved 6 and 4 folds the chances to achieve positive outcome, respectively. Six years below the mean age of 30 years, 31 weeks more treatment from the mean of 53 weeks and 6.5 points above the GAS mean score of 46.5 double the chances of improvement two years after treatment intake. Although deliberate self-injury was found to be a negative predictor, improvement rates in self-mutilating patients were significantly different in the two different treatment programs (60% in the step-down program versus 24% in the long-term residential program). A cluster analysis on Axis-I diagnoses identified a larger group whose primary Axis-I diagnosis was major depression and a smaller more heterogeneous group with anxiety or substance misuse diagnoses. No association with improved status at 24 months was found.

Of the two homogeneous clusters of co-morbid personality disorder diagnoses the large borderline and self-defeating group had achieved significantly greater level of improvement compared to the smaller borderline, avoidant, paranoid, dependent cluster. The difference in outcome between the two PD diagnostic clusters appears to be accounted for by a differential treatment response in program allocation: whereas almost 90% of B-SF patients allocated to the step-down model improved, only 52% of those allocated to the long-term residential program did so. There was no similar difference between the improvement rates in the two treatment arms for the B-P-A-D cluster. Thus, it seems that therapeutic advantage came especially from the step-down treatment of the self-defeating borderline group of patients.

## Discussion

The findings may carry potential clinical implications concerning patient selection and treatment delivery for inpatient and outpatient psychosocial programs for Cluster B personality disorder.

Limitations include a relatively low sample size for a regression analysis, and a larger sample of Cluster B patients may be needed to ensure greater reliability of results.

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# Factors affecting change in private psychotherapy patients of senior psychoanalysts: An effectiveness study

Erle, J. B., & Goldberg, D. A. (2003). The course of 253 analyses from selection to outcome. *Journal of the American Psychoanalytic Association, 51*, 257-292.

Friedman, R. C., & Downey, J. I. (2002). *Sexual Orientation and Psychoanalysis: Sexual Science and Clinical Practice*. New York: Columbia University Press.

## Brief Summary

There is a need for studies that provide systematic data concerning the complexity of psychodynamic psychotherapy as actually practiced in the community (Nathan, Stuart, & Dolan, 2000; Erle & Goldberg, 2003). The present report begins to address this need. The report covers data for private patients of experienced psychoanalytic practitioners; these patients present with a wide range of psychiatric symptoms and disorders, including multiple disorders. We also compare patients who received psychopharmacological treatment concurrently with psychotherapy with those receiving psychotherapy alone. The fact that all of the therapists who provided data were physicians is relevant here because they could conveniently prescribe medication as clinical judgment dictated without being concerned about splitting the treatment. A structured interview was constructed and administered to 51 psychoanalytic physician respondents by graduate students and research assistants under supervision. Each of 51 experienced psychiatrist/psychoanalysts was queried about the clinical characteristics of every private psychotherapy patient presently in treatment: 551 patients were included in the study; 88% of patients had an Axis I disorder, 59% had Axis I and Axis II disorders concurrently, and 11% Axis II only. Of these patients, 44% had been prescribed psychotropic medication on a daily basis for at least two weeks during the present treatment. Patients treated for the longest time (five years or more) were the most seriously psychiatrically disturbed. Patients improved with psychotherapy, and the improvement was related to the duration of treatment. The combined impact of diagnosis status, treatment duration, and treatment modalities provided a consistent pattern of treatment effectiveness.

## Evaluation

There have been no previous investigations of the clinical characteristics of patients treated by experienced psychiatrist-psychoanalysts with various types of dynamic psychotherapy, in treatments of varying durations. In fact, there has been no previous demonstration that collection of data from such a group is feasible. Much psychotherapy research is split off from psychotherapeutic practice as it is actually carried out in the community. Hence, therapists often view research as useful in the abstract, but not particularly relevant to their vocational lives or their identities as psychotherapists. For example, controlled, manual—based psychotherapy research is admittedly of great importance for treatment development and evaluation, and specialized clinics at major treatment centers offer treatment based on such manuals. Nonetheless, most psychotherapy is not offered in such settings, and the proportion of psychotherapists throughout the world who offer treatment based on manuals is negligible. In our design, we were guided by a need for clinical relevance; our study is aimed at the clinical judgments of practitioners across the full range of their patients. What we have tried to provide here is a cross—sectional snapshot of the private practices of senior, analytically trained psychiatrists, the patients, the treatments, and the treatment effects.

This investigation was labor—intensive. Psychoanalysts who provided data about their patients were willing to spend much time with our graduate student interviewers and participated with enthusiasm. Our study indicates that the general body of knowledge and beliefs termed “psychoanalytic,” particularly as represented in treatments characterized as “uncovering,” appears to be therapeutically

helpful to patients engaged in ongoing treatment, including patients who present with severe symptoms. We made no effort to ascertain the beliefs by therapists about the reasons for therapeutic progress, and we did not attempt to study specific therapeutic interventions. Precisely what the underlying assumptions that guided these treatments were remains to be examined in future research. Ideas that were once universally accepted, such as the central role of the Oedipus complex in development and psychopathology, (Friedman & Downey, 2002), and the role of transference in psychoanalytic treatment (Schachter, 2002), have been the subject of recent criticism. Debates between psychoanalysts of different schools (e.g., drive— conflict theory vs. object relations or self psychology) and different perspectives (e.g., one person vs. two—person psychologies) continue unabated. Our impression was that such debates were peripheral to the therapeutic work carried out by the clinicians who participated in this study.

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## From selection to outcome

Erle, J.B., Goldberg, D.A. (2003). The course of 253 analyses from selection to outcome. *Journal of the American Psychoanalytic Association*, 51, 257-292.

This paper presents two studies of the clinical work of experienced psychoanalysts, all of them trained at, and members of, the New York Psychoanalytic Institute. Study I is a retrospective study of all of the analytic work of sixteen analysts from 1973 to 1977 (161 patients), including their evaluations of the treatments. Study II is a prospective study of all the patients started in analysis by a group of twenty analysts between 1984 and 1989 (ninety-two patients) and followed to termination, again including evaluative reports. The participating analysts were not chosen as a representative group; we invited those we thought shared our interest in such a study. Similarly, the patients were not intended to be representative: they were the patients these analysts saw in analysis during the study periods, except those omitted for reasons of confidentiality. The analysts shared the view that analysis had been a beneficial treatment for many patients; each had had experience with patients where an analytic process did not develop.

In both studies, participating analysts reported their assessment of their patients' analyzability at the initial evaluation. These assessments were reviewed, and sometimes revised, in the subsequent periodic reports and at termination. Where an analytic process did not develop, the rating "unanalyzable" was used; in those cases, treatment was interrupted or continued as psychotherapy. We did not attempt to investigate the question of whether work with another analyst might have had a different outcome, either with patients where an analytic process did develop or where it did not. There were reports of patients with histories of apparently unsuccessful analytic treatment who were thought to be analyzable in this treatment.

The rating used here reports only the analyst's view of the outcome of this treatment; that is, the patient is designated analyzable or unanalyzable by this analyst in this treatment at this time. There are a number of factors that could produce different outcomes, such as the influence of a different theoretical position on technique or the impact of a different analyst. Kantrowitz (1995) has drawn attention to the issue of "match," which she suggests may be crucial to the success or failure of some analytic treatments.

## Contact

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Daniel A. Goldberg is on the faculty of the New York Psychoanalytic Institute. The authors want to express their gratitude for the generous and thoughtful participation of the twenty-four analysts who made this study possible.

# Change variables in the psychoanalytic treatment of children and adolescents: A research report

## Project

This empirical study was designed to investigate the effectiveness and the variables of change in psychoanalytic treatment of children and adolescents. The survey was conducted collecting information from therapists with regard to a defined number of cases on the development of treatment, and the changes observed. The basic hypothesis was that the change, to be effective, must address the aspects of functioning, the relational (Fonagy, 2002), and the organization of the inner world, as follows from the thought of Sandler (1994). Consequently, were used for the survey questionnaires aimed to collect information about the phenomenal aspects, the relational, the expressions of the inner world, then crossing them. We expected significant results from research as to the therapeutic process and associated variables.

The research described is the first stage of a larger project aimed to investigate also the point of view of young patients. The project, funded by the RAB of IPA, was launched in 2006, after discussion in London at 2005 RTP of IPA. Partial presentation of the results, concerning a comparison between cases concluded and discontinued (drop-outs), took place in Rome, 2008, at ISAPP Conference "*New Frontiers of the clinical Research in Adolescence*", organized by M. Ammaniti, under the title *Variables of change in the therapeutic process of children and adolescents*, published in the Conference Proceedings. Additional articles are under completion.

## Sample

The research was carried out by asking each of the therapists to answer extensively about a given number of cases, some ongoing, some who had completed therapy, some who had discontinued. Questionnaires were administrated to 125 experienced child psychoanalysts and psychodynamic psychotherapists belonging to Italian Psychoanalytic Society and to accredited Schools in different parts of the country. 24 valid questionnaires were returned, with an average of 19,2%. Overall responses covered 165 treated cases (average 6.79 cases for each psychoanalyst), 87 males and 78 females, distributed in three age groups (0-6, 7-12, 13-18). Of the 165 cases on which we have been answered, 63 cases were completed, 52 still in progress, 50 discontinued; 33 cases had started treatment in early childhood, 60 latency, 67 adolescence, 5 missing.

## Treatment

Treatments where therapists were asked to express were conducted with the psychoanalytic method, based on a proper setting and timing, performed by playing, drawings, dreams, in addition to the verbal expression. The duration of the cases discontinued had to be at least six months. No specific forms of pathology were selected for the survey, all forms of distress were included. During the processing of the data, we grouped the pathological forms into six groups relying on the severity and the quality of functioning of the subject.

## Measures

Questionnaires were aimed at highlighting the methodology, the process and the outcomes. We started from the assumption that the quality of development and consequently therapeutic transformation are involving the following areas: the modes of functioning, the quality of the inner world and the characteristics of the relationship or relationality; accordingly, we have formulated

questionnaires and asked therapists to express themselves on these areas at different stages of treatment, through multiple choice questions, Likert scales on 4-point and open-ended questions, the latter related to dreams, fantasies and typical ways of behavior (considered an expression of the inner world, Sandler 1994, and of the internal working models, Jones 1997, 2000). When analyzing the unconscious material, the focus was on the relational factor and its level of development. Several findings have emerged; the results of some Likert scales relating to cases concluded and discontinued, where the conclusion was considered one of the indices of therapeutic success, in addition to the quality of the transformations and the functioning characteristics, were cross-validated through comparison with the content of responses to open-ended questions, coded by three independent judges, (Cohen's  $K > .7$ ).

## Results

By the comments provided by the clinicians:

a significant finding concerns the fact that the identified variables have a parallel development, concordant in cases concluded, erratic in drop-outs;

as to the variables, have an influence on the outcome all the processes of acquisition of self-awareness, development of thought and mentalizing, the acquisition of a sense of trust and safety, knowledge and ability to express their own needs, acceptance of the other, the processing of traumatic factors; all the differences between cases concluded and discontinued are statistically significant at the Chi square test with  $p < 0.003$ ;

a cross-comparison with the content of responses to open-ended questions about dreams, fantasies and functioning characteristics (aimed at assessing the acquisition of 'internal' relatedness) confirmed the results obtained;

the quality of the relationship is crucial to the development of the therapeutic process, particularly at risk when prevailing feelings of constriction and challenge in the therapeutic relationship;

the severity of the disorder does not appear to have significant relevance to the outcome;

work with families appears as a common and positive resource, even if the methodology is not defined; it can be considered as a common evolution in effective technique and probably constitutes an important tool to stop the process of transgenerational transmission of problems and maladaptive patterns of functioning.

## Evaluation

Within the limits resulting from a retrospective study, conducted with non-standardized instruments, which involved a sample of therapists, the study provides a survey on the state of things with regard to the psychoanalytic treatment in children and adolescents; the results appear to provide useful information as for the assessment of factors related to therapeutic change, with intersection of phenomenal findings and data from the internal world. The results provided useful basis for switch to the collection of data from young patients.

The comparison between concluded and discontinued cases provides many elements for the evaluation of the cure and the efficacy variables, by showing that the balance of the various factors correlates with good outcome, while the unbalanced development correlates with more pronounced risk elements; major risk factors also correlate with insufficient processing of traumatic elements, insufficient quality of the therapeutic relationship and of the therapeutic alliance (feeling of constriction and challenge). These data were confirmed by the representational modalities of the inner world. The cross-examination of intra-psychic and phenomenal aspects appear interesting both to the clinic and diagnostic, by indicating ways for measuring the psychic change. The fairly large number of

cases described appears to provide greater reliability to the results, to be confirmed by further research on the side of patients.

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# Long-term psychoanalytic treatment of ADHD and ODD children: The Frankfurt ADHD and ODD Effectiveness Study

Leuzinger-Bohleber, M. (2010): Psychoanalytic preventions/interventions and playing “rough-and-tumble” games: Alternatives to medical treatments of children suffering from ADHD. *International Journal of Applied Psychoanalytic Studies*, 7, 332-338.

Leuzinger-Bohleber, M., Canestri, J., & Target, M. (Eds.). (2010). *Early Development and its Disturbances: Clinical, Conceptual and Empirical Research on ADHD and Other Psychopathologies and its Epistemological Reflections*. London: Karnac Books.

Läzer, K.L. (in print). Effectiveness of psychoanalytic psychotherapy and behavioral therapy treatment in children with attention deficit hyperactivity disorder and oppositional defiant disorder. *Journal of Infant, Child and Adolescent Psychotherapy*.

The Frankfurt ADHD and ODD Effectiveness Study was conducted between 2005 and 2013 at the Sigmund-Freud-Institut in cooperation with the Anna-Freud-Institut and the child and adolescent psychiatry unit at the university hospital Frankfurt/Main. The research was supported by the German Association of Psychoanalytic Child- and Adolescent Psychotherapists (VAKJP e. V.); the LOEWE initiative by the state of Hessen, Germany; Zinnkann Foundation; Research Advisory Board of the International Psychoanalytical Association, and the Sigmund-Freud-Institut.

## Background

A broader discourse on attention deficit hyperactivity disorder (ADHD) among psychoanalysts started in 2002 with the publication of a special issue of *Psychoanalytic Inquiry*, claiming that, until relatively recently, a number of practitioners on both sides of the debate from within and outside the psychoanalysis profession had discouraged the use of psychoanalytic treatment for patients with ADHD. Since then psychoanalysts have begun to share their clinical experience of treating ADHD children in several clinical case studies, thus providing psychoanalytic concepts for the understanding and treatment of the triad of inattention, impulsivity and hyperactivity. However, evidence based controlled studies for long term psychoanalytically informed therapies with ADHD children have hardly been performed until now.

## Objective

The study explores the effectiveness of long-term psychoanalytic treatment without medication and compares it with behavioral/ medication treatment of ADHD and/or oppositional deviant disorder (ODD) diagnosed children in publicly funded outpatient clinics. It was assumed that psychoanalytic psychotherapy without medication would be at least as effective in reducing the recurrence of the ADHD symptoms among children as a combination of behavioral treatment and medication.

## Method

Seventy-three children with DSM-IV diagnosis of ADHD and/or ODD participated in a controlled trial with a naturalistic observational design. The primary outcome was symptom reduction 38 months after the pre-treatment assessment using the diagnostic system for mental disorders in children and adolescents (DISYPS-KJ). Secondary outcomes were significantly lower scores for Conners Parent Scale (CPRS) and Conners Teacher Rating Scale (CTRS), Child Behavior Checklist (CBCL), and Teacher Report Form (TRF) scores.

## Treatment

*Psychoanalytic treatment* consisted of twice weekly therapy sessions of 50 minutes with the child and bi-weekly sessions of 50 minutes with parents provided by psychoanalysts in private practice. The treatment length varied from child to child. In average, the psychoanalytic treatment lasted 25.9 months (SD = 9.62). The manual by A. Staufenberg was developed during the Frankfurt Prevention Study between and was accepted and implemented by all psychoanalysts participating in the study.

*Behavioral/medication treatment.* Children attended either a manualized six-week concentration-training program or they attended a manualized two week anti-aggression training program. A parent-training program accompanied both programs. Additionally, children were prescribed methylphenidate, if needed, by a psychiatrist. In total, 63.3% of the children were medicated for a time period of 29.6 months on average (SD = 15.89).

## Results

Fifty-four children (74.0%) completed the follow-up 38 months on average after the baseline. Both treatment groups demonstrated significant symptom reduction, with no significant differences in effectiveness between the two groups. Teacher ratings as well as parent ratings showed a significant decline over time on the ADHD index scores, on oppositional behavior and hyperactivity/impulsivity levels and on internalizing and externalizing problem scores. Both groups demonstrated similar main effects of time. There were no significant interactions between group and time. The findings support the hypothesis that psychoanalytic psychotherapy without medication is as effective as behavioral therapy and/or medication treatment.

## Evaluation

While it is the first study of its kind, the study has limitations. First, the sample size is relatively small. Second, pertaining to the naturalistic design, one weakness is the resulting heterogeneity, which is evident both within and between the groups. This heterogeneity led to a biased sample in certain areas. The strength of the study is the naturalistic design. Psychotherapies were investigated as they were realized in the offices and institutions of 'real' psychotherapists with 'real' patients in Frankfurt nowadays associated with a high external validity of the findings. The study has scientifically followed severely disadvantaged children with a diagnosis of ADHD and/or ODD and their families over the course of a long-term psychoanalytical therapy and compared them in a naturalistic setting to a comparative group providing already well-validated behavioral/medication treatment. In this respect, the study is pioneer work.

## Clinical Trial Registration

DRKS-ID: DRKS00003356 <http://apps.who.int/trialsearch/trial.aspx?trialid=DRKS00003356>

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## Studies of child analysis practice in the U.S.

Hoffman, L, Karush, R. K., Garfinkle, M. S., Roose, S. P., & Cherry, S. (2009). A cross-sectional survey of child and adolescent analysts in New York City. *Journal of the American Psychoanalytic Association*, 57(4), 911-917.

Merchant, A., & Hoffman, L. (2013). Raising the curtain: Conversations with child and adolescent analysts. In M. O'Loughlin (Ed.), *The Uses of Psychoanalysis in Working with Children's Emotional Lives* (pp. 341-352). New York: Jason Aronson.

### Summary

There have been continued questions about the viability of the field of psychoanalysis, especially Child and Adolescent (C/A) analysis. Given the low number of child and adolescent analytic patients, the question must be asked, "Is C/A analytic education and analytic treatment relevant to adult analytic education and, more importantly, to the general mental health treatment of children?" Although there have been many scientific communications about the relevance of C/A analysis to adult analysis, there remains a lack of appreciation of the potential of C/A analysis even by the adult analytic community and in the general mental health field.

In order to understand the problem more clearly and in quantifiable terms, this work is an expansion of prior work by others such as Abrams (1979) that reported that nationally, there was a mean of 2.2 C/A cases per C/A analysts. The first step in our research was to conduct a survey which was reported in JAPA titled, *A Cross-Sectional Survey of Child and Adolescent Analysts in New York City* (JAPA, 2009, pp 911-917). This survey demonstrated that the majority of graduate child and adolescent analysts did not have active C/A analytic practices. As a result we developed a semi-structured interview to see if we could identify those factors that contribute to the development of a variety of career paths for C/A analysts.

The interview was divided into three parts:

Demographic and Questions about Professional Experiences

Factual questions about practice and education, incidents or moments in treatment with child, adolescent, and adult analytic/therapy patients and

Personal and social histories of the analysts themselves.

20 Graduate Analysts from Child and/or Adolescent Training programs from NYC and from other parts of the USA were interviewed (recorded with a high level recording device to allow for acoustic analysis). The audio-taped interviews were transcribed and analyzed using the measures of the referential process developed by Bucci and Maskit and colleagues. (See *Measures of the Referential Process*, ODR this edition for details of procedures) .

### Demographics

13 males and 7 females; 6 were child psychiatrists, 10 were psychiatrists, and 4 were in other mental health professions. 12 were from NYC and 8 from other parts of the USA. **Practice:** Total number of analytic patients (3 or more times a week): 3.35 per C/A Analyst (compared to 3.2+/-2.6 in the Cross-sectional survey). Number of C/A analytic patients .5 per C/A Analyst (compared to .9+/-1.2 in the Cross-sectional survey). The group was divided into C/A analysts who currently treated C/A analytic patients (8) and those who did not (12).

## **Analysis of narratives**

Thus far we have found that (1) emotional engagement in talking about playing in childhood and continued through adulthood is related to having a C/A analytic practice; (2) a suggestion (which needs to be further corroborated) that C/A who are more emotionally engaged (as evidenced by their high WRAD language) show greater variability in their intensity/loudness of voice; and (3) that all C/A analysts, regardless of their current status of working vs not working with C&A analytic patients, often described their C/A analytic education to have a remarkable impact on the way they understand adult patients, and/or the way they work with patients. The data needs to be further analyzed including completion of acoustic analysis, systematic utilization of the CCRT, and further systematic evaluation of the individual narratives.

## **Evaluation**

If one considers C/A analytic education and treatment relevant to the mental health treatment of children, future generations of analysts need to be educated so that C/A analytic insights can be applied and continue to evolve in a scientific manner. This study can help us understand (1) who is attracted to the field of C/A analysis; (2) who is most likely to be effective as a C/A analyst; (3); how can these qualities be taught to other C/A analysts and C/A students; and (4) can one generalize the findings of this study to all analysts and all students of psychoanalysis, to enable them to engage more patients in analytic treatment

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# How effective are long-term psychoanalytic treatments in adolescents? A comparison between the evaluations of the patients, their parents and their therapists

Seiffge-Krenke, I. (2010). „Beyond efficacy“: Welche Faktoren beeinflussen die Effizienz analytischer und tiefenpsychologisch fundierter Therapien bei Jugendlichen? [“Beyond efficacy”: Which factors influence the effectiveness of psychoanalytic and psychodynamic therapy of adolescents?]. *Forum der Psychoanalyse*, 26, 291-312.

Seiffge-Krenke, I., & Nitzko, S. (2011). Wie wirksam sind analytische und tiefenpsychologisch fundierte Langzeitpsychotherapien bei Jugendlichen? Ein Vergleich der Einschätzung von Patienten, ihren Eltern und Therapeuten [How effective are psychoanalytic and psychodynamic long term therapies in adolescents? Comparing the ratings by patients, their parents and therapists]. *Zeitschrift für Kinder- und Jugendpsychiatrie und Psychotherapie*, 39, 253-264.

## Brief summary of the studies

In the evaluation of psychotherapy outcome with children and adolescents, studies are lacking which analyze psychotherapy outcome from the perspective of different persons involved in this process. In the above studies, treatment efficacy of 30 and 28 long-term treatments with adolescents (mean age 13 years) is presented from the perspective of the afflicted adolescent, his or her parents and his or her therapists. In general, in a study of 30 long-term patients, psychodynamic therapy (mean 97 hours) was effective in reducing symptomatology, both from the perspective of therapist, adolescents and their parents, but the level of change differed significantly. In a second study, the design was further differentiated into a therapy group (n = 28) and a waiting group (n = 32), which did not differ in relevant features such as SES, marital status of the parents, age, gender, and diagnosis of the child. The sample was drawn from an outpatient unit with prevailing internalizing disorders (50.0 %); externalizing disorders (24%), personality disorders (18%) and somatoform disorders (5%) were less frequent. The treatment was psychodynamic therapy with a mean frequency of 89 hours (70 hours for individual treatment of the adolescent and 19 hours for accompanying work with parents).

Assessments were made 3 times over 1.5 years, at the beginning of the treatment (mean 7 hours), after 40 hours and at the end of the treatment (mean 68 hours). For assessments of parents and child, comparable instruments (YSR and CBCL) were applied. In the therapy group, the therapists reported a strong reduction in symptomatology (both on a psychic and a somatic level). Therapists further perceived a significant reduction in communicative disturbances of the patient with parents, siblings and friends over time. At the beginning of the treatment, adolescents reported higher symptom levels than their parents. Further, adolescents and their parents reported a significant reduction in symptomatology over time. However, parents perceived less change in symptomatology, compared to their children. The diagnosis (internalizing vs. externalizing disturbances) had no impact on the evaluation of treatment effectiveness of adolescents and parents. The quality of the therapists' work with parents did not impact psychotherapy outcome. Correlations between parents and adolescent were low ( $r = .113$ ; ns for internalizing and  $r = .239$ ; ns for externalizing symptoms) over time.

## Conclusions

Earlier studies also have shown low cross-informant correlations between adolescents and their parents regarding the assessment of symptomatology, due to changes in disclosure behavior. Both studies highlight that parents underestimate the severity of symptomatology in their child and also did not perceive as much change during therapy as therapists and children did. Therefore, particularly

during the adolescent years of a patient, psychotherapy should include the different perspectives of all persons involved.

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# Treatment and rehabilitation of severely traumatized refugees

Varvin, S., & Rosenbaum, B. (2011). Severely traumatized patients' attempt at reorganizing their relations to others in psychotherapy. In Freedman, N. Hurvich, M., & Ward, R. (Eds.), *Another Kind of Evidence* (pp. 167-182). London: Karnac Books.

Varvin S. (2011) Phenomena or data? Qualitative and quantitative research strategies in psychoanalysis. *Scandinavian Psychoanalytic Review*, 34, 117-123

Varvin, S. (2013). Psychoanalyse mit Traumatisierten. Weiterleben nach Extremerfahrungen und kompliziertem Verlust {Psychoanalysis with the traumatised patient: Helping to survive extreme experiences and complicated loss}. *Forum der Psychoanalyse*, 29, 372-389.

This is prospective treatment study of traumatized refugees. The aim is to follow them through two treatment modalities: ordinary outpatient treatment and treatment in psychoanalytic therapy in order to get knowledge on the following topics: personality and extreme traumatization, influence of early (childhood) traumatization and later traumatization, influence of context (especially acculturations stress in exile) on process and outcome, on what works in psychotherapy with extreme traumatized persons.

It is a naturalistic study with no random assignment. The more severely ill patients get psychoanalytic therapy mostly as outpatient clinics did not offer adequate treatment.

## Participants

Fifty-four mental health patients with refugee and trauma background were recruited to the study, 35 men and 19 women (response rate 70 %). The participants came from 15 different countries in Asia, Europe, and Africa. They had a mean stay in Norway of about 11 years, ranging from ½ to 28 years.

## Procedure

After being accepted for treatment, patients with refugee and trauma background referred to treatment in mental health specialist services either outpatient clinics (treatment as usual) or psychoanalytic private practice treatment.

Research assessment was performed at treatment start (T1), yearly during treatment, at termination (T2), after three years (T4), after five years (T5). Therapists were interviewed with semi-structured interviews after one year (T3), yearly as long as the treatment lasted, and after termination of treatment (T2).

## Analysis

Multi method, based on quantitative and qualitative methods.

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# From self-integration in personal schemas of morally experiences to self-awareness of mental states: A qualitative study among a sample of Portuguese war veterans

Kaplan, S., & Laub, D. (2009). Affect regulator in extreme traumatization - Fragmented narratives of Holocaust survivors hospitalized in psychiatric institutions. *The Scandinavian Psychoanalytic Review*, 32(2), 93-104.

Litz, B. T., Stein, N., Delaney, E., Lebowitz, L., Nash, W. P., Silva, C., & Maguen, S. (2009). Moral injury and moral repair in war veterans: A preliminary model and intervention strategy. *Clinical Psychology Review*, 29, 695-706.

Varvin, S. (2003). *Mental Survival Strategies after Extreme Traumatization*. Copenhagen: Multivers.

## Brief Summary

This study explored the understanding of the causes of their distress, the strategies used to cope with posttraumatic symptoms and the key resources and processes to which a group of veterans attributed their recovery from PTSD. Sample was composed of Portuguese war veterans (N=60), all males, without brain injury, neuropsychological disorders, physical disability, and psychiatric illness previous to military duty. All participants received a diagnosis of PTSD related to war when they started treatment. Non-recovered group included 30 participants with current positive diagnosis of PTSD, randomly selected among a group of outpatient receiving both psychiatric and psychological treatment for at least the last ten years. Recovered group included 30 recovered patients since negative diagnoses for current PTSD. These participants were randomly selected among a group of former patients and did not receive any treatment during the past year. Participants had no deterioration of their clinical condition following treatment. Both groups showed no differences for demographic, military background, and treatment variables. Two individual semi-structured interviews were conducted. All interviews were audio-taped and transcribed verbatim. Analysis of the interviews' transcripts was conducted using the Thematic and Categorical Analysis proposed by Bardin (2009). Codes were identified and labelled by tracking language and themes.

Six themes were identified to which participants attributed their recovery: war zone stressors, stressful life events, mental and coping strategies, self-integration in personal schemas of morally incongruent experiences, self-awareness of mental states, and perceived social support. Recovered participants showed higher occurrence of themes related to integration of the morally incongruent events within existing personal schemas or description of a process of transition in the integration of the morally incongruent events within existing self- and relational-schemas, capability to correlate their and others' behaviors to emotional states or understanding their own mental states and behaviors through the others' reactions, and description of a wider repertoire of coping strategies to cope with posttraumatic symptoms and current stress triggers. Non-recovered participants showed higher occurrence of a severe discrepancy between self- and other schemas and the moral injury event, inability to understand their own behavior and other's intentions and behaviors, childhood idealization, restriction of coping strategies and inadequate or insufficient social support.

## Recovery Model

Our findings suggest the benefits of psychoanalytic treatment with traumatized war veterans. Recovery from PTSD among those veterans was related to moral repair and higher mentalization abilities. Moral repair involved a gradual process of self-integration in personal schemas of morally incongruent experiences (Horowitz, 1992; Litz et al., 2009) resulting in the restoration of a sense of coherence achieved through assimilation of a new image of the body, images of others, and values and ideals in the structure of the self (Herman, 1992). Higher mentalization abilities enabled recovered

patients to find meaning to traumatic events and helped them to create a coherent narrative about the patient's childhood history. This achievement seems to play a key role in recovery of self-concept and identity coherence (Horowitz, 1992).

These findings should be tested by using a longitudinal design to analyse the evolution of these processes in the psychoanalytic treatment of those patients. This framework should combine research on process and outcome.

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# Psychotherapy utilization and care for severely disturbed patients

Löffler-Stastka, H., Voracek, M., Leithner, K., Fischer-Kern, M., Presslich, E., Kunz, C., & Meisel, T. (2003). Predicting psychotherapy utilization for patients with borderline personality disorder. *Psychotherapy Research*, 13(2), 255-264. doi: 10.1093/ptr/kpg023.

Löffler-Stastka, H., Blueml, V. & Boes, C. (2010). Exploration of personality factors and their predictive impact on therapy utilization: The externalizing mode of functioning. *Psychotherapy Research*, 20 (3), 295-308. DOI: 10.1080/10503300903436710.

Löffler-Stastka, H., Frantal, S., & Jandl-Jager, E. (2010). Überweisungserfolg in Psychotherapie bei Patienten mit Persönlichkeitsstörungen – Therapeutische Konsequenzen [Referral success to psychotherapy of patients with personality disorders – therapeutic consequences]. *Wiener klinische Wochenschrift*, 122(5-6), 165-172.

## Brief Summary

Psychotherapy plays an important role in the treatment of patients suffering from a personality disorder. It is known that many patients with personality disorders do not take up psychotherapy or drop out of treatment prematurely. The aim of the present study was the detection of factors in patients with personality disorders which influence the referral to psychotherapy.

After an exploratory study with psychiatric inpatients in 2003, personality characteristics (socio-demographic parameters, affect experience and regulation, quality of object relations, character traits, level of interpersonal problems) of 297 patients of a psychoanalytic-psychotherapeutic outpatient clinic were assessed. Their influence on therapy engagement were analysed by means of logistic regressions. Within univariate analysis certain personality traits (mature psychological functioning vs. negativistic personality features) showed predictive power. The multivariate analysis identified the patients' educational level as the principal indicator for psychotherapy utilization. Consequences for diagnostic initial interviews in connection with the role of the educational level for the therapeutic alliance are discussed. Further, the impact of economic aspects on therapy engagement is discussed.

## Contact

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# Effectiveness of psychoanalytic psychotherapy for children and adolescents with severe anxiety, depressive, and disruptive psychopathology in a naturalistic treatment setting

Weitkamp, K., Daniels, J. K., Hofmann, H., Timmermann, H., Romer, G., & Wiegand-Grefe, S. (2014). Psychoanalytic psychotherapy for children and adolescents with severe depressive psychopathology – preliminary results of an effectiveness trial. *Psychotherapy, 51*, 138-147.

## Methods

This partly waitlist-controlled field study aimed to evaluate the effectiveness of psychoanalytic short and long term psychotherapy for children and adolescents employing a prospective design.

231 children and adolescents (aged 4 to 21 years) and their parents who entered psychoanalytic therapy in private practices in northern Germany participated in this ongoing study (154 intervention group, 23 wait-list control and intervention group, and 54 wait-list control group). Data was collected from therapists, parents, and from the patients (aged 10 years and older) at the beginning and the end of treatment, as well as up to 5 points in time during therapy. Follow-up took place at 6 and 12 months after therapy. Amongst other measures, depressive pathology was measured with the CDI, anxiety pathology with the SCARED, disruptive pathology with the external symptom score of the CBCL/YSR, and quality of life with the KIDSCREEN.

The patients received individual psychoanalytic psychotherapy which was predominantly child-focused, complemented by parent sessions usually on a ratio of 4:1. The interventions were based on Anna Freud (1949/1980) and object-relations theory as set out by Winnicott (1958/1988). The actual applied practice of psychoanalytic psychotherapy in children and adolescents was written down in a field manual (Baumeister-Duru, Hofmann, Timmermann & Wulf, 2013). Adherence to this code of practice was checked with a retrospective treatment fidelity checklist filled out by the therapists at the end of treatment for each patient.

Data analyses were carried out using intention-to-treat (ITT) analysis. Missing values were analysed and imputed with expectation maximization (EM). In addition to ANOVAs with repeated measures, mixed linear models were utilised to take into account the nested structure of the data, e. g. therapists treating more than one patient.

## Results

Overall, patients showed pronounced impairments at the commencement of outpatient therapy.

**Depressive group** 50 patients were included in the depressive group. Patients received, on average, 97 sessions of therapy (range: 25-205). At the end of therapy, there was a significant reduction in depression in the treatment group (parent report:  $d=.88$ ; patient report  $d=.68$ ). The wait-list control group, which received minimal treatment, displayed a slight, but not statistically significant, symptom improvement in the patient report ( $d=.07$ ), but a significant improvement in the parent report ( $d=.49$ ). 66% of the patients could be rated as recovered or improved. At the time of the publication follow-up was still being collected and hence, could not be published (Weitkamp, K., Daniels, J. K., Hofmann, H., Timmermann, H., Romer, G. & Wiegand-Grefe, S., 2014). Analyses with the completed data-set indicate stable results comparable to the anxiety and disruptive pathology.

**Anxiety group** The 76 anxiety patients received on average 94 therapy sessions (range: 8-300). Both, parents and patients in the intervention group reported moderate symptom improvements at the end of therapy (parent:  $d=.58$ ; patient:  $d=.57$ ), which are stable at the 1-year follow-up and increase from the

patient perspective (parent:  $d=.37$ ; patient:  $d=.80$ ). When comparing the first therapy interval with the (minimal treatment) wait-list control group, both groups improved significantly with small effect sizes and no significant group differences. 69% of the patients could be rated as recovered or improved (Weitkamp, K., Daniels, J. K., Baumeister-Duru, A., Wulf, A., Romer, G., & Wiegand-Grefe, S., in prep.).

**Disruptive group** On average, the 65 intervention patients received 94.8 sessions (range: 19-300). Both, parents and patients in the intervention group reported moderate improvement of disruptive pathology at the end of therapy (parent:  $d=.69$ ; patient:  $d=.63$ ), which are stable at the 1-year follow-up (parent:  $d=.77$ ; patient:  $d=.68$ ). When comparing the first therapy interval with the (minimal treatment) wait-list control group, both groups improved significantly in the parent view on disruptive pathology with no significant group differences. The patients noted no significant differences neither in the first therapy interval nor the wait-list group (Weitkamp, K., Daniels, J. K., Daubmann, A., Romer, G., & Wiegand-Grefe, S., in prep.).

## Evaluation

The results suggest that psychoanalytic therapy is successful in alleviating different kinds of pathology and improving quality of life for children and adolescents. These effects remain stable across one year follow-up. This naturalistic study is high on external validity with some limitations attached: the control interval had a much shorter duration than most therapies and these wait-list patients received more often than not some supporting sessions. The therapy duration showed large variance. Lastly, the three symptom groups were not mutually exclusive, in a number of cases patients reported comorbid pathology.

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# Rorschach perception and thinking domain and mentalization based treatment: an outcome study

Del-Ben, C., Vilela, J., Crippa, J., Hallak, J., Labate, C., & Zuardi, A. (2001). Confiabilidade teste-reteste da Entrevista Clínica Estruturada para o DSM-IV – versão clínica (SCID-CV) traduzida para o português. *Revista Brasileira de Psiquiatria*, 23, 156-159.

## Abstract:

The objective was to identify perception and thinking changes in patients treated by psychoanalytical psychotherapy at a university public outpatient service. 68 patients participated, mainly women (80.9%), around 40 years old, and 11.5 years of education, who attended at least one session weekly for two years with a trainee therapist, psychiatrist or psychologist. The majority met the criteria for Major Depressive Disorder, (DSM-IV, Axis-I), and Cluster B and Cluster C on Personality Disorder (DSM IV, Axis-II). The Rorschach was administered upon admission and in annual follow ups. An adaptation from the Comprehensive System to the R-PAS was performed. The results showed statistically significant differences were found on the Perception and Thinking variables, indicating structural changes were achieved.

social avoidance behavior, alexithymics more often stop their inpatient treatment in the early phase of therapy. At baseline, alexithymic patients show higher levels of psychopathological distress compared to nonalexithymics. The symptom reduction in alexithymics is lower and the psychopathological distress at the end of the intervention is still significantly higher than in nonalexithymics. There are no or only little changes in Toronto Alexithymia Scale scores in both groups over the course of the treatment.

The residency program in psychiatry and the specialization program in health psychology of a school of medicine, EPM, include training in psychodynamic psychotherapy. Besides attending a theoretical course, the trainees must treat at least two patients deemed suitable for long-term psychodynamically oriented psychotherapy, once a week. The trainees meet weekly with a supervisor in a group session to discuss the progress of the therapy until the end of the program, after two years. The supervisors are staff members of the Department of Psychiatry with a solid foundation in psychoanalysis.

The proposal of the study was to assess the effects of the psychotherapeutic treatment on the patients. The school hospital, including its outpatient services, is a free of charge institution.

In order to carry out this proposal the patients, upon admission, were submitted to the Structured Clinical Interview for DSM-IV (Axis-I, and Axis II) by trained psychiatrists, following these criteria (a) inclusion: at least 18 years of age, interest and availability to attend the psychotherapeutic sessions; and (b) exclusion: schizophrenic disorder, antisocial personality disorder, dementia disorder, mental retardation. The Rorschach method was the selected psychological instrument for assessing the possible changes in personality aspects, and was administered upon the admission of the patient, and after one and two years of psychotherapy.

The sample comprised 68 patients, mainly women (55 or 80.9%), with the mean of 39.7 years old, and with the mean of 11.5 years of education, who attended at least one weekly psychotherapy session for two years. As to the diagnosis, 46 (67.6%) patients met the criteria for Major Depressive Disorder (DSM-IV, Axis-I), and 44 (64.7%) met the criteria for Personality Disorder (DSM-IV, Axis-II) with the prevalence of cluster B (borderline, narcissistic histrionic or antisocial) in 27 (39.7%) patients, followed by cluster C (avoidant, dependent or obsessive-compulsive) in 17 (25.0%) of patients.

The Rorschach was administered according to the Comprehensive System (Exner & Erdberg, 2005) and an adaptation to the R-PAS (Meyer, Viglione, Mihura, Erard, Erdberg, 2011). A statistical comparison was performed between time 1, that is, upon admission (t1) and after two years of treatment, that is, time 3 (t3).

The variables of Perception and Thinking Domain are (1) Ego Impairment Index-3 ;(2) Thought and Perception Composition (3) Weighted Sum of the six Cognitive Codes; (4) Severe Cognitive Codes; (5) Form Quality Percentages ; (6) Popular [P].

Statistical significant differences were found on four out of the six variables of the Perception and Thinking Domain.

The changes toward improvement on perception and thinking are notable, meaning a cognitive improvement among the patients as to reality testing, more conventional perceptions, a decrease in the interference of severe disturbances on thinking and a mental process, which indicated severe pathology. Therefore, there is a clear relationship between the mentalization based treatment or reflective function approach of the psychotherapists and the clear improvements on the perception and reasoning aspects of the patients. Fonagy, Gergely, Jurist & Target (2002) consider that um important aim of psychotherapy is the extension of mentalization.

The Rorschach proved to be an ideal instrument to capture the psychic changes caused by psychoanalytical psychotherapy. Psychic changes are those that occur inside the personality due to the development of the object relations, of the capacity to think and to symbolize. It is possible that for these patients with little ego integration and with damaged object relations, the psychotherapy was an experience of significant influence. Contemporary psychoanalysis places emphasis on the analytical relationship as a changing agent, not only in the sense of transference, but mainly as the analyst's functions related to the holding, according to Winnicott (1956), to the condition of contention and to the facilitation of communication. The true patience of the analyst, his tact, his tolerance, his empathy, his absence of judgment, and his non-critical objectivity are non-interpretative aspects that represent conditions and components of the psychoanalytical process. Therefore, for these patients, the psychotherapist as a holding, nurtured object interested in the patient's feelings, fantasies, life history and not just interested in symptoms and psychopathology can engender an impact capable of transforming the patient's psyches and consequently his life.

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# Alexithymia and outcome in psychotherapy

Grabe, H. J., Frommer, J., Ankerhold, A., Ulrich, C., Gröger, R., Franke, G. H., . . . Spitzer, C. (2008). Alexithymia and outcome in psychotherapy. *Psychotherapy and Psychosomatics*, 77, 189–194.

## Rationale

The construct of alexithymia focuses on difficulties in describing and expressing feelings, on the paucity of fantasies. Recent studies have associated alexithymia with dissociation, depression, anxiety disorders, pathological gambling and a broad range of psychopathologic features. Given the relative temporal stability, the pattern of correlations with traits of personality models like the NEO-FFI and the temperament and character model, alexithymia is considered to be a unique and distinct personality construct. However, there is an ongoing debate on the changeability of alexithymic traits by psychotherapy in the light of lacking absolute stability. The impact of alexithymia itself on outcome in psychotherapy is less clear. First, subjects with alexithymia are often socially avoidant, cold, less emotionally attached to others. This could lead to a reduced adherence to psychotherapy despite of severe mental distress. Second, the lack of imagination, psychological mindedness and awareness to emotional cues may significantly reduce the ability to be successfully engaged in psychotherapy. Third, early observations of Sifneos and others described alexithymic patients to respond poorly to dynamic psychotherapy. However, there has been little empirical research to investigate whether alexithymia predicts psychotherapy outcome. Some treatment studies found alexithymia to be associated with persistent somatization in somatoform disorders and with a negative outcome in medical treatment of functional gastrointestinal disorders. In short-term group therapy for outpatients with complicated grief and in short-term individual therapy for outpatients with mixed diagnoses, alexithymia predicted a negative outcome as well as in a naturalistic follow-up of outpatients with major depression. However, alexithymia did not interfere with the response to multimodal cognitive behavioral therapy in patients with obsessive-compulsive disorder.

## Method

We evaluated a large sample of inpatients undergoing intensive psychotherapeutic treatment to investigate the following hypotheses: Assuming higher levels of interpersonal stress and

## Evaluation

The first hypothesis was not confirmed by our data. Patients who stopped treatment within the first four weeks were not more alexithymic than patients who continued the treatment program. Although unexpected, this finding is in line with one study that found alexithymia not to interfere with the compliance to psychotherapy in patients referred to a psychiatric consultationliaison service. Additionally, one experimental study provided evidence that verbalized empathic response from the physician may be especially crucial for the alexithymic patients' postconsultation satisfaction and may thereby become the basis for a solid treatment alliance. The second hypothesis was fully confirmed by significantly higher levels of psychopathological distress in alexithymic patients at the beginning of the therapy. In contrast to our third hypothesis, the psychotherapeutic 'high-care' inpatient setting yielded a significant symptom reduction in alexithymics which was comparable to the relative symptom reduction in the nonalexithymic group. Still, the alexithymics had mean GSI scores at the end of the treatment that were almost identical to GSI scores of the nonalexithymic group in the beginning of the therapy. This corresponds to the finding of residual symptoms in depressed alexithymic patients after short-term psychotherapy. There were modest reductions of TAS-20 scores in the nonalexithymic group. Unexpectedly large reductions of TAS-20 scores were found in the

baseline-alexithymic group, indicating a lack of absolute stability of alexithymia during treatment. In contrast to Rufer et al., all three TAS factors decreased significantly during the treatment. However, we found evidence for a high degree of relative stability of TAS-20 scores between t0 and t2 in the total sample which is in line with a large body of evidence. Only 13–16% of the variance in the changes of TAS-20 scores was explained by the changes in GSI scores from baseline to t2. Therefore, besides the changes in psychopathological distress, other unmeasured or unknown factors contributed to the majority of changes in the TAS-20 scores. Acknowledging the significant decrease in TAS-20 scores and the robust symptom reduction of psychopathological distress (GSI) at the end of the treatment in the alexithymic group, we assume that the ‘high-care’ in-patient setting was very effective in improving the identification, the differentiation and the verbalization of emotions and feelings. Future studies should investigate the efficacy of different treatments in alleviating alexithymia and should use a recently developed interview for the assessment of alexithymia. Prospective follow-up studies are required to evaluate the impact of persistent alexithymia and residual psychopathological symptoms at discharge on long-term outcome.

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## Gender and perversion

Springer-Kremser, M., Leithner, K., Fischer, M. & Löffler-Stastka, H. (2003). Gender and perversion-- what constitutes a "bad mother". *Archives of Women's Mental Health*, 6 (2), 109-114. DOI: 10.1007/s00737-002-0153-3

Löffler-Stastka, H., Ponocny-Seliger, E., Fischer-Kern, M. & Leithner, K. (2005). Utilization of psychotherapy in patients with personality disorder: the impact of gender, character traits, affect regulation, and quality of object-relations. *Psychology and Psychotherapy*, 78 (4), 531-548. DOI: 10.1348/147608305X42217

### Goals

Based on case material obtained through psychoanalytic psychotherapy with female patients from a psychosomatic gynecological outpatient clinic, the characteristics of the psychic structure of these patients who presented symptoms of deliberate selfharm and of misusing and mistreating their children, are outlined. Another common trait is the embeddedness of their perverse behavior in a generational chain of transmission. Female patients who mistreat their children had been victims of traumatising experiences in their own biography, inflicted by their mothers and directed towards their bodies. Female perverse behavior, therefore, is fundamentally different from male perversion: the perverse act in women is aimed against themselves and/or their children. Currently used diagnostic statistical manuals lack categories to describe this symptomatology adequately. Further research is requested to understand a mother's perverse actions and thus develop treatment strategies, without marginalizing these patients.

### Method

To proceed, the aim of the study was to generate hypotheses for examining gender differences in variables with predictive value for the utilization of psychotherapy in patients with personality disorders (PDs). Personality traits, affect experience and regulation, the quality of object relations and interpersonal problems within the process of psychotherapy planning were assessed in psychiatric outpatients. Besides the structured clinical interviews for DSM-IV I+II, variables were assessed with the Shedler-Westen assessment procedure (SWAP-200), the affect regulation and experience Q sort (AREQ), the quality of object-relations scale (QORS), and the Inventory of Interpersonal Problems (IIP). Correlation and group difference statistics, regression and canonical correlation analysis were performed. Predictors concerning the utilization or non-utilization of psychotherapy were a schizoid PD rating a self-report of subassertive behaviour related to interpersonal problems in women, and a narcissistic PD rating in men. Canonical correlations between predictors and quality of object relations or interpersonal problems were found in women, while in men there was merely a tendency for predictor and affect regulation to be related. The results suggest that for men it is more important to interpret the dominating affect, while for women, understanding the pathological object relation pattern is useful for successful therapy planning. Influences of the specific dyadic constellations were investigated in different medical consultation setting.

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## Dismantling the difference

Löffler-Stastka, H. (2009a). Von der empirisch psychoanalytischen Prozess- und Ergebnisforschung zur klinischen Praxis [From empirical psychoanalytic research and outcome studies to the clinical practice]. *Psychotherapie Forum*, 17(1), 21-28. DOI: 10.1007/s00729-009-0276-3.

Löffler-Stastka, H. (2009b). "Affektlose Zustände?" ["Affectless states?"]. *Forum der Psychoanalyse*, 25 (3), 237-254. DOI: 10.1007/s00451-009-0005-0

Zimmermann, J., Löffler-Stastka, H., Huber, D., Klug, G., Alhabbo, S., Bock, A., & Benecke, C. (in press). Is it all about the higher dose? Why psychoanalytic psychotherapy is an effective treatment for major depression. *Clinical Psychology & Psychotherapy*.

### Goals

The empirical studies point at the necessity of interpreting affect-regulatory parameters, such as the hostile-externalizing-dysphoric parameter, from the very beginning of the treatment on. Acknowledgement and recognition of externalizing and projective mechanisms should be trained in the psychotherapeutic routine treatment in order to establish a stable working alliance with the patient. However, it is unclear whether the effectiveness of LTPP is due to distinctive features of psychodynamic/ psychoanalytic techniques or to a higher number of sessions.

### Method

We tested these rival hypotheses in a quasi-experimental study comparing psychoanalytic therapy (i.e., high-dose LTPP) with psychodynamic therapy (i.e., low-dose LTPP) and cognitive-behavioral therapy (CBT) for depression. Analyses were based on a subsample of 77 subjects, with 27 receiving psychoanalytic therapy, 26 receiving psychodynamic therapy, and 24 receiving CBT. Depressive symptoms, interpersonal problems, and introject affiliation were assessed prior to treatment, after treatment, and at the 1-, 2-, and 3-year follow-ups. Psychoanalytic techniques were assessed from three audiotaped middle sessions per treatment using the Psychotherapy Process Q-Set. Subjects receiving psychoanalytic therapy reported having fewer interpersonal problems, treated themselves in a more affiliative way directly after treatment, and tended to improve in depressive symptoms and interpersonal problems during follow-up as compared with patients receiving psychodynamic therapy and/or CBT.

### Results

Multilevel mediation analyses suggested that post-treatment differences in interpersonal problems and introject affiliation were mediated by the higher number of sessions, and follow-up differences in depressive symptoms were mediated by the more pronounced application of psychoanalytic techniques. We also found some evidence for indirect treatment effects via psychoanalytic techniques. These results provide support for the prediction that both a high dose and the application of psychoanalytic techniques facilitate therapeutic change in patients with major depression.

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## Experimental treatment studies

# Short-term psychodynamic psychotherapy and cognitive-behavioral therapy in generalized anxiety disorder: a randomized, controlled trial.

Leichsenring, F., Salzer, S., Jaeger, U., Kächele, H., Kreische, R., Leweke, F., . . . Leibing, E. (2009). Efficacy of short-term psychodynamic therapy and cognitive-behavioral therapy in generalized anxiety disorder: a randomized controlled trial. *American Journal of Psychiatry*, 166(8), 875-881.

## OBJECTIVE

While several studies have shown that cognitive-behavioral therapy (CBT) is an efficacious treatment for generalized anxiety disorder, few studies have addressed the outcome of short-term psychodynamic psychotherapy, even though this treatment is widely used. The aim of this study was to compare short-term psychodynamic psychotherapy and CBT with regard to treatment outcome in generalized anxiety disorder.

## METHOD

Patients with generalized anxiety disorder according to DSM-IV were randomly assigned to receive either CBT (N=29) or short-term psychodynamic psychotherapy (N=28). Treatments were carried out according to treatment manuals and included up to 30 weekly sessions. The primary outcome measure was the Hamilton Anxiety Rating Scale, which was applied by trained raters blind to the treatment conditions. Assessments were carried out at the completion of treatment and 6 months afterward.

## RESULTS

Both CBT and short-term psychodynamic psychotherapy yielded significant, large, and stable improvements with regard to symptoms of anxiety and depression. No significant differences in outcome were found between treatments in regard to the primary outcome measure. These results were corroborated by two self-report measures of anxiety. In measures of trait anxiety, worry, and depression, however, CBT was found to be superior.

## CONCLUSIONS

The results suggest that CBT and short-term psychodynamic psychotherapy are beneficial for patients with generalized anxiety disorder. In future research, large-scale multicenter studies should examine more subtle differences between treatments, including differences in the patients who benefit most from each form of therapy.

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# Munich Psychotherapy Study (MPS) – A three-year follow-up study: Psychoanalytic vs. psychodynamic therapy for depression

Huber, D., Henrich, G., Clarkin, J. & Klug, G. (2013). Psychoanalytic versus psychodynamic therapy for depression: a three-year follow-up study. *Psychiatry*, 76, 2, 132-149.

## Brief Summary

The aim of this study was to investigate the effectiveness of long-term psychotherapies. In a prospective, randomized outcome study, psychoanalytic therapy (mean duration: 39 months, mean dose: 234 sessions) and psychodynamic therapy (mean duration: 34 months, mean dose: 88 sessions) were compared at post-treatment and at one-, two-, and three-year follow-up in the treatment of patients with a primary diagnosis of unipolar depression. All treatments were performed by experienced psychotherapists / psychoanalysts. Independent raters assessed treatment fidelity using the Psychotherapy Process Q-set. A two-tailed t-test yielded a significant difference in therapeutic technique between the therapy-groups. Primary outcome measures were the Beck Depression Inventory and the Scales of Psychological Capacities, and secondary outcome measures were Global Severity Index of the SCL-90-R, the Inventory of Interpersonal Problems, the Social Support Questionnaire, and the INTREX Introject Questionnaire. Interviewers at pre- and post-treatment and at one-year follow-up were blinded; at two-, and three-year follow-up all self-report instruments were mailed to the patients. Analyses of covariance, effect sizes and clinical significances were calculated to contrast the groups.

We found significant outcome differences between treatments in terms of depressive and global psychiatric symptoms, personality functioning and social relations at three-year follow-up with psychoanalytic therapy being significantly more effective. No outcome differences were found in terms of interpersonal problems.

We concluded that psychoanalytic therapy with its higher dose and frequency and different therapeutic technique shows longer-lasting effects than psychodynamic therapy, demonstrating the full range of its benefits three years after termination of treatment.

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# Munich Psychotherapy Study (MPS) – A three-year follow-up study: Comparison of cognitive-behavioral therapy with psychoanalytic and psychodynamic therapy for depressed patients

Huber, D., Zimmermann, J., Henrich, G., & Klug, G. (2012). Comparison of cognitive-behaviour therapy with psychoanalytic and psychodynamic therapy for depressed patients – A three-year follow-up study. *Zeitschrift für Psychosomatische Medizin und Psychotherapie*, 58: 299–316.

Huber, D., Henrich, G., Gastner, J., & Klug, G. (2012). The Munich Psychotherapy Study: Must all have prizes? In R. Levy, S. Ablon & H. Kächele (Eds.), *Psychodynamic Psychotherapy Research. Evidence-Based Practice and Practice-Based Evidence* (pp. 51-69). New York: Humana Press.

## Brief Summary

In an extension of the above mentioned study we additionally investigated the effectiveness of long-term cognitive-behavioral therapy compared to psychoanalytic and psychodynamic therapy in the treatment of patients with depression. Therefore, in a quasi-experimental design 100 patients were compared at pre- and post-treatment and at three-year follow-up. Outcome measures see above.

We found significant outcome differences between psychoanalytic therapy and cognitive-behavioral therapy in depressive and global psychiatric symptoms, social-interpersonal and personality structure at three-year follow-up. Psychodynamic therapy was superior to cognitive-behavioral therapy only in the reduction of interpersonal problems.

We conclude that psychoanalytic (and partly psychodynamic) therapy shows significantly higher and longer-lasting effects compared to cognitive-behavioral therapy three years after termination of treatment.

## Evaluation

This study moves in the middle of the pragmatic-explanatory continuum, having significant scientific strengths as well as the potential capacity to inform healthcare decision-making regarding clinical practice; thus it can be rubricated as a pragmatic or practical clinical trial.

Our study has several limitations as well, as the small sample sizes and the lack of a Structured Clinical Interview for DSM-IV (SCID-I and SCID-II) assessment of primary and co-morbid diagnoses.

In terms of internal validity, the differing dose of the treatments (i.e., the number of sessions) can be considered to be a confounder. We believe that each treatment has a different underlying working model that needs a specified time frame with a stipulated number of sessions and specific interventions in order to initiate a specific process. Moreover, we deliberately wanted to investigate treatment packages with their prototypical doses to inform practitioners about their everyday practice, thus helping to bridge the notorious gap between research and practice.

This study should enlarge our empirically based knowledge of the enduring effects of long-term psychotherapies, especially psychoanalytic therapy.

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# Helsinki Psychotherapy Study

Knekt, P., Laaksonen, M., Härkänen, T., Maljanen, T., Heinonen, E., Virtala, E., & Lindfors, O. (2012). The Helsinki Psychotherapy Study: effectiveness, sufficiency, and suitability of short- and long-term psychotherapy. In R. A. Levy, S. Ablon & H. Kächele (Eds.), *Psychodynamic Psychotherapy Research. Evidence-Based Practice and Practice-Based Evidence* (pp 71-94). New York: Humana Press.

Knekt, P., Lindfors, O., Härkänen, T., Välikoski, M., Virtala, E., Laaksonen, M. A., . . . Helsinki Psychotherapy Study Group. (2008). Randomized trial on the effectiveness of long- and short-term psychodynamic psychotherapy and solution-focused therapy on psychiatric symptoms during a 3-year follow-up. *Psychological Medicine, 38*(5), 689-703.

Knekt, P., Lindfors, O., Renlund, C., Sares-Jäske, L., Laaksonen, M., & Virtala, E. (2011a). Use of auxiliary psychiatric treatment during a 5-year follow-up among patients receiving short- or long-term psychotherapy. *Journal of Affective Disorders, 135*, 221-230.

Knekt P, Lindfors, O., Laaksonen, M., Renlund, C., Haaramo, P., Härkänen, T., . . . Helsinki Psychotherapy Study Group. (2011b). Quasi-experimental study on the effectiveness of psychoanalysis, long-term and short-term psychotherapy on psychiatric symptoms, work ability and functional capacity during a 5-year follow-up. *Journal of Affective Disorder, 132*: 37-47.

Lindfors, O., Knekt, P., Virtala, E., Laaksonen, M., & the Helsinki Psychotherapy Study Group. (2012). The effectiveness of solution-focused therapy and short- and long-term psychodynamic psychotherapy on self-concept during a 3-year follow-up. *Journal of Nervous and Mental Disease, 200*, 949-953.

## Brief Summary

The aims of this ongoing study are to evaluate the effectiveness of two long-term and two short-term psychotherapies and the prediction of patient and therapist factors on the alliance and the outcome of short- vs long-term therapy (Knekt et al. 2012). Both quantitative and qualitative methods are used to meet these aims. Methodological research in the areas of development and implementation of statistical methods for evaluation of the effectiveness and efficacy and of measurement instruments is included. Two separate designs are used for the effectiveness study. In a randomized design, patients were assigned to one of three treatment groups: solution-focused therapy, short-term psychodynamic psychotherapy, and long-term psychodynamic psychotherapy. In a quasi-experimental design, patients who were randomly assigned to the psychotherapies are compared to patients who were self-selected for psychoanalysis. The prediction study is based on a cohort design. The participants are 367 outpatients from psychiatric services in the Helsinki region having long-standing depressive or anxiety disorder causing work dysfunction. Patients with psychotic disorder, severe personality disorder, adjustment disorder, bipolar disorder or substance abuse were excluded. The outcome assessment covers different measures of psychiatric symptoms and recovery (Knekt et al. 2008), need for treatment (Knekt et al. 2011a), work ability (Knekt et al. 2011b), personality functioning (Lindfors et al. 2012), social functioning, lifestyle, and cost-effectiveness. These outcome measures are administered longitudinally: prior to start of treatment and at 14 pre-chosen time points during a 10-follow-up from start of treatment. Solution-focused therapy included 12 and short-term psychodynamic psychotherapy 20 therapy sessions, both therapies lasting about half a year. The long-term therapies were open-ended, psychodynamic psychotherapy lasting about 3 years with about 240 sessions and psychoanalysis lasting about 5 years and about 650 sessions. Only solution-focused therapy was manualized whereas the psychodynamic therapies were conducted in accordance with clinical practice, where the therapists might modify their interventions according to the patient's needs within the respective framework. All the therapists had received standard training and were experienced: the mean number of years of work experience was 9 in the short-term and over 15 years in the long-term therapies.

About 30 original contributions have been published from this study within the areas of effectiveness, suitability, therapist factors, alliance, measurement methods, statistical methods, and qualitative research. A number of current sub-studies within these areas are ongoing (see cited literature above and our homepage).

## **Evaluation**

This study assesses the effectiveness of short-term vs long-term therapy during a very long time period from start of treatment. It also gives criteria, based on multiple patient perspectives, for whom long-term therapy seems necessary and who may recover by short-term therapy. The importance of auxiliary treatment in the evaluation of the sufficiency of treatment is introduced as a key element of outcome. The role of the therapeutic alliance in the prediction and mediation of the change processes will also be possible. The findings can thus be applied in clinical practice. The study will also give information on which therapist factors are suitable for long-term and which for short-term therapy and can thus be taken into account in therapist training. Limitations include the absence of a control group and manualization of the psychodynamic therapies.

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# Patient predictors of psychotherapy outcome in the Helsinki Study

Laaksonen, M., Knekt, P., & Lindfors, O. (2013). Psychological predictors of the recovery from mood or anxiety disorder in short-term and long-term psychotherapy during a 3-year follow-up. *Psychiatry Research*, 208, 162-173.

Laaksonen, MA, Sirkiä C, Knekt P, Lindfors O. (2014). Self-reported immature defense style as a predictor of outcome in short- and long-term psychotherapy. *Brain and Behavior*. Open Access, Doi:10.1002/brb3.190.

Lindfors, O., Knekt, P., Heinonen, E., & Virtala, E. (2014a). Self-concept and quality of object relations as predictors of suitability for short- and long-term psychotherapy. *Journal of Affective Disorders*, 152-154, 202-211.

Lindfors, O., Ojanen, S., Jääskeläinen, T., & Knekt, P. (2014b). Social support as a predictor of the outcome of depression and anxiety disorder in short-term and long-term psychotherapy. *Psychiatry Research*, 216, 44-51.

Joutsenniemi, K., Laaksonen, M., Knekt, P., Haaramo, P., & Lindfors, O. (2012). Prediction of socio-demographic factors on the outcome of short- and long-term psychotherapy. *Journal of Affective Disorders*, 141, 331-342.

## Brief Summary

The aims of this ongoing study are to evaluate the prediction of patient factors on the alliance and the outcome of short-, long-, and short- vs long-term therapy (Knekt et al. 2012). The prediction study is based on a cohort design and the data is coming from the Helsinki Psychotherapy Study. The participants are 367 outpatients from psychiatric services in the Helsinki region having long-standing depressive or anxiety disorder causing work dysfunction. Patients with psychotic disorder, severe personality disorder, adjustment disorder, bipolar disorder or substance abuse were excluded. Solution-focused therapy included 12 and short-term psychodynamic psychotherapy 20 therapy sessions, both therapies lasting about half a year. The long-term therapies were open-ended, psychodynamic psychotherapy lasting about 3 years with about 240 sessions and psychoanalysis lasting about 5 years and about 650 sessions. All the therapists had received standard training and were experienced. The outcome assessment covers different measures of psychiatric symptoms and recovery, need for treatment, work ability, personality functioning, social functioning, lifestyle, and cost-effectiveness. These outcome measures are administered longitudinally: prior to start of treatment and at 14 pre-chosen time points during a 10-follow-up from start of treatment. The predictors, mainly determined at baseline, included patients' psychiatric symptoms, psychological functioning, social functioning, and genetic factors (i.e. DNA determined from blood samples). The main focus of the study is the search for evidence-based criteria to be used in choosing an appropriate treatment for a patient. An interview-based pre-treatment suitability assessment measure of patient's personality characteristics and interpersonal dispositions has been developed and found to be useful in the selection of short- or long-term psychotherapy (Laaksonen et al. 2012, 2013). Several other patient factors, assessed by interview or questionnaires, have also emerged as potential predictors of prognosis in different therapies. Further study will extend the scope of the predictors of suitability and will evaluate the relative importance of them.

Several original contributions have been published from this sub-study (Joutsenniemi et al. 2012, Laaksonen et al. 2014, Lindfors et al. 2014a, 2014b), and a number of studies are ongoing (see cited literature above and our homepage).

## Evaluation

This study gives criteria, based on multiple patient perspectives, for whom long-term therapy seems necessary and who may recover by short-term therapy. The role of the therapeutic alliance in the prediction and mediation of the change processes will also be possible. The findings can thus be

applied in clinical practice. Limitations include the number of patients and possible residual confounding despite adjustment for potential confounding factors.

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# The effects of scheduled waiting for psychotherapy of depression

Ahola, P., Joensuu, M., Knekt, P., Lindfors, O., Saarinen, P.I., Tolmunen, T., Valkonen-Korhonen, M., Jääskeläinen, T., Virtala, E., Tiihonen, J., Lehtonen, J. *A manuscript in submission.*

Clinical Trials.gov NCT00594711

## Method

33 outpatients with major depressive disorder were randomly selected to start dynamic psychotherapy (twice a week) directly (DG, n = 17) and after waiting for six months (WG, n = 16). The symptoms were assessed using the HAMD-17, BDI, SCL-90-DEP, SCL-90-ANX, SCL-90-GSI and TAS-20 before and after waiting, and before and after 12 months of psychotherapy.

## Results

It was found that depressive symptoms declined significantly among the subjects during the waiting time and among those directly receiving psychotherapy without significant group differences. After 12 months of psychotherapy, a significantly stronger decline in anxiety was found in WG patients. Other outcome differences were not found and both groups showed significant symptom remission.

## Conclusions

We conclude that scheduled waiting for psychotherapy is clinically safe and associates with a significant decline in symptoms. We regard it likely that the scheduled protocol for the waiting time is perceived as a preparatory phase for treatment, which already has a significant effect on symptoms even though active treatment has not yet taken place. We furthermore suggest that this hope rising effect may be included in the initial stage of any scheduled treatment and its nonspecific effect should be recognised.

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# Mentalisation-based treatment of BPD

Bateman, A. W., & Fonagy, P. (2004). Psychotherapy for borderline personality disorder. Mentalisation-based treatment. Oxford: Oxford University Press.

Bateman, A. W., & Fonagy, P. (2004). Mentalisation-based treatment of BPD. *Journal of Personality Disorder*, 18(1), 36-51.

Bateman, A. W., & Fonagy, P. (2008). 8-year follow-up of patients treated for borderline personality disorder: Mentalization-based treatment versus treatment as usual. *American Journal of Psychiatry*, 165(5), 631-638.

## Objective

This randomized controlled trial tested the effectiveness of an 18-month mentalization-based treatment (MBT) approach in an outpatient context against a structured clinical management (SCM) outpatient approach for treatment of borderline personality disorder.

## Method

Patients (N=134) consecutively referred to a specialist personality disorder treatment center and meeting selection criteria were randomly allocated to MBT or SCM. Eleven mental health professionals equal in years of experience and training served as therapists. Independent evaluators blind to treatment allocation conducted assessments every 6 months. The primary outcome was the occurrence of crisis events, a composite of suicidal and severe self-injurious behaviors and hospitalization. Secondary outcomes included social and interpersonal functioning and self-reported symptoms. Outcome measures, assessed at 6-month intervals, were analyzed using mixed effects logistic regressions for binary data, Poisson regression models for count data, and mixed effects linear growth curve models for self-report variables.

## Results

Substantial improvements were observed in both conditions across all outcome variables. Patients randomly assigned to MBT showed a steeper decline of both self-reported and clinically significant problems, including suicide attempts and hospitalization.

## Conclusions

Structured treatments improve outcomes for individuals with borderline personality disorder. A focus on specific psychological processes brings additional benefits to structured clinical support. Mentalization-based treatment is relatively undemanding in terms of training so it may be useful for implementation into general mental health services. Further evaluations by independent research groups are now required.

## Contact

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# The LAC Depression Study

- Leuzinger-Bohleber, M., Bahrke, U., Beutel, M., Deserno, H., Edinger, J., Fiedler, G., . . . Will, A. (2010). Psychoanalytische und kognitiv-verhaltenstherapeutische Langzeittherapien bei chronischer Depression: Die LAC-Depressionsstudie {Psychoanalytic and cognitively-behavioral long term treatment in chronic depression: The LAC-Depression Study}. *Psyche – Zeitschrift für Psychoanalyse*, 64, 782-832.
- Beutel, M. E., Leuzinger-Bohleber, M., Rüger, B., Bahrke, U., Negele, A., Haselbacher, A., Fiedler, G., Keller, W. & Hautzinger, M. (2012). Psychoanalytic and cognitive-behavior therapy of chronic depression: study protocol for a randomized controlled trial. *Trials*, 13(1), 117 open access
- Leuzinger-Bohleber, M.; Bahrke, U.; Negele, A. (Hg.) (2013): *Chronische Depression. Verstehen – Behandeln – Erforschen*. (Schriften des Sigmund-Freud-Instituts. Reihe 1: Klinische Psychoanalyse: Depression, Bd. 3). Göttingen: Vandenhoeck & Ruprecht

The multicentric large LAC study was started in 2005 and is ongoing (last patients are still in treatments). It is supported by the DGPT (the umbrella organization of all psychoanalytical schools in Germany, the Heidehof Foundation, the German Research Foundation (DFG), the Sigmund-Freud-Institute, the IPA, Dr. M. Tann and other private donators.

## Background

Due to frequently demonstrated limited effectiveness of short-term psychotherapy for chronic depression we need trials of long-term psychotherapy. The LAC Depressionstudy is the first to determine the efficacy and effectiveness of controlled long-term psychodynamic and cognitive-behavioral (CBT) treatments and to assess the effects of preferential vs. randomized assessment.

## Methods/Design

Patients are assigned to treatment according to their preference or randomized (if they have no preference). Up to 80 sessions of psychodynamic or psychoanalytically oriented treatments (PAT) or up to 60 sessions of CBT are offered during the first year in the study. After the first year, PAT can be continued according to the 'naturalistic' usual method of treating such patients within the system of German health care (normally from 240 up to 300 sessions over two to three years). CBT therapists may extend their treatment up to 80 sessions, but focus mainly on maintenance and relapse prevention.

We have recruited a total of 402 patients (required were 60 per arm). A total of 11 assessments are conducted throughout treatment and up to five years after initiation of treatment. The primary outcome measures are the Quick Inventory of Depressive Symptoms (QIDS, independent clinician rating) and the Beck Depression Inventory (BDI).

We are using several interviews (psychoanalytical initial interviews, SKID I,II, OPD Interviews (Operationalized Psychodynamic Diagnostics), HUS (Heidelberger Umstrukturierungs Skala), SRS (Selfreflecting Scales), LIFE Interview and a broad spectrum of questionnaires.

## Treatment

Both treatments are manualized. The psychoanalytic treatments are based on a training by David Taylor and others using the Tavistock Treatment Manual for Depressed Patients (Taylor, 2010). The cognitive behavioral therapists have been trained by a manual developed by Martin Hautzinger (2003). The adherence of the therapies was studied using the Comparative Psychotherapy Process Scale Scales by Hilsenroth et al., 2005.

## **First Results**

In 2013 first statistical analyses of the preference arm and in 2014 first analyses of the randomization arm were conducted by the independent biostatistics center (Prof. Küchenhoff et al LMU Munich). The results will be available and published soon.

## **Discussion**

We combine a naturalistic approach with randomized controlled trial (RCT) to investigate how effectively chronic depression can be treated on an outpatient basis by the two forms of treatment reimbursed in the German healthcare system and we will determine the effects of treatment preference vs. randomization.

## **Trial registration**

<http://www.controlled-trials.com/ISRCTN91956346>

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# The INDDEP study: inpatient and day hospital treatment for depression- symptom course and predictor of change

- Zeeck, A., von Wietersheim, J., Weiss, H., Beutel, M., Hartmann S. (2013) : The INDDEP study: inpatient and day hospital treatment for depression- symptom course and predictor of change. *BMC Psychiatry*, 13, 100.

## Background

Depression can be treated in an outpatient, inpatient or day hospital setting. In the German health care system, episodes of inpatient or day hospital treatment are common, but there is a lack of studies evaluating effectiveness in routine care and subgroups of patients with a good or insufficient treatment response. Our study aims at identifying prognostic and prescriptive outcome predictors as well as comparative effectiveness in psychosomatic inpatient and day hospital treatment in depression.

## Methods /Design

In an naturalistic study, 300 consecutive inpatient and 300 day hospital treatment episodes in seven psychosomatic hospitals in Germany were included. Patients are assessed at four time points of measurement (admission, discharge, 3-months follow-up) including a broad range of variables (self-report and expert ratings). First, the whole sample will be analysed to identify prognostic and prescriptive extert rating). Secondly. For a comparison of inpatient and day hospital treatment, samples will will be matched according to known predictors of outcome.

## Discussion:

Naturalistic studies with good external validity are needed to assess treatment outcome in depression in routine care and to identify subgroups of patients with different therapeutic needs.

Trial registration: Current Controlled Trials: ISRCTN20317064

## Contact:

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# Erica Process and Outcome Study (EPOS) of goal directed, time-limited child psychotherapy with parental counselling

Carlberg, G, Thorén, A, Billström, S. & Odhammar, F. (2009). Children's expectations and experiences of psychodynamic child psychotherapy, *Journal of Child Psychotherapy*, 35 (2), 175-193.

Odhammar, F., Sundin, E., Jonson, M. & Carlberg, G. (2011). Children in psychodynamic psychotherapy. Changes in global functioning. *Journal of Child Psychotherapy*, 37, 261-279.

Nemirovski Edlund, J., Thorén, A. & Carlberg, G. (2014). Outcome of psychodynamic child psychotherapy in routine practice. *European Journal of Psychotherapy & Counselling*, 16, 228-244

## Brief Summary

The aim of Erica Process and Outcome Study (EPOS) was to study psychodynamic psychotherapy in routine practice. The increased pressure on child psychiatry makes it necessary to develop time-limited and well-defined psychotherapeutic methods.

Extensive data has been collected from 33 cases. Child guidance clinics from different parts of Sweden and Denmark were involved in the project. The form of psychotherapy studied was defined as "goal directed, time-limited child psychotherapy with parallel parental counselling". The children were between 5 and 10 years of age at the beginning of therapy. Therapy frequency was 1-2 sessions a week with a duration of 1-2 years. The parents met their counsellor once a week or at least every fortnight. Therapists and parents formulated goals and frames for the therapies as carefully as possible at the start of therapy. Besides routine psychological assessment at the start of therapy the following instruments were used: DSM-IV, HCAM–The Hampstead Child Adaption Measure, and SDQ–Strength and Difficulties Questionnaire. The same instruments were used after therapy. The process of change has been followed with various specific research instruments, questionnaires and interviews. These were used at the start, during and after the treatment period (Odhammar et al., 2011). In connection with each session the child psychotherapist and the parental counsellor made process notes and completed a form, FWC–Feeling Word Checklist, in order to follow the therapists' countertransference feelings and to facilitate studying sessions of special interest.

In a sub-study of EPOS children aged 6-10 years were interviewed before and after psychotherapy (Carlberg et al., 2009). The aim of this naturalistic study was to explore children's expectations and experiences of psychodynamic child psychotherapy. Semi-structured interviews, complemented with self-rating instruments and non-verbal components such as drawings and dolls, were conducted.

An overarching aim of the research work at the Erica Foundation is to build a database to improve our knowledge of outcome of psychodynamic child and adolescent psychotherapy, measured with instruments such as CGAS/GAF, HCAM, SDQ, SCL-90 and DSM-IV (Nemirovski et al., 2014).

## Evaluation

The combination of qualitative and quantitative methods in this study broadens the understanding of process and outcome in psychodynamic child psychotherapy in routine practice, which is an under-researched area.

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# Psychodynamic interpersonal therapy (PIT) for patients with multi-somatoform disorders (PISO)

Sattel, H., Lahmann, C., Gündel, H., Guthrie, E., Kruse, J., Noll-Hussong, M. . . . Henningsen, P. (2012). Brief psychodynamic interpersonal psychotherapy for patients with multisomatoform disorder: randomised controlled trial. *British Journal of Psychiatry*, 200(1), 60-67.

Sattel, H., Kittner, A., & Henningsen, P. (2011). Eine psychodynamisch-interpersonelle Kurztherapie für Patienten mit multisomatoformen Störung (PISO) - Passt dies für alle? {A brief psychodynamic-interpersonal psychotherapy for patients with multisomatoform disorder (PISO) – one size fits all?} *Psychotherapie Psychosomatik medizinische Psychologie*, 61, A070.

Otti, A., Gündel, H., Henningsen, P., Zimmer, C., Wohlschlaeger, A., & Noll-Hussong, M. (2013). Functional network connectivity of pain-related resting state networks in somatoform pain disorder: an exploratory fMRI study. *Journal of Psychiatry and Neuroscience*, 38(1), 57-65.

## Brief Summary

Working group PISO

In 2006 a group of researchers with a psychodynamic background (“PISO working group”) started after thorough preparation a large multicenter randomized clinical trial. The study was supported by the German Research Foundation DFG.

## Background

Patients with distressing bodily symptoms – in particular when these cannot be sufficiently explained by organic causes – are common in the healthcare system. Although many of these patients are not satisfied with the delivered medical treatment they remain to be heavy users of healthcare, thus incurring large costs to health services and society. Although there is some evidence that psychotherapy is a promising option for this disorder, trials studying cognitive-behavioural therapy (CBT) and short-term psychodynamic therapies have been of less than adequate size or did not address the full diagnostic range of these disorders.

## Methods

We conducted our study at six university departments of psychosomatic medicine, where we recruited 211 patients from the out-patient departments of neurology and internal medicine, from pain treatment centres and an orthopaedics private practice. The included patients required to have a minimum of three current somatoform symptoms (pain, dizziness, bowel dysfunction, fatigue, etc.) that are functionally disabling and that an organic disease or another mental disorder cannot sufficiently explain plus a history of somatoform symptoms on at least half of the days over at least 2 years, resulting in healthcare use. These were established by the somatoform disorders and hypochondria sections of the Structured Clinical Interview for DSM-IV (SCID). The data storage and monitoring as well as the statistical analysis of the primary outcome was executed by an independent clinical study coordination centre, following high methodological standards.

The dimensions assessed in our study covered self-report data on physical and mental quality of life, psychopathology (depression, somatization, (health-) anxiety), illness perception, health care use, attachment styles, alexithymia and an evaluation of the therapeutic process. The assessments were made before and after treatment, plus a follow up, which was carried out 9 months after end of therapy. Additionally heart rate variability was measured as an indicator for organismic adaptability.

## Treatment

Psychodynamic interpersonal therapy (PIT) consisted of 12 weekly sessions, which were specifically adapted to the needs of patients with bodily distress. Conceptually, our approach assumes that developmentally based dysregulations of (bodily) self-experience and relationships rather than unconscious conflicts are the primary basis for the symptoms. PIT was compared with an Enhanced Medical Care group, which received education and counselling regarding the therapeutic alternatives based on the evidence-based guidelines for the treatment of somatoform disorders/functional somatic syndromes in primary and somatic specialist care. Both treatments were manualized and the adherence of the therapists was determined for all therapeutic sessions.

## Results

As primary outcome we prespecified a clinically relevant improvement in bodily quality of life (as compared to the control group). Our findings suggest that this improvement can be achieved using a short-term intervention consisting of 12 PIT sessions in patients, who experience chronic and disabling bodily symptoms that have no recognised treatment. The success of the treatment was independent of the patients' bodily symptom characteristics of each patient, so that PIT was suited to improve bodily quality of life in patients with a multitude of different chronic physical symptoms.

So far additional analyses related to our study addressed economic aspects of PISO, attachment styles, functional MR-imaging studies and the use of heart rate variability in order to predict therapy outcome. These studies are published or underway.

Trial registration: International Standard Randomised Controlled Trial Number ISRCTN23215121.

## Contact

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# The efficacy of a psychoanalytic psychotherapy for panic disorders: Panic-Focused Psychodynamic Psychotherapy (PFPP)

Busch, F. N.; Milrod, B. L.; & Sandberg, L. S. (2009). A study demonstrating efficacy of a psychoanalytic psychotherapy for panic disorder: implications for psychoanalytic research, theory and practice. *Journal of the American Psychoanalytic Association*, 57 (1): 131-48.

Milrod, B. L.; Cooper, A.; & Shapiro, T. (1997). *Manual of Panic-Focused Psychodynamic Psychotherapy*. Washington, DC: American Psychiatric Press.

Milrod, B. L.; Leon, A. C.; Busch, F. N.; Rudden, M.; Schwalberg, M.; Clarkin, J.; Aronson, A.; Singer, M.; Turchin, W.; Klass, E. T.; Graf, E.; Teres, J. J.; & Shear, M. K. (2007). A randomized controlled clinical trial of psychoanalytic psychotherapy for panic disorder. *American Journal of Psychiatry*, 164, 265–272.

## Brief Summary

Systematic research on psychoanalytic treatments has been limited by several factors, including a belief that clinical experience can demonstrate the effectiveness of psychoanalysis, rendering systematic research unnecessary, the view that psychoanalytic research would be difficult or impossible to accomplish, and a concern that research would distort the treatment being delivered. In recent years, however, many psychoanalysts have recognized the necessity of research in order to obtain a more balanced assessment of the role of psychodynamic psychotherapy and psychoanalysis in a contemporary treatment armamentarium, as well as to allow appropriate evaluation and potentially greater acceptance by the broader mental health and medical communities. In this context, studies were performed on psychodynamic treatment, Panic-Focused Psychodynamic Psychotherapy (PFPP), initially in an open trial and then in a randomized controlled trial (RCT) in comparison with a less active treatment, Applied Relaxation Training (ART), for adults with primary DSM-IV panic disorder.

The PFPP studies were conducted from 1997 to 2005 at Weill Cornell Medical College, using therapists who were Ph.D. psychologists or M.D.s after psychiatric residency, all of whom completed at least three years of psychoanalytic training in New York City area APsaA-approved psychoanalytic training programs. All study therapists were trained on how to conduct PFPP in accord with the treatment manual. Initial cases were closely supervised. The PFPP manual (Milrod, Cooper, and Shapiro 1997) was constructed around a psychodynamic formulation of panic disorder, which incorporated the work of psychoanalytic theorists and clinicians as well information derived from psychological studies of patients with panic disorder—e.g., parental perceptions, premorbid personality traits, defense mechanisms. Based on these clinical observations and studies, a formulation was developed that outlines a series of dynamics central to panic disorder (Milrod et al., 1997), including ambivalence about autonomy and dependency, fear of anger disrupting needed attachments, narcissistic humiliation surrounding panic, ego deficiencies, and sexual conflicts (find detailed information about the therapeutical focus of the PFPP manual in Milrod et al., 1997). After the first draft of the manual was formulated, it was given to four psychoanalysts, all experts in treating anxiety, who had not been involved in its creation, for comment in an effort to ensure that the manual captured the way psychoanalysts in fact treat patients with panic disorder. All four felt the manual closely approximated their own psychoanalytic clinical work, suggesting that operationalizing these approaches need not create a rigid or nonpsychoanalytic treatment.

The open clinical trial of PFPP was initially accomplished between 1997 and 2000 and was not an efficacy study, as there was no comparison condition, but was designed to determine whether PFPP could be reliably delivered, and to assess its effects on patients with panic disorder. Twenty-one patients with primary DSM-IV panic disorder signed informed written consent forms and were treated with twenty-four sessions of PFPP over twelve weeks. No concurrent treatments were permitted during this clinical trial, and patients who presented on ineffective anti-panic medications (i.e., who

met symptomatic study entrance criteria while taking pharmacological agents) were tapered off of their medication regimens in order to gain access to the study. Four patients dropped out, and at termination sixteen of the remaining seventeen met “response” criteria, a greater than 40 percent reduction in the Panic Disorder Severity Scale (PDSS). In addition to a significant reduction in symptoms of panic disorder, the patients demonstrated significant improvement in measures of psychosocial function, anxiety unrelated to panic, and depression. Notably, comorbid major depression, present in eight of twenty-one patients, remitted with PFPP as well. Clinical improvements were maintained at six-month follow-up, without intervening treatment.

Following the open trial, our group proceeded with a randomized controlled trial (Milrod et al. 2007) in which PFPP was compared with a less active psychotherapy, applied relaxation training (ART), to assess efficacy. ART was chosen as a comparison therapy because it has been shown to be a credible and efficacious treatment for panic disorder. In the efficacy study, treatments were designed to match in number and frequency of sessions and in the degree of therapist experience, making this treatment trial a conservative one, less likely to show differences between treatment conditions. Nonetheless, a significantly greater reduction in a broad range of panic symptoms was observed after PFPP, compared with ART, as assessed by the Panic Disorder Severity Scale, the primary outcome measure. Using the a priori definition of “response”, PFPP demonstrated a significantly higher rate of response compared with ART: 73% vs. 39% ( $p = .017$ ). PFPP also led to significantly greater improvement in psychosocial function, as measured on the Sheehan Disability Scale (SDS):  $p = .014$ . The SDS is a self-report instrument using a visual analog scale in which the patient rates himself from 0 (not at all impaired) to 10 (extremely impaired) by symptoms in each of three areas: work or school, social life, and family life/home responsibilities. In addition, the PFPP studies assessed adherence with a well-operationalized scale demonstrated excellent interrater reliability (ICC [intraclass correlation coefficient] = .92), indicating that independent raters assessing the same sessions or therapeutic treatment obtain very similar results. Most of the study therapists have easily met adherence standards (Milrod et al. 2007).

## Evaluation

The PFPP efficacy study is part of a small but increasing effort to introduce psychoanalytic psychotherapy into the era of evidence-based medicine, in that it is the first psychoanalytic psychotherapy for a primary DSM-IV Axis I anxiety disorder to have demonstrated efficacy. We can expect that nonpsychoanalytic colleagues, and institutions that monitor clinical practice (the American Psychiatric Association, the Institute of Medicine, the National Institute for Health and Clinical Excellence in the UK), will show a new respect for psychoanalytic psychotherapy for panic disorder. This study should give pause to those within our own ranks who maintain that psychoanalysis and psychoanalytic psychotherapy cannot be empirically studied.

## Contact:

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# The Personality Disorders Institute (PDI) of the Weill Cornell Medical College

Clarkin, J. F., Levy, K. N., Lenzenweger, M. F., & Kernberg, O. F. (2004). The Personality Disorders Institute / Borderline Personality Disorder Research Foundation randomized control trial for borderline personality disorder: Rationale, methods, and patient characteristics. *Journal of Personality Disorders, 18*(1): 52-72.

Clarkin, J. F., Levy, K. N., Lenzenweger, M. F., & Kernberg, O. F. (2007). Evaluating three treatments for borderline personality disorder: A multiwave study. *American Journal of Psychiatry, 164*, 922-928.

Clarkin, J. F., & Levy, K. N. (in press). Empirical status of Transference Focused Psychotherapy. *Psychoanalytic Inquiry*.

The Personality Disorders Institute (PDI) of the Weill Cornell Medical College, under the leadership of Otto F. Kernberg and John F. Clarkin, has the goal of investigating personality pathology, and developing empirically a psychodynamic treatment for these disorders. The empirical investigations of the PDI are guided by object relations theory which posits the centrality of internalized representations of self and other, and related affects in both the pathology and a central focus of therapeutic change (Kernberg, 1984; Kernberg, 2012; Kernberg & Caligor, 2005).

## Groundwork

In order to empirically investigate complex and clinically relevant object relations concepts, a self-report inventory and a semi-structured interview have been developed. The Inventory of Personality Organization (IPO) is a self-report instrument that measures the constructs of identity diffusion, primitive defenses, reality testing, aggression, and moral values (Lenzenweger, Clarkin, Kernberg, & Foelsch, 2001). The object relations constructs in the IPO have significant associations with other key personality traits (Lenzenweger, McClough, Clarkin, & Kernberg, 2012). The Structured Interview of Personality Organization (STIPO) is a semi-structured interview which reliably assesses patients' identity, defenses, quality of object relations, coping strategies, aggression, and moral values (Stern, Caligor, Clarkin, Critchfield, Horz, MacCornack, Lenzenweger, & Kernberg, 2010). The STIPO has been used to demonstrate personality organization changes following a dynamic treatment (Doering, et al, 2010).

We have done extensive empirical work examining the nature of borderline personality disorder (BPD). We examined the criteria for BPD diagnosis by factor analysis (Clarkin, Hull, & Hurt, 1993), and found three factors in the condition: identity diffusion, affective dysregulation, and impulsivity. By using object relations theory combined with finite mixture modeling, we have isolated three groups of borderline individuals (Lenzenweger, Clarkin, Yeomans, Kernberg, & Levy, 2008). These three groups vary not only in terms of severity but also in terms of combination of adjustments to aggression, paranoid ideation, and antisocial traits. Aggression in BPD patients is influenced by the patients' attachment style (Critchfield, Levy, Clarkin, & Kernberg, 2008). In a cross-cultural study with colleagues in Germany, we have used the Adult Attachment Interview (AAI) to examine attachment and mentalization in patients with co-occurring BPD and narcissistic personality disorder (Diamond, Levy, Clarkin, Fischer-Kern, Cain, Doering, Hörz, & Buchheim, in press).

## Manualisation

An object relations treatment for personality disorders has been detailed in two treatment manuals. Transference-focused psychotherapy (TFP) has been described for patients with BPD and borderline personality organization (Clarkin, Yeomans, & Kernberg, 2006). In addition, a version of this

psychodynamic treatment has also been described for patients with higher level personality pathology (Caligor, Clarkin, & Kernberg, 2007).

## **Experiment**

TFP for patients with borderline personality disorder has been empirically examined and supported in two randomized clinical trials, one in New York City (Clarkin, Levy, Lenzenweger, & Kernberg, 2007), and one in Europe (Doering, Hörz, Rentrop, Fischer-Kern, Schuster, Benecke, Buchheim, Martius, & Buchheim, 2010). In addition to symptom reduction, TFP resulted in an increase in narrative coherence and reflective functioning (Levy, Meehan, Kelly, Reynoso, Weber, Clarkin, & Kernberg, 2006), and improvement in personality organization (Doering, Hörz, Rentrop, Fischer-Kern, Schuster, Benecke, Buchheim, Martius, & Buchheim, 2010). We have isolated predictors of change and rates of change in the treatment of BPD patients (Lenzenweger, Clarkin, Levy, Yeomans, & Kernberg, 2012).

## **Perspectives**

Our current work builds on these previous findings. We are in the process of using pre-treatment genetic markers combined with neurocognitive functioning (fMRI) to predict response to TFP over a treatment episode of 18 months. A major goal of the extended treatment is not only symptom reduction, but also significant improvement in work functioning and satisfaction in interpersonal relations.

## **Contact**

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# The Munich - New York Collaborative Study (MNYS): The psychodynamic treatment of BPO

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 (Buchheim, P., Dammann, G., Lohmer, M., Martius, Ph. (Munich) & Kernberg, O., Clarkin, J. (New York))

## 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. Personality Disorders Institute, Weill Cornell Medical College: Treatment development for personality disorders

The Personality Disorders Institute (PDI) of the Weill Cornell Medical College, under the leadership of Otto F. Kernberg and John F. Clarkin, has the goal of investigating personality pathology, and developing empirically a psychodynamic treatment for these disorders. The empirical investigations of the PDI are guided by object relations theory which posits the centrality of internalized representations of self and other, and related affects in both the pathology and a central focus of therapeutic change (Kernberg, 1984; Kernberg, 2012; Kernberg & Caligor, 2005).

In order to empirically investigate complex and clinically relevant object relations concepts, a self-report inventory and a semi-structured interview have been developed. The Inventory of Personality Organization (IPO) is a self-report instrument that measures the constructs of identity diffusion, primitive defenses, reality testing, aggression, and moral values (Lenzenweger, Clarkin, Kernberg, & Foelsch, 2001). The object relations constructs in the IPO have significant associations with other key personality traits (Lenzenweger, McClough, Clarkin, & Kernberg, 2012). The Structured Interview of Personality Organization (STIPO) is a semi-structured interview which reliably assesses patients' identity, defenses, quality of object relations, coping strategies, aggression, and moral values (Stern, Caligor, Clarkin, Critchfield, Horz, MacCornack, Lenzenweger, & Kernberg, 2010). The STIPO has been used to demonstrate personality organization changes following a dynamic treatment (Doering, et al, 2010).

We have done extensive empirical work examining the nature of borderline personality disorder (BPD). We examined the criteria for BPD diagnosis by factor analysis (Clarkin, Hull, & Hurt, 1993), and found three factors in the condition: identity diffusion, affective dysregulation, and impulsivity. By using object relations theory combined with finite mixture modeling, we have isolated three groups of borderline individuals (Lenzenweger, Clarkin, Yeomans, Kernberg, & Levy, 2008). These three groups vary not only in terms of severity but also in terms of combination of adjustments to aggression, paranoid ideation, and antisocial traits. Aggression in BPD patients is influenced by the patients' attachment style (Critchfield, Levy, Clarkin, & Kernberg, 2008). In a cross-cultural study with colleagues in Germany, we have used the Adult Attachment Interview (AAI) to examine attachment and mentalization in patients with co-occurring BPD and narcissistic personality disorder (Diamond, Levy, Clarkin, Fischer-Kern, Cain, Doering, Hörz, & Buchheim, in press).

An object relations treatment for personality disorders has been detailed in two treatment manuals. Transference-focused psychotherapy (TFP) has been described for patients with BPD and borderline personality organization (Clarkin, Yeomans, & Kernberg, 2006). In addition, a version of this psychodynamic treatment has also been described for patients with higher level personality pathology (Caligor, Clarkin, & Kernberg, 2007).

TFP for patients with borderline personality disorder has been empirically examined and supported in two randomized clinical trials, one in New York City (Clarkin, Levy, Lenzenweger, & Kernberg, 2007), and one in Europe (Doering, Hörz, Rentrop, Fischer-Kern, Schuster, Benecke, Buchheim, Martius, & Buchheim, 2010). In addition to symptom reduction, TFP resulted in an increase in narrative coherence and reflective functioning (Levy, Meehan, Kelly, Reynoso, Weber, Clarkin, &

Kernberg, 2006), and improvement in personality organization (Doering, Hörz, Rentrop, Fischer-Kern, Schuster, Benecke, Buchheim, Martius, & Buchheim, 2010). We have isolated predictors of change and rates of change in the treatment of BPD patients (Lenzenweger, Clarkin, Levy, Yeomans, & Kernberg, 2012).

Our current work builds on these previous findings. We are in the process of using pre-treatment genetic markers combined with neurocognitive functioning (fMRI) to predict response to TFP over a treatment episode of 18 months. A major goal of the extended treatment is not only symptom reduction, but also significant improvement in work functioning and satisfaction in interpersonal relations.

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# The Vienna-Munich TFP Study: An RCT on Transference-Focused Psychotherapy vs. Treatment by Experienced Community Psychotherapists for Borderline Personality Disorder

Doering, S., Hörz, S., Rentrop, M., Fischer-Kern, M., Schuster, P., Benecke, C., . . . Buchheim, P. (2010). Transference-focused psychotherapy v. treatment by community psychotherapists for borderline personality disorder: randomised controlled trial. *British Journal of Psychiatry*, *196*, 389-395.

Fischer-Kern, M., Schuster, P., ND, Tmej, A., Buchheim, A., Rentrop, M., Buchheim, P., . . . Fonagy, P. (2010). The relationship between personality organization, reflective functioning, and psychiatric classification in borderline personality disorder. *Psychoanalytic Psychology*, *27*(4), 325-409.

Diamond, D., Yeomans, F., Levy, K., Hörz, S., Fischer-Kern, M., Delaney, J., & Clarkin, J. (2013). Transference focused psychotherapy for patients with co-morbid narcissistic and borderline personality disorder. *Psychoanalytic Inquiry*, *33*(6), 527-555.

Diamond, D., Levy, K. N., Clarkin, J. F., Fischer-Kern, M., Cain, N., Doering, S., . . . Buchheim, A. (2014). Attachment and mentalization in patients with co-morbid narcissistic and borderline personality disorder. *Personality Disorders: Theory, Research, and Treatment*, *5*(4), 428-433.

## Brief Summary

The Munich-Vienna TFP Study was performed between 2004 and 2007. It is an RCT that compares Transference-Focused Psychotherapy (TFP) with a high quality treatment-as-usual, i.e. treatment by experienced community psychotherapists (ECP). One hundred and four female patients with borderline personality disorder (BPD) were treated for one year. TFP resulted in a significantly higher remission rate, fewer drop-outs, fewer suicide attempts, fewer psychiatric in-patient admissions, higher improvement of personality structure and psychosocial functioning. No group differences occurred with regard to self-harming behavior and self-assessment of general psychopathology.

## Treatment

TFP is a manualized psychoanalytic psychotherapy for patients with borderline personality organization that was developed by Otto F. Kernberg (Clarkin et al. 2006). TFP is based on psychoanalytic object relations theory. It is a twice-per-week outpatient individual psychotherapy that combines psychodynamic principles with a structured setting and a treatment contract. The treatment focuses on the transference; once the treatment frame is in place, the core task in TFP is to identify internal object relations dyads that act as the “lenses” which determine the patient's experience of the self and the world. The aim of the treatment is to integrate split-off representations of the self and the objects and, thus, foster a maturation of personality organization.

## Method

Outpatients were recruited at university hospitals in Munich and Vienna. They were randomly assigned to either TFP or ECP. The study period covered one year, treatments were continued, if indicated. At baseline and after one year comprehensive assessments were conducted. These covered self-ratings (BDI, STAI, BSI) and interview measures (SCID-I and -II, STIPO, AAI) and observer assessments of psychosocial functioning (GAF score), self-harming behavior, and service use. Attachment style, coherence, and reflective functioning (RF) were determined from the Adult Attachment Interview (AAI).

Intent-to-treat analyses were performed in a twofold way: observed cases (OC) as well as last observation carried forward (LOCF). In addition completer analyses were conducted.

## Results

In the TFP group significantly fewer drop-outs occurred (38.5% v. 67.3%) and also significantly fewer patients attempted suicide ( $d = 0.8$ ,  $P = 0.009$ ). TFP was significantly superior with regard to borderline symptomatology ( $d = 1.6$ ,  $P = 0.001$ ), psychosocial functioning ( $d = 1.0$ ,  $P = 0.002$ ), personality organisation ( $d = 1.0$ ,  $P = 0.001$ ) and psychiatric in-patient admissions ( $d = 0.5$ ,  $P = 0.001$ ). Both groups improved significantly in the realm of depression and anxiety and the transference-focused psychotherapy group in general psychopathology, all without significant group differences ( $d = 0.3$ – $0.5$ ). Self-harming behaviour did not change in either group. Moreover, improvement in RF was significantly greater in the TFP group as compared with the ECP group. The effect was of medium size ( $d = 0.45$ ). Attachment status improved significantly in the TFP group, but not in the ECP group: Twelve out of 38 TFP patients available for follow-up changed from insecure to secure attachment status, whereas none did so in the ECP group. The coherence scale improved strongly in the TFP group (effect size  $d=1.27$ ) and just moderately in the ECP group ( $d=0.32$ ).

OC analyses revealed similar results as LOCF analyses with higher effect sizes and lower levels of significance. Completer analyses with control for treatment dose remained significant for GAF score, DSM-IV criteria for BPD, and personality organization.

## Conclusion

TFP is an efficacious psychoanalytic psychotherapy for the treatment of patients with borderline personality organization.

## Trial registration

Clinical trials.gov: NCT00714311.

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# Manualized Supportive-Expressive Psychotherapy Versus Nonmanualized Community-Delivered Psychodynamic Therapy for patients with personality disorders: Bridging efficacy and effectiveness

Vinnars, B., Barber, J.P., Norén, K., Gallop, R., Weinryb, R.M. (2005). Manualized Supportive-Expressive Psychotherapy Versus Nonmanualized Community-Delivered Psychodynamic Therapy for Patients With Personality Disorders: Bridging Efficacy and Effectiveness. *American Journal of Psychiatry*, 162, 1933–1940.

Vinnars, B., Barber, J.P., Norén, K., Thormählen, B., Gallop, R., Lindgren, A., Weinryb, R.M. (2007). Who can benefit from time-limited dynamic psychotherapy? A study of psychiatric outpatients with personality disorders. *Clinical Psychology and Psychotherapy*, 14, 198–210.

Vinnars, B., Thormählen, B., Gallop, R., Norén, K., & Barber, J. P. (2009). Do personality problems improve during psychodynamic supportive-expressive psychotherapy? Secondary outcome results from a randomized controlled trial for psychiatric outpatients with personality disorders. *Psychotherapy Theory, Research, Practice, Training*, 46(3), 352-375.

## Brief Summary

Time-limited manualized dynamic psychotherapy was compared with community-delivered psychodynamic therapy for outpatients with personality disorders.

{Vinnars, 2005 #140}

In a stratified randomized clinical trial, 156 patients with any personality disorder diagnosis were randomly assigned either to 40 sessions of supportive-expressive psychotherapy (N=80) or to community-delivered psychodynamic therapy (N=76). Assessments were made at intake and 1 and 2 years after intake. Patients were recruited consecutively from two community mental health centers (CMHCs), assessed with the Structural Clinical Interview for DSM-IV Axis II Personality Disorders, and included if they had a diagnosis of any DSM-IV personality disorder. The outcome measures included the presence of a personality disorder diagnosis, personality disorder severity index, level of psychiatric symptoms (SCL-90), Global Assessment of Functioning Scale score, and number of therapy sessions. General mixed-model analysis of variance was used to assess group and time effects.

In both treatment conditions, the global level of functioning improved while there were decreases in the prevalence of patients fulfilling criteria for a personality disorder diagnosis, personality disorder severity, and psychiatric symptoms. There was no difference in effect between treatments. During the follow-up period, patients who received supportive-expressive psychotherapy made significantly fewer visits to the CMHCs than the patients who received community-delivered psychodynamic therapy.

Manualized supportive-expressive psychotherapy was as effective as nonmanualized community-delivered psychodynamic therapy conducted by experienced dynamic clinicians.

## Evaluation

The main limitation of the study is that the lack of a placebo or inactive control does not allow to conclude that treatment is responsible for the outcomes obtained. However, this is a limitation of all comparative studies that for ethical reasons are forced to eliminate placebo groups. Nevertheless,

comparison with naturalistic observations of untreated patients indicates that the present results are likely not due to the mere passage of time.

In conclusion, time-limited manualized supportive-expressive psychotherapy can be introduced in a community setting with promising results. However, it is not superior to psychiatric open-ended nonmanualized dynamic therapy conducted by experienced clinicians.

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# The Danish National Schizophrenia project (DNS II): Prospective, comparative, longitudinal, multicentre study of psychodynamic psychotherapy of first-episode psychosis. A controlled design of non-selected, consecutively referred/admitted patients.

- Harder S, Koester A, Valbak K, Rosenbaum B. Five-year follow-up of supportive psychodynamic psychotherapy in first-episode psychosis: long-term outcome in social functioning. *Psychiatry: Interpersonal and Biological Processes*, 2014;77(2):155-68
- Rosenbaum, B., Harder, S., Knudsen, P., Koester, A., Lindhardt, A., Valbak, K., & Winther, G. Supportive psychodynamic psychotherapy versus treatment as usual for first episode psychosis: two-year outcome. *Psychiatry: Interpersonal and Biological Processes*, 2012;75(4): 331 – 341

## Background

During recent decades, psychodynamic treatment has lacked empirical, systematic outcome studies that it as an evidence-based intervention for patients with schizophrenia spectrum disorders. After 1984 radical conclusions were drawn concerning psychodynamic psychotherapy for patients with schizophrenia:

“the evidence from at least half a dozen studies would indicate that no further research on the intensive individual psychotherapy of schizophrenics based on psychodynamic or interpersonal principles is warranted” (Klerman, 1984).

“Individual and group psychotherapies adhering to a psychodynamic model (defined as therapies that utilize interpretation of unconscious material, focus on transference, and regression) should not be used in the treatment of persons with schizophrenia” (Lehman & Steinwachs, 1998, PORT Recommendation, § 22). This recommendation was removed in an update of the treatment recommendation - not because it was considered false, but because it was implicitly understood that everyone knew that psychodynamic treatment had been proven ineffective.

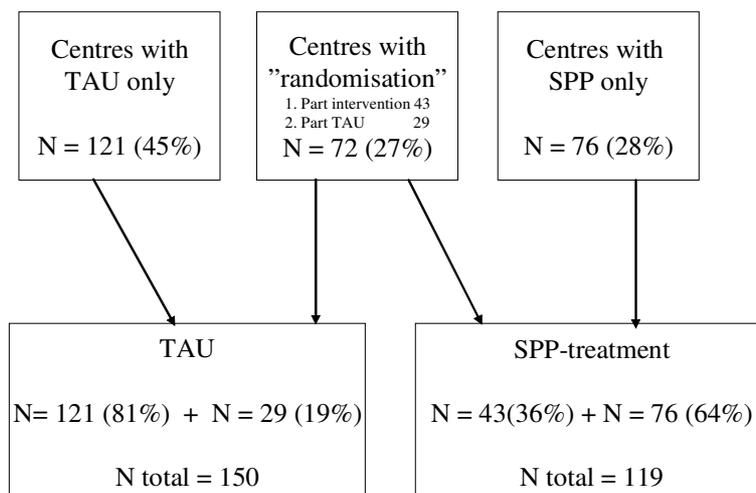
## Design and Sample

The study was designed as a prospective, longitudinal, comparative, multi-centre investigation. The included patients were offered either: 1) manualised Supportive Psychodynamic Psychotherapy as a supplement to treatment as usual (named the SPP), or 2) TaU for two years (called the TaU).

All centres involved in the study had all shown a previous interest in investigating the methods of supportive psychodynamic psychotherapy, even though not all of them had sufficient resources to offer individual psychotherapy in a systematic way which would be needed for carrying out a randomised controlled study. Thus, a controlled design was chosen in which the centres in both groups included rural and urban sites, university and non-university clinics, as well as large and small departments.

A total of 269 consecutively referred patients with first-episode psychosis of the F2- type according to the ICD-10 were included over two years (October 1997 to September 1999). Fourteen psychiatric centres participated. The SPP group consisted of 119 patients consecutively admitted to eight centres, and the TaU group consisted of 150 patients consecutively admitted to nine centres (see Figure 1).

Figure 1



The sample consisted of 181 males and 88 females, mainly of Nordic origin (90%). The patients' median age at inclusion was 23.7 yrs. (range 16.2-35.9 years), and median age at onset of illness was 20.0 yrs. (range 6-35 years). A total of 48% were living alone, 26% had no friends, 70 % were without education, 22% had not worked within the past year, and 30 % had some kind of moderate substance abuse. The median values for Global Assessment of Functioning (GAF) were 31 for GAF<sub>symptom</sub> and 35 for GAF<sub>function</sub>.

## Procedures and measures

Patients with a first-episode psychosis admitted to either the inpatient unit or to the community mental health centre, in 1997-1999, were systematically assessed within two weeks to determine whether they conformed to the diagnosis of ICD-10 F20-F29.

The following assessment and measurement scales were used: demographic and socio-economic charts, Operational Criteria Checklist for Psychotic Illness (OPCRIT) (McGuffin, Farmer & Harvey, 1991), GAF in the DSM-IV (APA, 1994), Strauss-Carpenter (Strauss & Carpenter, 1974; Strauss & Carpenter, 1977) and the PANSS (Kay, Fiszbein & Opler, 1987).

The test battery was repeated after two and five years. All assessments were conducted by trained interviewers who were independent of, but not blinded to, the treatments offered to the patients. Reliability testing was made by means of videos of interviews with patients from the different centres.

Allocation to treatment is visualised in Figure 1. In three centres (27% of the sample), patients from the first part of the intake were allocated to the SPP group and from the second part of the intake to the TaU group. No further selection was made regarding this allocation of patients. In five centres (28% of the sample), all patients were offered SPP (in addition to TaU), whereas six centres (45% of the sample) offered only TaU to the project patients.

## Interventions

### TaU

In Denmark, all TaU-treatment was consistently conducted by a doctor and contact persons from the staff. TaU consisted of different treatment modalities administered according to the patients' individual needs and available resources at the psychiatric unit at the moment of treatment. Treatment encompassed short psychoeducation programmes, individual meetings with contact persons (mainly nurses and assistant nurses) and other consultants (psychologist, social worker), group meetings, and medical advice (including low-dosis medication).

### Psychodynamic supportive psychotherapy

The SPP was based on a model of psychosis that understands the condition as a result of pathogenetic pathways that involve an array of biological, psychological and social risk factors that lead to a disturbed development and functioning in several basic psychological capacities.

The *supportive* elements in this approach contained, among others, the following:

Helping the patient to understand his/her feelings, attitudes and subjective intentions in the concrete interpersonal relationships

Helping the patient recover from the psychosocial losses related to his or her suffering from psychosis by, in a trusting manner, reformulate the patient's story of development with elements of hope and realistic optimism counterbalancing the patient's negative and self-denigrating attitude

Applying an array of supportive techniques, including:

clarifications, affirmations and suggestions; holding and containing the patient's painful state of mind; maximising adaptive strategies, encouraging patient activities; helping the the patient to understand how psychotic mechanisms work psychologically in the individual and in the specific interactions with others, and how other people might be expected to react with common sense reactions.

The term '*psychodynamic*' refers to the following characteristics of the therapeutic approach:

It aims to establish a working alliance that functions even in the periods marked by the patient's ambivalent, confusing or negative attitude (transference) towards the therapist

It uses the dynamics of the therapeutic relationship and setting ('transference' in a broad sense) to understand communication processes in other relationships outside the setting of psychotherapy

It emphasises the role and influence of the counter-transference on the therapist's understanding and responses

It understands emotions and thoughts communicated in the therapy as instances that illustrate for both patient and therapist what may happen in daily life situations in which the patient communicates and interact with others

It emphasises the importance and presence of unconscious processes

It empathises with the patient's affective states and unresolved states of mind based on a theoretical model for understanding the patient's difficulties in dealing with emotional experience

It recognises and respects the co-existence of both psychotic and non-psychotic aspects of the personality (Bion)

It acknowledges the importance of developing levels of mental functioning enabling the patient to deal with emotional experiences in a more adaptive way, i.e. 'turning the raw sense impressions into thoughts' and 'thoughts into thinking' (Bion).

The therapists were psychiatrists and psychologists with an average length of training in psychodynamic psychotherapy, most of them between 1-4 years of training. There was no systematic external control of the therapists' adherence to the psychotherapy manual, but each case was regularly supervised at the centers which offered SPP as part of the study. Seminars in which the contents and ideas of the manual were presented and discussed in depth were conducted for therapists and supervisors in order to enhance uniformity in therapeutic thinking and conduct.

## Results

There was no significant difference between groups at inclusion concerning sex, symptom level as measured by  $GAF_{\text{symptom}}$  and PANSS, functional level as measured by  $GAF_{\text{function}}$ , work status and substance abuse.

### Reliability

ICC was calculated for PANSS-positive = 0.70, PANSS-negative = 0.74,  $GAF_{\text{symptom}}$  = 0.56 and  $GAF_{\text{function}}$  = 0.74. The ICC agreement is thus good for PANSS and  $GAF_{\text{function}}$ , and moderate, but acceptable for  $GAF_{\text{symptom}}$ .

At year two, data were obtained from 99 patients (83%) in the SPP group and from 113 patients (75%) in the TaU group. The two attrition groups did not differ at baseline.

### Improvement of symptomatology and social function after two years

The improvement over the two years for the SPP group alone was at a significant level for  $PANSS_{\text{pos}}$  ( $p=0.000$ ;  $\text{Eta}^2: 0.50$ ),  $PANSS_{\text{neg}}$  ( $p=0.001$ ;  $\text{Eta}^2: 0.10$ ),  $GAF_{\text{function}}$  ( $p=0.000$ ;  $\text{Eta}^2: 0.39$ ) and  $GAF_{\text{symptom}}$  ( $p=0.000$ ;  $\text{Eta}^2 0.39$ ).

The difference in improvement between the SPP group and the TaU group:

We found significantly higher levels of improvement in the SPP group than in the TaU group for  $GAF_{\text{function}}$  ( $p=0.000$ ;  $\text{Eta}^2: 0.054$ ) and  $GAF_{\text{symptom}}$  ( $p=0.010$ ;  $\text{Eta}^2: 0.022$ ), whereas the difference did not reach the level of significance for  $PANSS_{\text{pos}}$  ( $p=0.067$ ;  $\text{Eta}^2: 0.012$ ) and  $PANSS_{\text{neg}}$  ( $p=0.873$ ).

At five years follow-up, 148 (55%) of the patients were re-assessed. No significant differences were found between the degrees of missing in the two intervention groups. Furthermore, patients who dropped out and those who remained did not differ significantly at baseline with regard to social functioning, positive and negative symptoms

At five year, the analysis of the clinical data using the mixed model for repeated measurement revealed a significant difference between the two treatment groups in favor of SPP for our primary outcome measure of social functioning. For our secondary outcome measures, a significant difference was found for overall symptoms, and for positive psychotic symptoms, whereas no significant difference was found for PANSS negative symptoms. No significant interaction was found between treatment group and time. This indicates a stable superior effect of SPP when compared to ST from 1–5 years

## Evaluation

### Strengths and limitations of the study

The strengths of the present study include 1) a large number of consecutively referred patients who were not pre-selected to treatment (neither by themselves, the therapists nor the centres); 2) different types of treatment centres in both the experimental group and the comparison group (small/big,

urban/rural, university/non-university); 3) a large percentages of the Danish population (approx. 25%) is covered by the investigation; 4) SPP therapists with an average level of training were recruited, not just master clinicians; 5) a manual to guide the therapy was deployed; 6) the two groups were compared at the beginning of the investigation on variables of symptomatology (GAF, PANSS), social factors (sex, ethnicity, marital status, habitation, educational level, work, social network and abuse) in order to explore possible bias. No differences between the two groups were found.

The limitations of the study include a) lack of individual randomisation and b) lack of systematic evaluation of adherence to the SPP psychotherapy manual.

## **Contact**

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## Anna Freud Centre / UCL: Improving mood with psychoanalytic and cognitive therapies (IMPACT Study)

- Goodyer, I., Tsancheva, S., Byford, S., Dubicka, B., Hill, J., Kelvin, R., . . . Fonagy, P. (2011). Improving mood with psychoanalytic and cognitive therapies (IMPACT): a pragmatic effectiveness superiority trial to investigate whether specialized psychological treatment reduces the risk for relapse in adolescents with moderate to severe unipolar depression: study protocol for a randomized controlled trial. *Trials*, 12, 175.
- Midgley, N., Cregeen, S., Hughes, C., Rustin, M. (2012). Psychoanalytic psychotherapy as a treatment for depression in adolescents. *Child and Adolescent Psychiatric Clinics of North America*, 22, 67-82.
- Henton, I. and Midgley, N. (2012) "A path in the woods": A study of child psychotherapists' participation in a large randomised controlled trial'. *Counselling and Psychotherapy Research*, 12, 204-13.
- Midgley, N., Ansaldo, F. and Target, M. (2014). The meaningful assessment of therapy outcomes: Incorporating a qualitative study into a randomized controlled trial evaluating the treatment of adolescent depression'. *Psychotherapy*, 51(1), 128-137.

### Brief Summary

IMPACT is a randomised controlled relapse prevention trial aiming to assess and compare the effectiveness of three therapeutic interventions in the treatment and relapse prevention of adolescent depression: Cognitive Behavioural Therapy (CBT), Short Term Psychoanalytic Psychotherapy (STPP) and Specialist Clinical Care (SCC). The trial is a collaboration between the University of Cambridge, UCL and the University of Manchester. The study aims to recruit 540 participants in total aged between 11 and 17 with moderate/severe depression. Recruitment is from Child and Adolescent Health Services (CAMHS) within National Health Service (NHS) Trusts across three major regions in the UK: North London, East Anglia and Manchester and the Wirral.

All participants are randomly allocated to one of the three interventions and after their first therapy session, are reassessed at 6, 12, 36, 52 and 86 weeks. The study is based on an 'intent to treat' design and is a pragmatic trial to reflect how these services are provided, and used, in real NHS settings by the adolescent population. An additional aim of the trial is to explore whether, or how, cortisol levels and genes might influence individual responses to treatment; this is being conducted via lab-analysis of saliva samples collected from consenting participants at baseline and at their 36-week follow up assessments. Furthermore, the study intends to estimate the overall health, social and educational costs of the interventions based on research findings, and build ground for future adolescent depression treatment recommendations.

IMPACT also contains two further voluntary sub-branches: MR-IMPACT, which involves using magnetic resonance imaging to explore brain function and intervention effects amongst depressed adolescents, and IMPACT-ME, a qualitative study exploring young people's experiences of overcoming depression, as well as their expectations and experiences of treatment in the IMPACT trial.

### Contact:

Professor Peter Fonagy, Professor Mary Target, Dr Nick Midgley – all Anna Freud Centre, and Research Department of Clinical, Educational and Health Psychology, UCL.

## Leipzig Psychoanalytic Child Therapy (PaCT)

Göttken, T., White, L. O., Klein, A. M., & von Klitzing, K. (2014). Short-term psychoanalytic child therapy for anxious children: A pilot study. *Psychotherapy, 51*(1), 148- 158.

Göttken, T., & von Klitzing, K. (2014). *Manual for Short-term Psychoanalytic Child Therapy (PaCT)*. London: Karnac.

Müller-Göttken, T., White, L. O., von Klitzing, K., & Klein, A. M. (2014). Reflexive Kompetenz der Mütter als Prädiktor des Therapieerfolgs mit Psychoanalytischer Kurzzeittherapie im Alter von 4-10 Jahren [Maternal Reflective Functioning as a predictor of therapeutic success of psychoanalytic short-term therapy for children aged 4-10 years]. *Praxis der Kinderpsychologie und Kinderpsychiatrie, 63*, 796-814.

### Brief Summary

The Psychoanalytic Child Therapy (PaCT; Göttken & von Klitzing, 2014.) for children aged 4 to 10 is conceptualised and manualized to treat emotional and affective symptoms. Consisting of 20-25 psychotherapy sessions, PaCT is held in a variety of settings (parent-child, child alone, parents alone), in which a relational theme that has led to the development of a symptom is uncovered and worked through. This relational theme constitutes the focus of treatment, in terms of a psychodynamic hypothesis of the current predominant conflict. Starting from psychoanalytical treatment concepts, PaCT aims for two effects: first, the treatment seeks to alter the child's mental representations and, by extension, his or her cognitive-emotional style. Second, it attempts to improve the parents' own insight into the inner psychic states of their child by regular psychoanalytically oriented parental work.

A recent study (Göttken, White, Klein, & von Klitzing, 2014) aimed to investigate the effectiveness of PaCT for 4- to 10-year-olds with anxiety disorders in an outpatient setting. Therefore, a quasi-experimental wait-list controlled study was conducted. Outcomes were assessed with standardized diagnostic interviews and parent as well as teacher reports of internalizing and total problems at three time points. After treatment, over half of the children of the treatment group no longer met the criteria for anxiety disorder while no children of the wait-list group remitted across the wait-list interval. In addition, parent and teacher reports showed significant symptom reduction on internalizing and total problems.

### Evaluation

There is a lack of well-evaluated treatment programs for anxiety disorders in early childhood. PaCT may close this gap as it shows that psychodynamic therapy offers an effective line of treatment for childhood internalizing symptoms and disorders in the eyes of clinicians, children, parents, and teachers. It would be worthwhile to extend the evaluation of PaCT by using randomization procedures and larger sample sizes.

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# EVALuation of two psychoanalytic prevention/intervention programs “Early Steps” and “Faustlos” in day-care centers with children at risk: a cluster randomized controlled trial

Leuzinger-Bohleber, M.; Fischmann, T.; Läzer, K.L.; Pfenning-Meerkötter, N.; Wolff, A.; Green, J. (2011): Frühprävention psychosozialer Störungen bei Kindern mit belasteten Kindheiten {Early prevention of psychosocial disturbances for children with strained childhood}. *Psyche – Zeitschrift für Psychoanalyse*, 65, 989-1022.

Läzer, K.L.; Leuzinger-Bohleber, M.; Rüger, B.; Fischmann, T. (2013). Evaluation of two prevention programs ‘Early Steps’ and ‘Faustlos’ in daycare centers with children at risk: the study protocol of a cluster randomized controlled trial. *Trials* 2013, 14:268

<http://www.trialsjournal.com/content/14/1/268/abstract>

Neubert, V.; Läzer, K.L.; Hartmann, L.; Fischmann, T.; Leuzinger-Bohleber, M. (2014): Early prevention in day-care centres with children at risk – the EVA research project. In: Emde, R.N.; Leuzinger-Bohleber, M. (eds) (2014): *Early Parenting and Prevention of Disorder: Psychoanalytic Research at Interdisciplinary Frontiers* (pp. 242-259). London: Karnac.

## Background

While early programs to prevent aggression and violence are widely used, only a few controlled trials of effectiveness of psychoanalytically based prevention programs for preschoolers have been evaluated. This study compares “Faustlos” (a violence prevention program) and “Early Steps” (a psychoanalytically based, whole day-care center intervention to prevent violence) in day-care centers in socioeconomically deprived neighborhoods.

## Methods/Design

Preschoolers in 14 day-care centers in Frankfurt, Germany, participate in a cluster randomized controlled trial (CRCT). The day care-centers were randomly chosen from a representative baseline survey of all Frankfurt’ day-care centers carried out in 2003 (n = 5300) with the following stratifying factors: children’s aggressiveness, hyperactivity, anxiety and socioeconomic status. Additionally, the geographic identification of socioeconomically deprived neighborhoods regarding low income children was taken from the Frankfurt Municipality Statistics. Children’s attachment classification and children’s aggressiveness, hyperactivity, anxiety and social competence are measured as outcome criteria before and after two years of intervention. The programs in the study aim to reach a high-risk population. Therefore, the combination of a random sampling of day-care centers out of a representative baseline survey in all day-care centers in Frankfurt and the application of official data on the local distribution of low income children are unique features offered by the EVA study design. Data on preschooler’s attachment representations are collected in socioeconomically deprived neighborhoods for the first time.

## Results

In the EVA study we studied more than 300 „children-at-risk“. Only 35% showed a secure attachment in contrast to 60-70% in normal populations at the beginning of the study (see table 1: basic assessment Manchester Child Attachment Story Stem)

Sample (in %)	<i>N</i> <sub>children</sub>	Insecure-Avoidant (A)	Secure (B)	Insecure-Ambivalent (C)	Insecure-Disorganized (D)
<b>EVA study<sub>baseline</sub></b>	<b>241</b>	<b>34</b>	<b>35</b>	<b>9</b>	<b>22</b>
Early Steps <sup>n.s.</sup>	134	38	32	7	23
Faustlos <sup>n.s.</sup>	107	28	38	13	21
<b>West Europe</b> (9 samples, van Ijzendoorn & Kroonenberg, 1988)	510	28	66	6	-
<b>USA</b> (21 samples, van Ijzendoorn et al., 1992)	1584	21	67	12	-
<b>Israel Cities</b> (Sagi et al., 2002)	758	3	72	21	3

The psychoanalytically based prevention programs proved to be highly effective: the psychosocial behaviour of the children improved by both programs. But only children in the intensive psychoanalytical intervention program EARLY STEPS changed their attachment style from insecure to secure. – The teachers in the EARLY STEPS Kindergartens improved their professional skills, mainly by the regular psychoanalytical case supervision.

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# The influence of a secure attachment relationship under conditions of high risk

- Neubert, V., & Läzer, K. L. (2011). *Leitfaden für ein Elterninterview zur Erfassung von Risikofaktoren*. Unpublished manuscript, Frankfurt am Main.
- Neubert, V., Läzer, K. L., Hartmann, L., Fischmann, T., & Leuzinger-Bohleber, M. (2013). Early Prevention in Day-Care Centres with Children at Risk - The EVA Research Project. In R. Emde & M. Leuzinger-Bohleber (Eds.), *Early parenting research and prevention of disorder: Psychoanalytic research at interdisciplinary frontiers* (pp. 242–260). London: Karnac.
- Neubert, V. (2015) *Bindung und Risiko – Wie weit reicht die protektive Kraft sicherer Bindung?* Unpublished dissertation, Frankfurt am Main.

## Brief Summary

Growing up under conditions that are risky and pose a threat to the children's development, for instance due to a precarious domestic or socio-economic situation, is no individual case in our society. Especially children who grow up under the above-mentioned circumstances tend to develop psychopathologic abnormalities like internalizing and externalizing behavioral problems. In order to conceptualize specific offers for prevention and support, it is necessary to gain a precise understanding of the risks that the children in question are exposed to. This concerns the direct effects of the risk factors as well as the consequences of their collaboration with protective factors like a secure attachment relationship.

The study at hand analyses the interaction of attachment and risk in terms of the degree of severity of behavioral problems of children in middle childhood who are part of the high risk population of the EVA research study. Data about risk exposure of families and children's problematic behavior was collected within the scope of guideline-based interviews with parents. Attachment was evaluated with the support of the Manchester Child Attachment Story Task (MCAST).

Main findings of this evaluation refer to the cumulative interaction of risks as well as the influence of single risk factors on the degree of severity of behavioral disorders (e.g. parental stress level, experience of violence within the family, experience of separation within the family). Psycho-social or family-related risk factors appear to be of high relevance whereas class-related or socio-economic factors do not seem to be directly related to the appearance of problematic behavior. Moreover, an interaction of attachment type and the amount of risks in regard to the degree of severity of problematic behavior becomes apparent.

Based on these findings, the thesis argues in favour of the conception of individual prevention and support offers which consider the specific living conditions of children taking part in the research study and, additionally, which start from the relationship level. Standardised programs do not comply with the needs of families with complex structures of environment and relationships in high risk milieus.

## Evaluation

We have evaluated the interaction of attachment and risk in terms of the degree of severity of behavioral problems of children in middle childhood who are growing up under high risk conditions. On the basis of this evaluation we argue in favour of the conception of individual (psychoanalytically oriented) prevention and support offers which consider the specific living conditions of children in a high risk milieu and, additionally, which start from the relationship level.

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## The Catamnesis in Project EVA: First Results

- Läser, K. L., Leuzinger-Bohleber, M., Rüger, B. & Fischmann, T. (2013). Evaluation of two prevention programs ‚Early Steps‘ and ‚Faustlos‘ in daycare centers with children at risk: the study protocol of a cluster randomized controlled trial. *Trials*, 268(14).
- Neubert, V.; Läser, K.L.; Hartmann, L.; Fischmann, T.; Leuzinger-Bohleber, M. (2014): Early prevention in day-care centres with children at risk – the EVA research project. In: Emde, R.N.; Leuzinger-Bohleber, M. (eds) (2014): *Early Parenting and Prevention of Disorder: Psychoanalytic Research at Interdisciplinary Frontiers* (242-259). London: Karnac.
- Target, M., Fonagy, P., Shmueli-Goetz, Y. (2003). Attachment representations in school-age children: the development of the child attachment interview (CAI). *Journal of Child Psychotherapy*, 29(2),171-186

### Background

In a sample of so called ›children at risk‹ Project EVA assesses the differential effects of two established prevention programs - *Faustlos* which is a standardized violence prevention program and the psychoanalytical informed early prevention program *Early Steps* (**for more details see Leuzinger-Bohleber et al. p.156 in this volume**)

One of the numerous outcome variables of Project EVA is the change of the children’s attachment patterns of the due to intervention. The Manchester Child Attachment Story Task (MCAST) was used prior and after the intervention to monitor the children’s development between the age of 4 and 7. Due to developmental consideration, concerning both verbal and behavioral aspects, the MCAST was no longer appropriate when the children grew older. Thus the Child Attachment Interview was assessed in a subsample (n = 47) two years later for catamnesis.

### Instruments

The Manchester Child Attachment Security Task (MCAST) is a structured doll play methodology which enables identification and detailed classification of internal representations of attachment relationships in young (pre-)school-age children (Green et al. 2000).

The Child Attachment Interview (CAI) is a semi-structured interview which borrows most questions from the Adult Attachment Interview (AAI). The interview tries to assess the children’s capacity to regulate emotions and attention when recounting attachment-related episodes (Target et al. 2003).

### Results

The psychoanalytic informed prevention program *Early Steps* (n = 28) seems to have a positive and substantial effect on attachment security, both in short-term and in long-term development. In contrast, the children in *Faustlos* (n = 19) did not show significant changes in attachment over the three measurement time points.

### Evaluation

Nonetheless those encouraging findings are preliminary and need to be replicated in a larger sample. The research team is currently working on it. The naturalistic design of the study does not allow simplistic interpretations - but still the results point to the superiority of *Early Steps* to *Faustlos* in regard to the effects on attachment security.

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# The connection between styles of attachment and social behaviour in children of a high risk sample – Empirical study utilizing the Child Attachment Interviews and the Strengths and Difficulties Questionnaire –

- Goodman, R. (1997). The Strengths and Difficulties Questionnaire: A research note. *Journal of Child Psychology and Psychiatry*, 38(5), 581-586.
- Leuzinger-Bohleber, M. (2009). *Früher Kindheit als Schicksal? Trauma, Embodiment, soziale Desintegration; psychoanalytische Perspektiven* (1. Auflage). Stuttgart: Kohlhammer.
- Leuzinger-Bohleber, M., Fischmann, T., Laezer, K. L., Pfenning-Meerkötter, N. Wolff, A. & Green, J. (2011). Frühprävention psychosozialer Störungen bei Kindern mit belasteter Kindheit. *Psyche – Zeitschrift für Psychoanalyse*, 65(09/10). 1-33.
- Target, M., Fonagy, P. & Shmueli-Goetz, Y. (2003). Attachment representations in school-age children: the development of the child attachment interview (CAI). *Journal of Child Psychotherapy*, 29(2), 171-186.

## Summary

Many studies conducted in the context of attachment theory already show a connection between attachment and social behaviour. Securely attached children accordingly possess greater social skills. An insecure attachment conversely constitutes a risk factor for the development of adjustment difficulties, problem behaviour and – under influence of other risk factors – also for psychopathological development. These connections were examined in a high risk sample of 44 children between seven and nine years of age as part of this Master's Thesis. The Thesis was carried out in conjunction with the longitudinal EVA-study, the Evaluation of two early prevention programmes in daycare centers that compares two early prevention programmes in daycare centers in Frankfurt districts with increased level of social problems, working with a cluster-randomised controlled trial. The presented study is the first catamnestic examination of the EVA-Study. The hypothesis, that securely attached children are deemed to be more socially competent by their parents than insecurely attached children, was examined, utilizing the Child Attachment Interviews (CAI, Target, Fonagy & Shmueli-Goetz, 2003) and the Strengths and Difficulties Questionnaires (SDQ, Goodman, 1997). This hypothesis could not be upheld. However, the insecurely attached children consistently showed results that were more problematic than those of the securely attached children. The insecurely attached children were significantly younger than the securely attached children. The results were put into context with previous findings, discussed under consideration of methodcritical aspects, and additional research queries were developed.

## Aims

- To examine whether there is a relation between the attachment styles and the social behavior of children at the age of 7 to 9 in a high-risk sample
- To examine the relations between attachment styles and social behavior with the age and sex of the children
- To examine the influence of the two prevention programs on the attachment styles and on the social behavior
- To generate further research through explorative data analysis

## Methods:

### Participants

The examined sample is a subsample of the EVA-study (N = 307), which embraces 14 daycare centres in socially deprived neighborhoods, randomly chosen based on a representative survey of all Frankfurt daycare centres in 2003 and social indicators 2008. The participants are randomly assigned to the two intervention programs. The presented study contains N = 44 (22 female) children at the age of 84 and 111 months (M = 97.59 months; SD = 8.19 months). These children belong to 6 of the 14 day-care centres. The parents of all interviewed children were informed about the CAI and agreed to it before we interviewed the children. The interviews were conducted between February 2013 and October 2013.

### Data analysis

A chi-square test was used to examine the relation between attachment and social behavior. ANOVA and *t*-tests were applied to differentiate test differences in the social behavior as a function of the attachment style. Furthermore, ANOVA and *t*-tests were used to examine the relation between attachment style and age as well as social behavior and age. Moreover, ANOVA and *t*-tests were applied to investigate the relation between sex and intervention program with attachment style and social behavior.

## Results

### Attachment and Social Behavior

Not securely attached children got higher scores on all Problem scales and lower scores on the Prosocial Behavior scale (Not significant: all  $F < 3.16$ , all  $p > .083$ ).

### Attachment and Age

Not securely attached children (A, C, D) are statistically significant younger than securely attached children ( $t(42) = 2.25$ ,  $p = .030$ ,  $d = 0.68$ ).

Social behavior and Age were not related in this sample.

### Attachment and Sex

N = 44, f = 22, m = 22

Girls: B = 54,5%, A = 31,8%, C = 4,5%, D = 9,1%

Boys: B = 36,4%, A = 36,4%, C = 13,6%, D = 13,6%

→ Not significant

### Social behavior and Sex

Boys got higher scores on all Problem scales and lower scores on the Prosocial Behavior scale than girls. The results have been significant only for the scale Hyperactivity ( $F(1,42) = 6.75$ ,  $p < .013$ ,  $\eta^2 = 0.14$ ).

## Discussion

The hypothesis could not be confirmed. Insecurely attached children in this sample, however, did show more problematic results concerning their social competences compared to securely attached children. Furthermore, the insecurely attached children were significantly younger than the securely attached children. These findings need to be verified in a larger sample. The problem of the possible lacking comparability of different attachment-instruments needs to be discussed and examined in a greater context.

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# FIRST STEPS: A psychoanalytically based early prevention for immigrant families: a cluster randomized trial

Lebiger-Vogel, J.; Busse, A.; Fritzemeyer, K.; Burkhardt-Mussmann, C.; Paul, L.-S.; Leuzinger-Bohleber, M. (2014): First Steps: an integration project for infants with an immigrant background – conceptualisation and first impressions. In: Emde, R.N.; Leuzinger-Bohleber, M. (Eds.): *Early Parenting and Prevention of Disorder: Psychoanalytic Research at Interdisciplinary Frontiers* (pp. 260-282). London: Karnac.

Leuzinger-Bohleber, M. (2014b): “Out-reaching psychoanalysis”: a contribution to early prevention for “child-at-risk”? In: Emde, R.N.; Leuzinger-Bohleber, M. (Eds.): *Early Parenting and Prevention of Disorder: Psychoanalytic Research at Interdisciplinary Frontiers* (pp. 20-49). London: Karnac.

Hasselhorn, M.; Andresen, S.; Becker, B.; Betz, T.; Leuzinger-Bohleber, M.; Schmid, J. (2014): Children at risk of poor educational outcomes: Search of a transdisciplinary theoretical framework. *Child Indicators Research*, 7, 695-697.

## Background

The integration of children with an immigrant background is known to have become one of the most urgent social responsibilities in Germany. Children with an immigrant background are still disadvantaged in the German educational system and are more likely to live in high-risk environments. Quite a number of projects supporting the integration of children with an immigrant background into the German society exist although most of them are not scientifically evaluated. Most of them focus on the acquisition German language and therefore address older children (and adults). However, international experts agree that social integration is not only a matter of languages but includes earlier developmental processes of the children in the first months of life connected to adequate early parenting and a prevention of social withdrawal into parallel societies.

## Methods/Design

The psychoanalytically based project FIRST STEPS focuses on earliest integration of children with an immigrant background, supporting the parents parenting capacities in the critical phase of migration and early parenthood. By using a prospective randomized comparison group design the effectiveness of a psychoanalytically oriented early prevention program (intervention A) is compared to the outcomes of to groups offered by paraprofessionals (intervention B). Intervention A is a professional offer supporting the immigrant families based on the developmental knowledge on early parenting combining home and center based interventions. Intervention B is a center based offer by paraprofessionals with an immigrant background. 160 families are randomly assigned to intervention A or B. They are supported and assessed during the first three years of the children’s lives until entering Kindergartens. Social and family stressors, the quality of the parent-child-interaction, child attachment security, the affective, cognitive and social development of the children as well as the social integration of the families are assessed.

## Results

Until now 380 immigrant families have been recruited in Frankfurt a. M. and in Berlin. First results show that professionally supported good early parenting (Intervention A) improves the social-emotional, cognitive and language development of immigrant children as well as the social integration of their families. Because of these encouraging results, a roll-out across different cities in Germany is planned. Due to the “difficult-to-reach” immigrant families difficulties in recruitment, uptake and retention of participants it was surprising that FIRST STEPS was accepted by these families.

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# Risk indicators in early emotional development: detection, intervention and follow-up in the first level of care with an interdisciplinary approach. Uruguay

Bonifacino, N.; Mussetti, D.; & Plevak, A. (2011) The pediatric consultation: a first step into infant mental health. Switzerland. *Devenir*, 23(2):117-27.

Plevak, A.; Schelotto, M.; Bonifacino, N.; & Mussetti, D. (2012) Consulta pediátrica en la primera infancia: una oportunidad para la detección de indicadores de riesgo en el desarrollo emocional: experiencia de tamizaje e intervención precoz. Montevideo. *Archivos de Pediatría de Uruguay*, 83(2):25-30.

Bonifacino, N.; Plevak, A.; Mussetti, D.; & Silveira, A. (2014) Retraimiento sostenido. Un indicador de riesgo en el desarrollo temprano. Detección e intervención en el primer nivel con la escala ADBB. Experiencia en dos centros de salud pública del área metropolitana. Montevideo. *Archivos de Pediatría de Uruguay*, 85(1):31-39.

## BRIEF SUMMARY

In this work complex psychoanalytical conceptions were taken to an operative field to promote the dialog with related disciplines in an integrative conception of the individual health. From this perspective the psychoanalytical intervention is open to the pediatric medicine interest, recognizing the pediatric consultation as a first step into Infant mental health from the first level of care.

The study was carried out offering pediatricians training in a psychoanalytical perspective of early emotional development and recognizing the relevant position for the intervention of these professionals which are in the closest relationship with the infant and his/her parents. This position is reinforced because of the parents' transferential aspects that are involved in this professional relationship that take care of the infant's health. We also offered pediatricians training in ADBB scale (Alarm Baby Distress Scale), which proposes a systematized observation of the infant during the well-baby visit, with the purpose to detect early indicators of relational withdrawal. This is a symptom that is found in the clinic of the most important psychopathological situations of first infancy: attachment disturbances, autism, early interactive difficulties – such as the one caused by the effect of mother depression – post-traumatic syndromes, early relationship difficulties. It also appears as a consequence of organic factors such as sensorial handicaps (auditory and visual), chronic or severe pain, and in sickness. The progressive nature of its installation in the relational pattern of the baby makes its early expressions hard to detect and easily overlooked in the clinical observation without the help of a specific instrument to detect it. The instrument we propose for its detection is simple, accessible and user-friendly. It evaluates 8 items related to the relational pattern of the baby. It is validated in different countries and has a good internal coherence. In a second step of the experience we provide pediatricians trained in the scale, resources to implement interventions oriented by ADBB assessment and aimed to improve the condition of the infants in which indicators of withdrawal were detected. Early detection of withdrawal indicators was done with ADBB scale during well-baby visit to 67 babies between 2 and 14 months, who were video-taped in four pediatric visits during 2010 in two Public Health Centers. Two parallel ways were done to compare results. One pediatrician trained in ADBB since the beginning of the study assessed 30 babies and in the cases which she detected withdrawal, she did interventions oriented to promote in the parents new resources in the interaction with the baby. The others 37 babies were assisted in their regular pediatric visits in the traditional way by other nine pediatricians, who were trained in ADBB and in the implementation of interventions after the second video-taped consultation.

Statistical analysis of the data showed that in the group of 37 infants, 40% presented withdrawal in the 1st. assessment, 57% in the 2nd, and in the 3rd one, which was done after the training, the percentage

of withdrawal decrease to 13%. In the parallel group of 30 infants the percentages were: 7% in the 1st. assessment, 13% in the 2nd, 10% in the 3rd, and 3% in the 4th one.

## **EVALUATION**

An interdisciplinary approach that includes a psychoanalytic perspective of early emotional development and the use of ADBB scale in the well-baby visit, enables pediatricians to a wider and earlier detection of risk indicators in the infant emotional development, and allows them make efficient interventions which improve the condition of the babies, increasing the quality of the care from the first level.

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## Cost-effectiveness studies

# The effects of long-term psychoanalytic treatment on healthcare utilization and work impairment and their associated costs

Berghout, C. C., Zevalkink, J., & Hakkaart-Van Roijen, L. (2010). The effects of long-term psychoanalytic treatment on healthcare utilization and work impairment and their associated costs. *Journal of Psychiatric Practice* 16, (4), 209-216.

De Maat, S., Philipszoon, F., Schoevers, R., Dekker, J., & De Jonghe, F. (2007). Costs and benefits of long-term psychoanalytic therapy: Changes in health care use and work impairment. *Harvard Review Psychiatry*, 15, 289-300.

## Brief Summary

Long-term psychoanalytic treatment is perceived as an expensive ambulatory treatment for mental illnesses. However, there are indications that psychoanalytic treatment can result in cost savings in the long term. In this study, the effects of long-term psychoanalytic treatment on healthcare utilization and work impairment were investigated and the associated societal costs were calculated. The authors assessed healthcare utilization and work impairment of patients before, during, and after long-term psychoanalytic treatment (N = 231). The results show that the difference in total costs associated with healthcare utilization and work impairment between pre- and post-treatment was €2,444 (U.S.\$3,070 using average exchange rates for 2006, the year for which these data were calculated) per person per year. Two years after treatment termination, these cost savings had increased to €3,632 (\$4,563) per person per year. This indicates that one can expect decreased consumption of medical care and higher work productivity right after psychoanalytic treatment, but also that long-term psychoanalytic treatment can generate economic benefits in the long run. However, one cannot conclude that all invested costs will be earned back eventually. More research is needed on the cost-effectiveness of psychoanalytic treatment.

## Evaluation

Of course, long-term psychoanalytic treatment should be considered beneficial not only because it can reduce costs associated with healthcare utilization and work impairment. The primary goal of psychotherapy is to improve a patient's psychological state, with reductions in societal costs being a secondary goal. The authors emphasize that indirect cost savings should not be a prerequisite for funding of psychotherapy. A cost-effective treatment is not necessarily cheap or cost-saving, but rather is characterized by clinically significant psychological and/or societal gains that make the invested costs worthwhile. It is recommended that state-of-the-art cost-effectiveness analyses be conducted in future studies.

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## Cost-effectiveness of therapies of different mode and length

Maljanen, T., Paltta, P., Härkänen, T., Virtala, E., Lindfors, O., Laaksonen, M., . . . the Helsinki Psychotherapy Study Group. (2012). The cost-effectiveness of short-term psychodynamic psychotherapy and solution-focused therapy in the treatment of depressive and anxiety disorders during a 1-year follow-up. *Journal of Mental Health Policy and Economy*, 15, 3-13.

Maljanen, T., Tillman, P., Härkänen, T., Virtala, E., Lindfors, O., Knekt, P., & the Helsinki Psychotherapy Study Group. (2014). The cost-effectiveness of short-term psychodynamic psychotherapy and solution-focused therapy in the treatment of depressive and anxiety disorders during a three-year follow-up. *Open Journal of Psychiatry*, 4, 238-250.

### Brief Summary

The aims of this ongoing study are to evaluate the cost-effectiveness of two short-term and two long-term psychotherapies (Knekt et al. 2012). The study is based on the data of 367 psychiatric outpatients, participants of the Helsinki Psychotherapy Study, having long-standing depressive or anxiety disorder causing work dysfunction. Patients with psychotic disorder, severe personality disorder, adjustment disorder, bipolar disorder or substance abuse were excluded. Solution-focused therapy included 12 and short-term psychodynamic psychotherapy 20 therapy sessions, both therapies lasting about half a year. The long-term therapies were open-ended, psychodynamic psychotherapy lasting about 3 years with about 240 sessions and psychoanalysis lasting about 5 years with about 650 sessions. All the therapists had received standard training and were experienced. Both direct costs (therapy sessions, outpatient visits, medication, inpatient care) and indirect costs (production losses due to work absenteeism, value of neglected household work, lost leisure time and unpaid help received) due to the treatment of psychiatric problems were estimated, prior to start of treatment and at 14 pre-chosen time points during a 10-follow-up from start of treatment. Likewise, the assessment of effectiveness was based on repeated measurement of psychiatric symptoms and recovery, need for treatment, and work ability. Incremental cost-effectiveness will be estimated.

Original contributions (Maljanen et al. 2012, 2014) have been published from this sub-study and are ongoing (see cited literature above and our homepage).

### Evaluation

This cost-effectiveness study, with an exceptionally long- follow-up, will provide information for evaluating the economic and health-related benefits of different short-term and long-term psychotherapies. The study may have implications for the allocation of health-care resources.

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# Cost-offset effect of psychotherapy in reducing medical health service utilization.

Kraft, S., Puschner, B., Lambert, M. J., & Kordy, H. (2006). Medical utilization and treatment outcome in mid- and long-term outpatient psychotherapy. *Psychotherapy Research*, 16 (2), 241-249.

This study examined service use and its relation to outcome in people receiving outpatient psychotherapy with a special focus on the possible cost-offset effect of psychotherapy in reducing medical health service utilization.

## Sample

Between September 1998 and February 2000 all adult insurees of a large private insurance company ("Deutsche Krankenversicherung", DKV) who applied for reimbursement of their outpatient psychotherapy were asked to participate in the TRANS-OP study (see Open Door Review...). Due to the considerable time and effort for the collection and analysis of service use data, a randomized subsample of 200 participants who had applied either for cognitive behavioral therapy (CBT, N=100) or psychodynamic psychotherapy (PD, N=100), was drawn of the original sample (N=939). Medical utilization data were analyzed only for participants who had returned at least the baseline questionnaire (N=176).

## Measures

Information about medical utilization (outpatient and inpatient treatments) was made available by the DKV via computerized, aggregated records of insurance claims. Psychological distress was assessed with the German adaptation (EB-45; Lambert, Hannover, Nisslmüller, Richard, & Kordy, 2002) of the Outcome Questionnaire-45 (OQ-45.2; Lambert et al., 1996). Somatic distress was measured with the Giessener Complaints Questionnaire (GBB-24; Brähler & Scheer, 1995).

## Results

Mean medical costs continually increased before the start of outpatient psychotherapy and decreased thereafter. This pattern was more pronounced for hospital days, with a sharp decline immediately after the start of treatment. Medical costs during 6 months decreased from 2,183.36 € (SD= 2491.29) at start of psychotherapy to 1,609.44 € (SD=1,951.62) two years later (26.3%). During the same time, hospital days showed a 78.7% decrease from 3.33 (SD=10.35) to 0.71 (SD=4.11). However, these differences were not statistically significant.

Improvement in somatic well-being within the 18 months after start of therapy was significantly related to a reduction in medical costs, even when controlling for pretreatment medical costs. Furthermore, the reduction in health care costs was somewhat larger in younger patients, and cost reduction was somewhat larger in patients with fewer sessions. No difference in reduction of medical care utilization was found between the two forms of psychotherapy.

## Evaluation

This is one of the few studies which examined cost offset after mid- and long-term outpatient psychotherapy. To our knowledge, by then it was the first that analyzed the association of cost offset and mental health treatment outcome, and it was the only European study besides Sandell et al. (2001) in which direct health care costs, and not only hospital or disability days, were obtained from objective data sources (i.e., insurance claims).

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## Process Studies

## The role of alliance in the relationship between therapist competence and outcome in Brief Psychodynamic Psychotherapy

Despland, J.-N., de Roten, Y., Drapeau, M., Currat, T., Beretta, V., & Kramer, U. (2009). The role of alliance in the relationship between therapist competence and outcome in brief psychodynamic psychotherapy. *Journal of Nervous and Mental Disease, 197*(5), 362-367. doi: 10.1097/NMD.0b013e3181a20849

### Summary

Therapist competence is a key variable for psychotherapy research. Empirically, the relationship between competence and therapeutic outcome has shown contradictory results and needs to be clarified, especially with regard to possible variables influencing this relationship. A total of 78 outpatients were treated by 15 therapists in a very brief 4-session format, based on psychoanalytic theory. Data were analyzed by means of a nested design using hierarchical linear modeling. No direct link between therapist competence and outcome has been found, however, results corroborated the importance of alliance patterns as moderator in the relationship between therapist competence and outcome. Only in dyads with alliance change over the course of treatment was it clear that competence is positively related to outcome. These findings are discussed with regard to the importance for outcome of therapist competence and alliance construction processes.

The results support to a large extent our 3 hypotheses. The results also indicate that no direct relationship exists between level of competence and outcome in BPI. This means that even after training in BPI and years of experience, a high level of therapist competence does not guarantee a positive outcome (Barber et al., 2006; Sandell, 1985). This also means that other variables, or variable combinations, account better for outcome variation. Results indicate that competent therapists tend to establish a growing alliance over the course of BPI, compared with less competent therapists. The highly significant coefficients indicate the important contribution of the therapist's level of competence in alliance construction processes. The latter are conceived as coconstruction processes, based on patient-dependent, therapist-dependent and dyad-specific variables. One could say that within the context of relational progression (growing alliance), the more competent the therapist, the better the outcome, whereas, paradoxically, within the context of relational stagnation (stable alliance), the more competent the therapist, the less positive the outcome (small symptom reduction, no change, or deterioration). For the latter, the exact opposite holds true; competence does have a direct effect on outcome, but no interaction effect has been found. Thus, the more competent the therapist is on the subscale of general psychotherapeutic attitude, the better the outcome. This result might reflect that the therapist's basic interactional and therapeutic skill of empathic, nonjudgmental consideration towards the patient is a necessary, but as such, an insufficient therapeutic ingredient in psychodynamic psychotherapy. It seems that alliance has an influence on the relationship between competence and outcome. We find, on the one hand, for the subsample with relational progression over the 4 sessions of BPI, therapist competence is of importance in the sense that low competence yields low outcome. As the level of training is related to competence, in the cases of relational change, more training in BPI, for example, in the form of more frequent case supervisions should help to produce a positive outcome. It also indicates that competence is certainly a necessary condition for treatment outcome, but as such insufficient; alliance evolution, as an emergent characteristic of a successful therapeutic

process, needs to be taken into account. On the other hand, in cases stagnating in alliance over the 4 sessions of BPI, therapist competence is also important but in the opposite sense: low to moderate competence yields the best outcome and the more competent the therapist, the less positive the outcome. It could be said that, in the latter cases, the therapist does “more of the same” by delivering competent interventions, which finally have only a limited impact on symptom change. Two reasons might be at stake: (1) in these patients, the impact of the intervention is confined to an internal psychodynamic level, with no direct impact on our outcome measure (2) The patient—due to his dysfunctional relationship patterns—establishes a rigid level of alliance and is thus highly resistant to the therapeutic relationship and the therapist’s interpretations, even more so if they are competently delivered. These results complete Barber et al’s (2006) study on the moderator effect of adherence. For competence, as we defined it, a linear moderator model might be most accurate, compared with adherence, where a curvilinear yields similar effects of alliance. Using these approaches, we conclude that the highest competencescore is the optimal within the differential context of growing alliance, whereas for adherence, the median adherence is in any case the optimal (Barber et al., 2006).

Because context-embeddedness of the technique (e.g., “skillfulness” and “providing a therapeutic milieu”) is the main difference between Barber et al’s (2006) definition of adherence and ours of competence, we hypothesize that more outcome variance is explained with the wide concept of competence, compared with adherence, when taking into account the context of the applied psychodynamic technique. If this assumption holds true, it might also account for the absence of effect of the competence measure by Barber et al. (2006) who defined competence less broadly than it was done in our study (see Introduction section).

On the other hand, it might be argued that our definition of competence is so broad that risks of confounds with other context variables, such as the therapeutic alliance, are not excluded. Empirically, such a critic does not stand further examination, as the differential effect of stable alliance demonstrates: even if the therapist’s competence varies in these dyads, alliance remains the same, indicating at least some independence between these variables. Several limitations of this study should be underlined. This is a naturalistic study; although the distribution of the patients between the therapists was controlled for, the patients were not randomly assigned to the therapists. Consequently, there was no controlled distribution of patients to therapists according to their number of years of training and experience. Such a control would have enabled us to partial out the influence of therapists’ training and level of experience. In this study, it confounds with competence due to high correlations.

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# Accuracy of therapist perceptions of patients' alliance: Exploring the divergence

Hartmann, A., Joos, A., Orlinsky, D.E., Zeeck, A. (2014). Accuracy of therapist perceptions of patients' alliance: Exploring the divergence. *Psychotherapy Research*, <http://dx.doi.org/10.1080/10503307.2014.927601>

## Summary

The therapeutic alliance is a well-established predictor of psychotherapy outcome, yet much research has shown that therapists' and patients' views of the alliance can diverge substantially. Therapists systematically underestimate their patients' perceived level of alliance, and the correlation between therapist and patient estimates of patient alliance is only moderate. The present study explored the divergence between therapists' and patients' perspectives on patients' alliance experience, and its relations to therapists' concurrent work involvement and session process experiences.

## Sample

The study sample includes 98 treatment cases, conducted by 26 psychodynamic psychotherapists of varying experience levels. Half of the sample consisted of individual outpatient treatments (private practice) and the other half were individual treatments in a day clinic setting (university hospital). Most of the 98 patients suffered from a major depressive disorder.

## Results

Therapist-patient divergence was significantly related to therapists' case-wise work involvement, but not to therapist's views of session process. The best predictor of therapist-patient divergence was therapists experiencing a "distressed practice" work involvement pattern.

Although therapists' work involvement experiences are not commonly investigated, they can be a relevant predictor of therapy processes.

## Evaluation

Although the sample comprised 98 therapies, the nesting of therapies in 26 therapists limited the statistical power of the investigation and its results. Yet the findings already appear to have interesting and potentially clinically relevant if tentative implications.

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# Alliance in individual psychotherapy

Horvath, A. O.; Del Re, A. C.; Flückiger, C.; & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy* 48(1): 9-16.

Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy Relationships that Work* (pp. 33-70). New York: Oxford University Press.

## Summary

The concept of the alliance is currently one of the most intensely researched subjects in the psychotherapy research literature. This new research synthesis examines the relation between alliance and the outcomes of individual Psychotherapy, including over 200 research reports based on 190 independent data sources, covering more than 14,000 treatments. Research involving 5 or more adult participants receiving genuine (as opposed to analogue) treatments, where the author(s) referred to one of the independent variables as “alliance,” “therapeutic alliance,” “helping alliance,” or “working alliance” were the inclusion criteria. Several potential moderators also were explored.

In terms of the research synthesis presented in this report, it is important to emphasize that the authors know about the lack of a precise consensual definition of the alliance construct. As a consequence, the alliance and its relation to outcome and other therapy variables has been gleaned from studies which, in practice, define the alliance by the diverse instruments used to measure it. Within the 201 studies in this collection of data, over 30 different alliance measures were used—not counting different versions of the same instruments. Similar to previous reports, the four “core measures”: California Psychotherapy Alliance Scale, (CALPAS), Helping Alliance Questionnaires (HAQ), Vanderbilt Psychotherapy Process Scale (VPPS), and Working Alliance Inventory (WAI) accounted for approximately 2/3 of the data. In research on the shared factor structure of the WAI, CALPAS and HAQ, the concept of “confident collaborative relationship” was identified as the central common theme. Each of these four instruments has been in use for over 20 years and has demonstrated an acceptable level of internal consistency. Fifty-four of the research reports in this data set used less well validated instruments or assessment procedures; the relation of most of these measures to the core instruments, or to each other, are not well documented, and sometimes nonexistent. As noted, the diversity in the “de facto” definition of the alliance that has emerged via the use of a variety of assessment measures has become an important source of variability across studies.

For identifying studies published between 1973 and 2000, the authors relied on data from previous analyses (Horvath & Symonds, 1991 & Horvath & Bedi, 2002) but the effect sizes (ES) were recalculated (using more up-to-date methods) for all but 10 of the oldest unpublished studies which were no longer available. To locate data from the years 2000 to 2009, first electronic databases were searched (PsycINFO/EBSCO) using the same keywords as the Horvath and Bedi (2002) analysis. Next the bibliography of studies included in the analysis was cross-referenced. The criteria for inclusion in this report were: (1) the study author referred to the therapy process variable as “*alliance*” (including variants of the term); (2) the research was based on clinical as opposed to analogue data; (3) five or more adult patients participated in the study, and; (4) the data reported were such that we could extract or estimate a value indicating the relation between alliance and outcome. In contrast to previous meta-analyses, the literature search was extended to material available in Italian, German, or French, as well as English. The number of studies in the current study is roughly double the size of the data available for the previous (Horvath & Bedi, 2002) meta-analysis.

The analyses of this research synthesis were done using the assumptions of a random model and numerical estimates were calculated using restricted maximum likelihood (random effects) model. The aggregate effect size (ES), for the 190 independent alliance/outcome relations was  $r = .275$ . The 95% confidence interval of this averaged ES ranged from .249 to .301. The magnitude of the relationship

we found in the current meta-analysis is a little larger but similar to the values reported in previous research (Horvath & Symonds, 1991  $r = .26$ ,  $k = 26$ ; Horvath & Bedi, 2002,  $r = .21$ ,  $k = 100$ ). The median effect size of ESs of the current data set was .28 suggesting that the group of effect sizes we collected was not strongly skewed. The overall effect size of .275 is statistically significant at  $p = .0001$  level indicating a moderate but highly reliable relation between alliance and psychotherapy outcome. In Addition, the impact of six categorical variables were investigated that have the potential of moderating the relation between alliance and outcome: alliance measure (CALPAS, VPPS, HAq, WAI, and Other); alliance rater (client, therapist, observer); time of alliance assessment (Early, Mid, Late, Averaged); outcome measure (BDI, SCL, Dropout); type of treatment (CBT, IPT, Psychodynamic, Substance Abuse); and publication source (journal, books/chapters, unpublished/thesis). There are several noteworthy features that apply to all of these results: All of the aggregate alliance-outcome correlations in each category are statistically significant beyond  $p = .001$ . This result strongly supports the claim the impact of the alliance on therapy outcome is ubiquitous irrespective of how the alliance is measured, from whose perspective it is evaluated, when it is assessed, the way the outcome is evaluated, and the type of therapy involved.

The quality of the alliance *matters*. The next most common feature is the finding that, with very few exceptions, within each of these subsets of data, the ES are very diverse in magnitude. It was noted earlier that heterogeneity of the ESs in a large-scale meta-analysis is not unusual. However, these results indicate that the high degree of variability remains practically unchanged within each level of these potential moderators.

## Evaluation

The positive relation between the quality of the alliance and diverse outcomes for many different types of psychological therapies is confirmed in this meta-analysis. While the overall ES of  $r = .275$  accounts for a relatively modest proportion of the total variance in treatment outcome, the magnitude of this correlation, along with therapist effects, is one of the strongest and most robust predictors of treatment success empirical research has been able to. By including all research in which the authors refer to the process variable as *alliance*, the study might have collected and summarized a number of different kinds of things. A practical response to this conceptual problem is to conclude that this meta-analysis reports the results of alliance-outcome relation *as it is researched at this time*. In general, Studies on the alliance construct are an important contribution to psychotherapy research by creating diverse implications for therapeutic practice.

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# The working alliance and the stability of therapeutic outcomes in the treatment of depressed patients: A process-outcome study

Huber, D., Henrich, G., Clarkin, J. & Klug, G. (2013). Psychoanalytic versus psychodynamic therapy for depression: A three-year follow-up study. *Psychiatry*, 76(2), 132-149.

Huber, D., Zimmermann, J., Henrich, G. & Klug, G. (2012). Comparison of cognitive-behaviour therapy with psychoanalytic and psychodynamic therapy for depressed patients—A three-year follow-up study. *Zeitschrift für Psychosomatische Medizin und Psychotherapie*, 58(3), 299-316.

## Summary

In a process-outcome design comparing different forms of psychotherapy (psychoanalytic psychotherapy, psychodynamic psychotherapy, and cognitive-behavioral therapy) the study investigated whether the working alliance has differential impact on outcomes and their stability.

The working alliance is viewed as a mediator variable serving to explain the treatment process and its influence on different outcomes. We assume the working alliance to be one of three components constituting the therapeutic relationship that is, beyond the working alliance, the real relationship between patient and therapist and the transference.

Meta-analyses suggest working alliance as a robust predictor of different outcomes, however, the predictive power is relatively low, explaining only 7% of the outcome variance. Nevertheless, the working alliance can be regarded as a substantial predictor, taking into account that other curative factors explain rarely more than 15% of outcome variance.

The patient sample is derived from the prospective and partly randomized MPS sample consisting of 100 patients (intent-to-treat sample) who met the DSM-IV criteria for major depressive disorder (psychoanalytic psychotherapy=35, psychodynamic psychotherapy=31, cognitive-behavioral therapy=34); the completer sample comprises 85 patients. Therapy sessions of each patient have been audiotaped but 13 cases had to be excluded due to low audio quality (psychoanalytic psychotherapy=26, psychodynamic psychotherapy=24, cognitive-behavioral therapy=22).

Patients were assessed at pretreatment, at post-treatment and at follow-up each year after treatment termination up to three years. Self-rating questionnaires important for the study described here are the Beck-Depression Inventory (BDI) and the Inventory of Interpersonal Problems (IIP-short version).

As Stiles and Goldsmith (2010) recommended, we decided to measure the process in a multimodal way including patients, therapists and external rater assessments. For measuring the working alliance we choose the Working Alliance Inventory (WAI-observer rating short form). The WAI is a trans-theoretical instrument suitable for different treatment approaches, based on three dimensions:

agreement on tasks

agreement on goals

development of bond.

Measurement points for WAI are 6 and 12 months after beginning of treatment; ratings are performed by trained raters.

As a second process measure we use the Helping Alliance Questionnaire (patient and therapist version [HAQ-P and HAQ-T]). The inventory consists of 11 items assessing two aspects of the therapeutic working alliance:

perceived helpfulness by the therapist

collaboration and bond with the therapist.

Measurement points for HAQ-P and HAQ-T are 6 and 12 months after beginning of treatment. In an explorative approach the following main research questions are addressed:

Does working alliance (WAI and HAQ) predict therapy outcomes (BDI and IIP) and their stability through follow-up?

Are there differences in the predictive power of working alliance as a function of the modality of measurement (patient, therapist, external rater)?

Do differences exist concerning the predictive power of working alliance as a function of treatment (psychoanalytic psychotherapy, psychodynamic psychotherapy, cognitive-behavioral therapy)?

Statistical analyses are performed by multiple regression analyses.

## **Evaluation**

The study intends to contribute to the relevance of the working alliance as part of the therapeutic relationship. Within this frame, the treatment dependent impact of the working alliance will enhance a better understanding of different mechanisms of change.

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# Therapeutic alliance and psychotherapy process

Colli A., & Lingiardi V. (2009). The Collaborative Interactions Scale: A new transcript-based method for the assessment of therapeutic alliance ruptures and resolutions in psychotherapy. *Psychotherapy Research, 19*, 718-734.

Lingiardi V., Colli A., Gentile D., & Tanzilli A. (2011). Exploration of session process: Relationship to depth and alliance. *Psychotherapy, 48*, 391-400.

Lingiardi V. (2013). Trying to be useful: Three different interventions for one therapeutic stance. *Psychotherapy, 50*, 413-418.

## Summary

The goal of our studies was to investigate the relationship between psychotherapy process, therapeutic alliance, and therapist activity using an assessment method based on therapy sessions' transcripts. The research design implied that independent raters evaluated psychotherapy sessions of various theoretical approaches (mostly psychodynamic and cognitive-behavioral) with different process measures.

In a first study, we presented the validation and the application of a new rating system for the assessment of alliance ruptures and repairs in psychotherapy: the Collaborative Interactions Scale (CIS; Colli, Lingiardi, 2009). The CIS (composed of two main scales: one for the evaluation of patient rupture and collaborative processes, CIS-P, and one for the evaluation of therapist positive and negative contributions to the therapeutic relationship, CIS-T) furnishes a great deal of information about: 1) the patient capacity to self-disclose intimate and salient information in session, to experience emotions in a modulated fashion, to work actively with the therapist's comments, or to deepen the exploration of salient themes; and 2) two main aspects of therapist activities: the quality of the intervention (timing, attunement, tactfulness, comprehensibility) and their form (e.g., clarification, confrontation, interpretation). The CIS is a reliable rating system, useful in both empirical research and clinical assessments. In the second study, we explored the relationship between the depth of elaboration, the therapeutic alliance, and some dimensions of psychotherapy process (including the therapist's interventions, the patient's contributions, and patient/therapist's patterns of interaction) evaluated with the Psychotherapy Process Q-Set (PQS; Jones, 1985, 2000). In line with the findings of Blagys and Hilsenroth (2000), our research showed the importance of therapist interventions that focus on the patient's affects (particularly those regarded as unacceptable emotions and feelings), recurring and enduring interpersonal patterns, and the "here and now" of the relationship in the increase of the depth of elaboration and patient/therapist alliance (see also Lingiardi, 2013).

## Evaluation

The aims of these studies were to study in a clinically articulated and empirically grounded way the psychotherapy process in order to clarify what happens during the session, which kind of therapist interventions are more effective in relation to specific process factors (such as the depth of elaboration, or ruptures and resolutions processes), and which kind of patient/therapist dynamics are related to a good therapeutic relationship. The main limitations is that for the moment we studied only the observer perspective of evaluation; even if our findings are in line with previous studies that use both patient and therapist perspectives, in the future it will be necessary to investigate all the three perspectives simultaneously.

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# Psychological Intervention and Change in Depression Process Studies

Krause, M., Altimir, C., & Horvath, A. O. (2011). Deconstructing the therapeutic alliance: Reflections on the underlying dimensions of the concept, *Clínica y Salud*, 22(3), 267-283.

Krause, M., Altimir, C., Pérez, C., & de la Parra, G. (2015). Generic change indicators in therapeutic processes with different outcomes. *Psychotherapy Research* (in press).

## Background

Cumulative findings in psychotherapy research support the centrality of the therapeutic relationship, and especially of the alliance, for psychotherapy and change. This underscores the importance of examining the intrinsic relational character of the psychotherapeutic change process, through the study of the specific micro-processes involved in the dynamic construction and maintenance of the therapeutic relationship that ultimately bear influence over therapeutic change. It is of particular interest to further explore the ways in which patient and therapist mutually regulate and negotiate their affective exchange in the process of establishing and shaping the alliance.

## Subprojects

1. Analysis of the underlying dimensions of the concept of alliance
2. Generic Change Indicators in therapeutic processes with different outcomes
3. A single case study of patient and therapist's verbal and nonverbal relational offers during rupture and resolution strategy episodes.
4. A single case study of patient and therapist's synchronic facial-affective regulation during ruptures and resolution strategies and its association with process outcome, alliance, and therapy evolution.

## Research questions

1. What is the relationship between the processes that build up the elements of the therapeutic relationship that belong to different synchronic levels of analysis (micro, meso and macro) and how do they evolve along the psychotherapeutic process?
2. What are the implicit and explicit elements, expressed through facial and verbal behavior, respectively, of the affective regulation process between patient and therapist in episodes of rupture of the alliance and of resolution strategies, in a psychoanalytic psychotherapy?

## Design and method

Subproject 1: Systematic qualitative study of former patients and therapists' reports of their experience in therapy; and qualitative analysis of the item contents of the most often used instruments of alliance. Subproject 2: transversal comparison of over 39 therapeutic processes regarding ongoing change, and final outcome. Subprojects 3 and 4: A single case study, systematically analyzed with qualitative and quantitative procedures, regarding nonverbal facial behavior and regulatory processes within the negotiation of the alliance. A nested analysis approach was implemented for the association between variables belonging to different levels of analysis.

## Sample

Subproject 2: 39 therapeutic processes. Subprojects 3 and 4: 1 individual therapy

## Treatment

Subproject 2: Individual psychodynamic and gestalt, family social-constructionist, couples humanistic and group CBT. Subprojects 3 and 4: Individual short-term Psychodynamic focal therapy.

## Measures

Outcome Questionnaire (OQ-45.2), Working Alliance Inventory (WAI), Rupture Resolution Rating System (3RS), Facial Action Coding System (FACS), Generic Change Indicators (GCI).

## Results

During the momentary deterioration of the alliance –expressed in rupture episodes–, patient facially expresses negative affect and attempts to regulate her emotional arousal, and the degree of affective contact and involvement with the therapist, while therapist attempts to down-regulate his own emotional expressions. Simultaneously, at the verbal level, therapist attempts relational offers such as proposing, questioning and being conciliator, while patient offers a receptive stance. Meanwhile, during therapist’s reparatory attempts, patient nonverbally re-establishes contact and emotional involvement with the therapist, while therapist verbally offers the patient a friendly and validating attitude, at the same time that facially expresses patient’s dissociated negative affects based on an active assessment of the patient’s internal affective state. Finally, participants’ synchronic smiles were observed in rupture and resolution strategies episodes, indicating a positive affective attunement and attempts to preserve the bond in the presence of relational conflict.

All studies indicate that clinical significant change is related to high-stage transformations of representations in the patient, particularly those referred to the construction and consolidation of new meanings, and a synergic relationship between initial-stage representational changes and higher-ordered ones was observed in these therapies.

## Evaluation

Future studies require an accumulation of more in-session episodes and therapies, for the confirmation of the micro-facial affective patterns observed in the present study, and their evolution and change along the therapy process. Future studies should also attempt measuring the therapeutic alliance at the episode level, so that more clear associations can be made between the oscillations of the alliance and that of the facial-affective regulatory patterns, the ruptures and resolution strategies, and the process outcome indicators.

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# Psychological Intervention and Change in Depression. Adolescent psychotherapy: Therapeutic alliance, subjective change and relational patterns

## Background

The empirical study of psychotherapy with children and adolescents has fallen behind the studies with adults, being of recent development. These studies occur in artificial contexts, include only some types of psychotherapies (mostly CBT) at the expense of research in natural contexts. Studies that consider the children's and adolescents' own perspectives about the therapeutic process are scarce. Alliance is a central generic change factor.

The quality of the alliance relates consistently to outcome. The alliance observed during the first sessions, has a stronger relation with treatment outcomes than the alliance measured in the middle of treatment or the mean value of the alliance. In psychotherapy with adolescents there are contradictory evidence regarding which of the first sessions relates more to final outcome and which perspective relates stronger to outcome.

On the other hand, different psychoanalytic theories conceptualize adolescence as a vital moment in which it's possible to define specific psychological conditions whit process qualities. These features are triggered with puberty and mobilize different relational tasks. In this context, it's important to study the influence of relational characteristics of adolescents in the therapeutic process at different levels.

## Research questions

This research has two sub-studies:

- In therapeutic processes with adolescents: How is the relation of the therapeutic alliance with change (process and outcome) and adherence, considering the perspective of the adolescents and their therapists and the differences of psychodynamic therapies compared to other therapies.
- Which are the characteristics of relational patterns of adolescents? What is the link between Prevalent Relational Patterns in adolescence, the change process and Therapeutic Alliance?

## Subprojects

- Therapeutic alliance, communicative actions, and generic change indicators in the initial phase of psychotherapy with adolescents, and their connection with outcomes and adherence to treatment.
- Relational patterns in adolescents with depressive symptoms.

## Design and method

The studies are multiple case study design. The studies use mixed designs that combined qualitative techniques and quantitative analysis. Process studies have a non-experimental design, with data obtained from natural intervention contexts.

## Sample

-20 adolescents (15 female, 5 male); 13-17 years old. Disorders / complaints: Depression (8), Anxiety (3), Behavioral problems (3), Adaptation disorders (3) Developmental crisis (2), Others (1). Therapy approaches: psychodynamic, systemic, social-construccionist and CBT.

-10 individual Psychotherapies with adolescents with depressive symptoms (Approximately 8 sessions) videotaped. Were analyzed psychotherapies with psychodynamic, integrative and cognitive focus.

## Measures

Horvath's Working Alliance Inventory - WAI (Chilean Version: Santibáñez, 2001) (first three sessions).

Outcome Questionnaire OQ 45.2 (Chilean Version: De la Parra & Von Bergen, 2001)

Generic Change Indicators (GChI, Krause, et al., 2007)

Relevant episodes: Change Episodes (Krause et al., 2006; Krause et al., 2007) and Rupture Episodes (Safran & Muran, 1996, 2000, 2006).

CCRT-LU (Luborsky, 1977; Albani, C., et al. 2002; CCRT-LU-S: López del Hoyo, et al., 2004)

## Results

Initially, therapeutic alliance (3rd session) correlates with final results (results OQ), both for adolescents (total score) and therapists (sub scale goals). There are no differences by theoretical orientation. Only the alliance perceived by therapists (not by adolescents) – of session 1 and 2 – relates to intermediate results (6th session). The alliance of session 2 (subscale goals) perceived by psychodynamic therapists, correlates with intermediate results.

Alliance, evaluated from the perspective of the adolescents in session 2, specifically on the task subscale, predicted the probability of finalizing the process. This was not observed when the alliance was measured from the perspective of the therapists. Alliance, perceived by the therapist in session 1 and 2, correlates with the Ongoing Change (GCI obtained in that session). Ongoing Change (higher GCI in the first three sessions) predicted adherence to therapy.

In the second sub-study, we have found a link between harmony in relationship narratives and the level of depressive symptoms and the Predominant Relational Patterns appear in relevant episodes of psychotherapy.

## Evaluation

Therapists and adolescents perspectives on the alliance are related to the development of the process and the final outcome, but the therapists perspective relates specifically to ongoing change and intermediate outcome, while the adolescents perspective relates to adherence. The fact that ongoing change predicts adherence means that early changes (first three sessions) help adolescents to stay in therapy.

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## Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: a meta analytic review. *Journal of Consulting and Clinical Psychology*, 68(3), 438-450.

To identify underlying patterns in the alliance literature, an empirical review of the many existing studies that relate alliance to outcome was conducted. After an exhaustive literature review, the data from studies (58 published, 21 unpublished) were aggregated using meta-analytic procedures. The results of the meta-analysis indicate that the overall relation of therapeutic alliance with outcome is moderate, but consistent, regardless of many of the variables that have been posited to influence this relationship. For patient, therapist, and observer ratings, the various alliance scales have adequate reliability.

Across most alliance scales, there seems to be no difference in the ability of raters to predict outcome. Moreover, the relation of alliance and outcome does not appear to be influenced by other moderator variables, such as the type of outcome measure used in the study, the type of outcome rater, the time of alliance assessment, the type of alliance rater, the type of treatment provided, or the publication status of the study. In the past two decades, psychotherapy researchers and practitioners have postulated that the therapeutic alliance—defined broadly as the collaborative and affective bond between therapist and patient—is an essential element of the therapeutic process. The primary reason the alliance has grown in significance is the consistent finding that the quality of the alliance is related to subsequent therapeutic outcome. Another reason interest in the alliance has increased in the past 20 years is the inability of researchers to find a consistent difference in the effectiveness of psychotherapy across orientations. Consequently, many contemporary theories of psychotherapeutic change now emphasize the importance of the alliance, so much so that some theorists have referred to the alliance as the "quintessential integrative variable" (Wolfe & Goldfried, 1988, p. 449) of therapy. Although there are differences among the many alliance conceptualizations, most theoretical definitions of the alliance have three themes in common: (a) the collaborative nature of the relationship, (b) the affective bond between patient and therapist, and (c) the patient's and therapist's ability to agree on treatment goals and tasks (Bordin, 1979).

Using various techniques, this review indicates that alliance is moderately related to outcome ( $r = .22$ ). The average alliance-outcome correlation is within the range of many other effect sizes that are associated with psychotherapy outcome. In addition, the relation of alliance and outcome appears to be consistent, regardless of many of the variables that have been posited to influence this relationship. Indeed, the test of homogeneity suggests that the correlation represents a homogeneous population. In sum, the present metaanalysis indicates that the overall alliance-outcome correlation represents a single population of effects that cannot be reduced by a moderator variable into a more explanatory model of the relation of the alliance and outcome. This meta-analysis supports the belief that the relation of the therapeutic alliance with outcome is consistent within the psychotherapy literature. What is evident from this review is that the strength of the alliance is predictive of outcome, whatever the mechanism underlying the relation. From the empirical review of the reliabilities of the various alliance scales, it seems clear that all the alliance measures have adequate reliability. Although the overall reliability index for the various scales was somewhat lower than that found in the previous meta-analysis (.79 vs. .86), the present index still reaches an acceptable standard of consistency. Moreover, when the overall alliance index was separated by individual alliance scales, every alliance measure had an overall reliability index above .70. Surprisingly, even the scales that are not well established as measures of the alliance had adequate reliabilities. Given these results, all the alliance scales seem to have acceptable reliability. This meta-analysis did not implicate a specific alliance scale

as being more reliable than the others, but it also failed to eliminate a scale from further consideration as a research tool because of its psychometric properties. These results suggest that researchers cannot base their choice of an alliance scale on its reliability indices; the scales all tend to receive strong support. The alliance ratings of patients, therapists, and observers all tended to have adequate reliability. Although the ratings of therapists seemed to be slightly less consistent than those of patients and observers, therapists' ratings of the alliance were still within the acceptable range. Across therapy sessions, patients tended to rate the alliance more consistently than did therapists or observers. On the basis of the present meta-analysis, it seems that patients tend to view the alliance as stable, whereas therapists and observers tend to indicate more change over time in their alliance ratings.

The implications of this finding are clear: Because patients tend to view the alliance consistently throughout treatment, they are more likely to view the alliance as positive at termination if their initial assessment was positive. Thus, therapists must be effective at establishing positive alliances with their patients early in the therapy process. However, because of the small sample size of this comparison, the greater consistency of patient ratings across alliance sessions should be considered a tentative finding.

Most of the alliance scales have been shown to be related to outcome. The Penn scales, the Vanderbilt scales, the WAI, and the CALPAS were moderately correlated with outcome, but the TARS failed to receive support. In addition, the Penn scales, the Vanderbilt scales, the WAI, and the CALPAS have received far more empirical scrutiny than any of the other alliance scales. Of these measures, the WAI is likely to be appropriate for most research projects. The scale was designed to measure alliance factors in all types of therapy and to measure the theoretical constructs underlying the alliance. The scale provides both an overall alliance score and also an assessment of Bordin's (1979) three aspects of the alliance: the bond, the agreement on goals, and the agreement on tasks. The WAI also provides an assessment of Horvath and Luborsky's (1993) two core aspects of the alliance measured by most scales: (a) therapist-patient affective attachments and (b) collaboration or willingness to invest in the therapy process. In addition, patient-, therapist-, and independent observer-rated versions of the scale are available, as are shortened versions of these scales. The overall correlation of alliance and outcome did not seem to be influenced by publication status. Although the unpublished studies included in the meta-analysis had a slightly lower average correlation than did the published studies, the difference was not significant. Similarly, it is highly unlikely that enough unlocated studies with null results exist in file drawers to reduce the overall alliance-outcome correlation to a level of nonsignificance. Indeed, it would take 331 studies averaging null results to reduce the correlation of the alliance and outcome to .05.

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# Repairing Alliance Ruptures

- Safran, J. D., & Muran, J. C. (2006). Has the concept of the alliance outlived its usefulness? *Psychotherapy, 43*, 286-291.
- Safran, J. D., Muran, J. C., & Eubanks-Carter, C. (2011). Repairing alliance ruptures. *Psychotherapy, 48* (1), 80-87.
- Safran, J. D., & Muran, J. C., Samstag, L. W., & Stevens, C. (2002). Repairing alliance ruptures. In J. C. Norcross (Ed.), *Psychotherapy relationships that work*. New York, NY: Oxford University.

## Brief Summary

One of the most consistent findings emerging from psychotherapy research is that the quality of the therapeutic alliance is a robust predictor of outcome across a range of different treatments and that, conversely, weakened alliances are correlated with unilateral termination by the patient. In the last two decades, there has emerged what we have characterized as a “second generation” of alliance research that attempts to clarify the factors leading to the development of the alliance as well as those processes involved in repairing ruptures in the alliance when they occur (Safran, Muran, Samstag, & Stevens, 2002). A rupture in the therapeutic alliance can be defined as a tension or breakdown in the collaborative relationship between patient and therapist (Safran & Muran, 2006). In this article, we provide a review of this research and metaanalyses of two different types of relevant studies.

The first set of analyses examined the association between the presence of rupture-repair episodes and treatment outcome in three studies including a total of 148 patients. The aggregated correlation was  $.24$ ,  $z = 3.06$ , 95% CI  $[.09, .39]$ ,  $p = .002$ , a medium size effect that indicates that the presence of rupture-repair episodes was positively related to good outcome. The second set of analyses examined the impact of rupture resolution training or supervision on patient outcome in eight published studies including a total of 376 patients. Both prepost and group-contrast effect sizes were calculated. The mean weighted prepost  $r$  for the rupture resolution training studies was  $.65$ ,  $z = 5.56$ , 95% CI  $[.46, .78]$ ,  $p = .001$ . Given the particularly large effect sizes produced by two studies, the results were recalculated excluding these studies (leaving six studies with 252 patients), yielding an effect size of  $.52$ ,  $z = 6.94$ , 95% CI  $[.40, .63]$ ,  $p = .001$ . These results provide evidence that rupture resolution training/supervision led to significant patient improvement; however, with a prepost design, we cannot determine whether this improvement was greater than what patients would experience with treatment from therapists who were not trained in rupture resolution. A meta-analysis of the between-groups effect sizes for the seven studies with control conditions (a total of 343 patients) yielded a mean weighted effect size of  $.15$ ,  $z = 2.66$ , 95% CI  $[.04, .26]$ ,  $p = .01$ . When one outlier study was removed, leaving six studies with 321 patients, the mean weighted effect size was reduced to  $.11$ ,  $z = 2.24$ , 95% CI  $[.01, .21]$ ,  $p = .03$ . These results indicate that rupture resolution training/supervision leads to small but statistically significant patient improvements relative to treatment by therapists who did not such training.

## Evaluation

We have reviewed the growing body of evidence indicating that repairing ruptures in the therapeutic alliance is related to positive outcome. On the basis of this review, researchsupported implications for therapeutic practices are described.

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# Investigating the impact of alliance-focused training on interpersonal process and therapists' capacity for experiential reflection

- Benjamin, L. S. (1974). Structural analysis of social behavior. *Psychological Review*, 81, 392-425.
- Safran, J. D., & Muran, J. C. (2007). *Therapist Relational Interview: Administration manual*. Unpublished manuscript.
- Safran, J. D., Muran, J. C., Demaria, A., Boutwell, C., Eubanks-Carter, C. & Winston, A. (2014). Investigating the impact of alliance-focused training on interpersonal process and therapists' capacity for experiential reflection. *Psychotherapy Research*, 24(3), 269-285.

## Brief Summary

In this article we present preliminary findings from a research program designed to investigate the value of alliance-focused training (AFT), a supervision approach designed to enhance therapists' ability to work constructively with negative therapeutic process. In the context of a multiple baseline design, all therapists began treating their patients using cognitive therapy and then joined AFT supervision groups at either session 8 or 16 of a 30 session protocol.

Study 1 investigated the impact of AFT on patient and therapist interpersonal process as assessed through the Structural Analysis of Social Behavior (SASB; Benjamin, 1974). Study 2 investigated the impact of AFT on therapists' tendency to reflect on their relationships with their patients in an experientially grounded fashion, as assessed via the Experiencing Scale (EXP). Since one of the goals of AFT is to train therapists to use their own emerging feelings as important clues regarding what may be taking place in the therapeutic relationship, we hypothesized that they would show increased levels of EXP after undergoing AFT. This dimension of therapists' reflective style was assessed with the use of a semi-structured interview designed to probe for therapists' tendency to reflect on their own internal experience when responding to questions about their relationships with the patients they were treating in the study. This interview, known as the Therapist Relationship Interview (TRI; Safran & Muran, 2007) was then coded with the Experiencing Scale (EXP).

The results of both studies 1 and 2 were for the most part consistent with hypotheses. In Study 1, several significant shifts in both therapist and patient interpersonal process emerged after CBT was augmented with AFT. All significant differences in therapist inter-personal process (except for Disclosing & Expressing) emerged on the "other" or "transitive" surface of the SASB (Surface 2). All significant differences in patient interpersonal process emerged on the "self-focused" or "intransitive" surface of the SASB (Surface 1). Consistent with our hypotheses, the majority of significant differences between training modalities in both therapist and patient interpersonal processes emerged regardless of time of implementation of AFT (session 8 or session 16).

In Study 2, results were consistent with the hypothesis that after receiving AFT, therapists would demonstrate a greater tendency during TRI interviews to reflect on their relationships with their patients in a personally involved, experientially grounded fashion than they did after receiving CBT training.

## Evaluation

Taken together, the findings of studies 1 and 2 provide intriguing preliminary evidence regarding the potential of alliance-focused training to have a positive impact on both in-session interpersonal process, and on therapists' capacity to reflect on the therapeutic relationship in a fashion that incorporates their own felt experience. Further research will be essential to evaluate whether

differences in SASB and EXP ratings are related to ultimate outcome. Since all patients received some combination of CBT and AFT, we did not expect to find between-group differences in treatment outcome. It will, however, be critical to examine whether differences in treatment process are meaningfully related to one another and predictive of treatment outcome. At the present time, we continue to enter more patients and therapists into the larger, ongoing research project, and will be in the position to examine these questions in the future.

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## To what extent is alliance affected by transference? An empirical exploration

Dinger, U., Zilcha-Mano, S., McCarthy, K. S., Barrett, M. S., & Barber, J. P. (2013). Interpersonal problems as predictors of alliance, symptomatic improvement and premature termination in treatment of depression. *Journal of Affective Disorders, 151*, 800–803.

Zilcha-Mano, S., McCarthy, K. S., Dinger, U., & Barber, J. P. (2014, May 26). To what extent is alliance affected by transference? An empirical exploration. *Psychotherapy*. Advance online publication. <http://dx.doi.org/10.1037/a0036566>

### Summary

Will patients project their representations of significant others onto the therapist in a way that influences the formation of the therapeutic alliance? To address this issue, the current study explored the following questions: (1) To what extent are pretreatment representations of others projected onto the therapist and thereby predict the development of alliance throughout the course of treatment? (2) To what extent are these projections affected by the real relationship? (3) Are there specific representations of others that are more prone to be projected onto the alliance? To this end, data on 134 patients from a randomized controlled trial for depression comparing dynamic supportive–expressive therapy with supportive clinical management combined with pharmacotherapy or placebo were used. Findings demonstrated that the patients’ pretreatment representations of significant others predicted a substantial part of the alliance with the therapist throughout the course of treatment. However, the representations of others were not automatically projected onto the alliance but rather the projections were also influenced by the real relationship with the therapist. Throughout this process, the alliance evolves into a collage of significant others. A process of assimilation seemed to emerge during treatment, in which the most relevant representations of significant others were projected onto the alliance with the therapist.

### Evaluation

The alliance is considered an essential aspect of psychotherapy by many theorists and researchers (e.g., Muran & Barber, 2010). In the current study we delved into one of the possible origins of the alliance by examining the extent to which it could be explained by the patient’s representations of significant others. Our findings showed that representations of significant others, as examined before treatment begins, predicted a substantial part of the alliance with the real therapist: benevolent representations of others at intake were positively related to the alliance subsequently developed with the therapist, while malevolent representations of others were negatively related to the alliance subsequently developed with the therapist. The current findings constitute fertile ground for further examination of a variety of clinically important questions. While the current study focused on describing general phenomena, future research could examine the effect of individual differences between patients (such as patient’s interpersonal problems, Dinger, Zilcha-Mano, McCarthy, Barrett, & Barber, 2013, or attachment orientation) as well as the effects of specific characteristics of the real therapist (such as the therapist’s attachment orientation, or the therapist’s personal therapy experience, Gold & Hilsenroth, 2009), and the characteristics of the specific interactions between the patient and the therapist on the phenomena described in this study. Additionally, as the current study is not ideal for evaluating therapist effects, future large-scale studies with appropriate designs for investigating therapist’s effect (e.g., appropriate patients–therapist ratio and number of therapists, see Baldwin &

Imel, 2013 for comprehensive description), should further examine the influence of the therapist's effect on the findings. Moreover, our interpretations of the findings (e.g., our "incubation process" suggestion) should be examined in clinical practice and research to learn about their potential utility.

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## Experimental study of transference work (FEST)

Høglend, P., Bøgwald, K., Amlo, S., Marble, A., Ulberg, R., Sjaastad, M. C., . . . Johansson, P. (2008). Transference interpretations in dynamic psychotherapy: Do they really yield sustained effects? *American Journal of Psychiatry*, *65*, 763-771.

Høglend, P., Perry, J. C., Dahl, H.-S., Lorentzen, S., & Hersoug, A. G. (2011). Long-term effects of transference interpretation in dynamic psychotherapy of personality disorders. *European Psychiatry*, *26*, 419-424.

Johansson, P., Høglend, P., Ulberg, R., Amlo, S., Marble, A., Bøgwald, K.-P., & Sørbye, Ø. (2010). The mediating role of insight for long-term improvements in psychodynamic therapy. *Journal of Consulting and Clinical Psychology*, *78*, 438-448.

Høglend, P. (2014). Exploration of the patient-therapist relationship in psychotherapy. *American Journal of Psychiatry*, *171*(10), 1056-1966.

### Goal

FEST is designed to investigate long-term effects of transference work in dynamic psychotherapy.

### Method

We randomly assigned 100 patients to 1 year of dynamic psychotherapy with a low to moderate level of transference work or to the same type of therapy without transference work. The same therapists administered both treatments after extensive training. Treatment integrity was documented with ratings of more than 450 full sessions. The only component that differed between the two treatments was use of a low to moderate frequency of transference work interventions. Thus, the design makes it possible to study causal effects of transference work.

### Results

There was no overall effect of transference work. However, patients with a low quality of object relations benefited significantly more from therapy with transference work compared to therapy without transference work (1). This effect was sustained during a 3-year followup period (2). Patients with mature relationships and greater psychological resources benefited equally well from both treatments. Furthermore, female patients responded significantly better than men to therapy with work (3). Among the 46 patients with one or more personality disorders, 17 of 23 patients (74%) no longer met diagnostic criteria for any personality disorder in the transference group, versus 10 of 23 patients (43%) in the comparison group. The dropout rate was 0% in the transference group and 22% in the comparison group. Patients who did not receive transference work had about four times more additional mental health specialist treatment during the 3-year follow-up period, compared with patients who received transference work (4). All the therapists in this study had extensive experience and were specifically trained to deliver the two treatments, which limits generalizability to ordinary clinical practice.

### Discussion

The long-term effect of transference work among patients with low-quality object relations was mediated (explained) by increased gain of insight during therapy (5). Several studies suggest that changes in insight or self-understanding are specific to dynamic psychotherapy and are not associated with other treatments, such as cognitive-behavioral therapy or antidepressant medication. FEST

extended this work by linking these of specific techniques to gains in insight and subsequent improvement in interpersonal functioning (6).

These findings are consistent with the clinical theory that insight may be a specific mechanism of change in dynamic therapy. It should be noted, however, that the association between insight and outcome cannot be experimentally controlled. The true causal mechanism of change could be some unknown variable correlated with insight. This is an inevitable limitation, to date, in mediator studies.

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# An experimental study of transference interpretations

Høglend, P., Amlo, S., Marble, A., Bögwald, K.-P., Sörbye, Ö., Sjaastad, M. C., & Heyerdahl, O. (2006). Analysis of the patient-therapist relationship in dynamic psychotherapy: An experimental study of transference interpretations. *American Journal of Psychiatry*, *163*, 1739-1746.

Høglend, P., Bogwald, K. P., Amlo, S., Marble, A., Ulberg, R. S., M.C., & Johansson, P. (2008). Transference interpretations in dynamic psychotherapy: Do they really yield sustained effects? . *American Journal of Psychiatry*, *165*, 763-771.

Høglend, P., & Gabbard, G. (2012). When is transference work useful in psychodynamic psychotherapy? A review of empirical research. In R. Levy, J. S. Ablon & H. Kächele (Eds.), *Psychodynamic Psychotherapy Research* (pp. 449-467). New York: Humana Press.

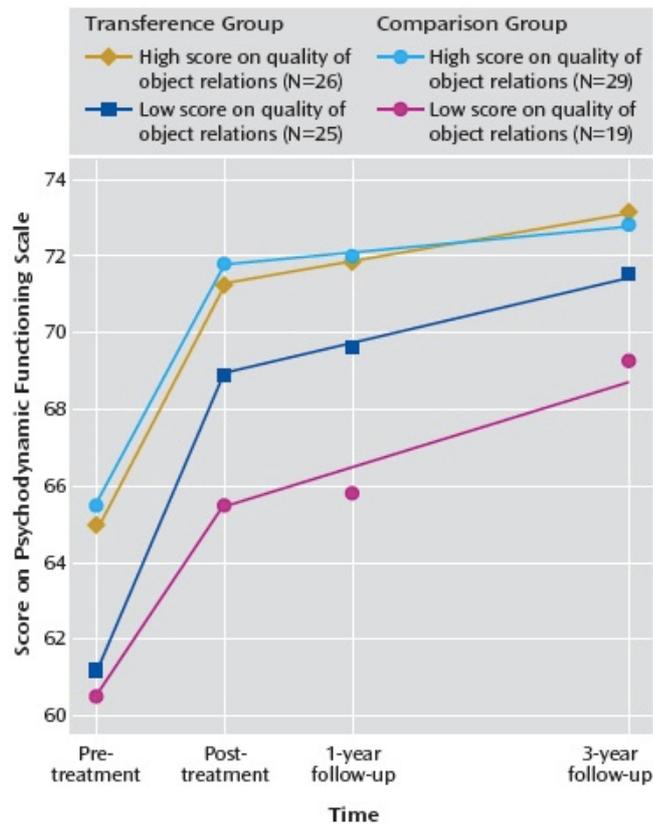
## Objective

Transference interpretation has remained a core ingredient in the psychodynamic tradition, despite limited empirical evidence for its effectiveness. The purpose of this study was to measure the effects of transference interpretations (the assumed core active ingredient) in dynamic psychotherapy, using an experimental design.

## Method

This was a randomized controlled clinical trial, dismantling design, plus follow-up evaluations 1 year and 3 years after treatment termination. One hundred outpatients seeking psychotherapy for depression, anxiety, personality disorders, and interpersonal problems were referred to the study therapists. One group received dynamic psychotherapy over 1 year, with a moderate level of transference interpretations, while the other group received dynamic psychotherapy with no transference interpretations. Patients were randomly assigned to receive weekly sessions of dynamic psychotherapy for 1 year with or without transference interpretations. Five full sessions from each therapy were rated in order to document treatment fidelity.

Outcome variables were the Psychodynamic Functioning Scales, Inventory of Interpersonal Problems Scale-Circumplex version, Global Assessment of Functioning Scale, and Symptom Checklist-90-R. Quality of Object Relations Scale (lifelong pattern) and personality disorders were preselected as possible moderators of treatment effects. Change was assessed using linear-mixed Outcome variables were the Psychodynamic Functioning Scales (clinician rated) and the Inventory of Interpersonal Problems (selfreport). Rating on the Quality of Object



## Clinically significant results

Despite an absence of differential treatment efficacy, both treatments demonstrated significant improvement during treatment and also after treatment termination. However, patients with a lifelong pattern of poor object relations profited more from 1 year of therapy with transference interpretations than from therapy without transference interpretations. This effect was sustained throughout the 4-year study period.

## Conclusions

The goal of transference interpretation is sustained improvement of the patient's relationships outside of therapy. Transference interpretation seems to be especially important for patients with long-standing, more severe interpersonal problems.

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## Countertransference as object of empirical research?

Kächele, H., Erhardt, I., Seybert, C., & Buchholz, M. B. (2015). Countertransference as object of empirical research? *International Forum of Psychoanalysis*, in press.

Peräkylä, A. (2011). A psychoanalyst's reflection on conversation analysis's contribution to his own therapeutic talk. In C. Antaki (Ed.), *Applied Conversational Analysis. Intervention and Change in Institutional Talk* (pp. 222–243). New York: Basingstoke, Palgrave Macmillan.

Buchholz, M.B. (2015). Growth - What reconciliation of conflicts could mean. A lesson from the history of psychoanalysis. *International Forum of Psychoanalysis*, 24, (2), 88-95.

### Goal

The concept of countertransference as a robust cornerstone of psychoanalytic work has gained in momentum over the last five decades. It is a prime example for elastic concepts covering the range from microprocess to global clinical phenomena. Empirical research on treatment process has for a long time - for good reasons - avoided to even try to measure countertransference. Today we encounter various efforts for a methodology to measuring countertransference. The paper organizes the various approaches in terms of stages of research.

#### *Clinical Case Studies:*

Using the PEP-database searching for the term countertransference in the titles of papers one learns about 730 articles which use the term countertransference from 1952 til 2012; since 2000 the information provided (193 papers and books) underlines that countertransference indeed enjoys a high degree of attention.

#### *Descriptive Studies:*

Descriptive studies as a formal research activities fulfill the task to systematically describe the phenomena under scrutiny. Singer and Luborsky (1977) point out that most psychotherapy researchers feel „that a scientific orientation requires controlling certain variables even if doing so means that the phenomena studied are not in their most natural form. Consequently much psychotherapy research deals only with approximations of the actual clinical experience“ (p.438).

#### *Experimental Analogue Studies*

A fairly ecologically valid experimental study on the issue of countertransference propensities was performed by Beckmann (1974). Applying a psychoanalytically informed, but psychometrically sound questionnaire, the Giessen-Test (Beckmann & Richter 1972) he studied a group of psychoanalytic candidates who observed many patients in a psychoanalytic initial interview through a one-way-window. Candidates who qualified with higher levels of depressive features overrated the degree of hysterical features in the patients; vice versa candidates who qualified with higher levels of hysterical features overrated the degree of depressive features in the patients; and candidates with higher levels of obsessiveness overrated the degree of obsessiveness in the patients.

#### *Naturalistic Studies*

A recent review on the state of the art concerning countertransference was provided by Hayes, Gelso, & Hummel (2011). They review three metaanalyses; the first focuses on the impact of countertransference on the outcome of treatment, the second focuses on the issue whether the capacity to manage countertransference reduces the actualization of countertransference feelings and the third asks whether managing the countertransference improves the outcome.

*Conversational studies* on countertransference are becoming more and more popular as only the detailed microanalysis of what goes on in the session allows to identify hidden dimensions. Countertransference-aspects are addressed here in an important, but very indirect way. The “third-position”-utterance seems to come from a “resonating alignment” (Buchholz 2013) which produces a feeling in the analyst that something is still missing and that a further utterance should follow. “Something more” refers to what Stern et al. (1998) had termed “non-interpretative mechanisms”. So it seems that modern audio- and video technique, used by conversation analysts and “baby-watchers” since the 1960s in a similar way, really opens new horizons for the detailed analysis of what is really said and done in a psychoanalytic session. In a personal comment Peräyklä (2011a) debates how the (alleged) “anti-mentalism” of conversation analysis and the more introspective approach of psychoanalysis can be brought together on the basis of detailed observation. It seems that we might expect for the future a clarification of what the “clinical facts” (Tuckett 1994) of psychoanalysis are and how the future role of countertransference will be.

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# Countertransference phenomena and personality pathology in clinical practice: An empirical investigation

Betan, E. J., Heim, A. K., Conklin, C. Z., & Westen, D. (2005). Countertransference phenomena and personality pathology in clinical practice: An empirical investigation. *American Journal of Psychiatry*, 162(5), 890-898.

Betan, E. J., & Westen, D. (2009). Countertransference and personality pathology: Development and clinical application of the Countertransference Questionnaire. In R. A. Levy & J. S. Ablon (Eds.), *Handbook of Evidence-Based Psychodynamic Psychotherapy. Bridging the Gap Between Science and Practice* (pp. 179-198). New York: Humana Press.

## Objective

This study provides initial data on the reliability and factor structure of a measure of countertransference processes in clinical practice and examines the relation between these processes and patients' personality pathology.

## Method

A national random sample of 181 psychiatrists and clinical psychologists in North America each completed a battery of instruments on a randomly selected patient in their care, including measures of axis II symptoms and the Countertransference Questionnaire, an instrument designed to assess clinicians' cognitive, affective, and behavioral responses in interacting with a particular patient.

## Results

Factor analysis of the Countertransference Questionnaire yielded eight clinically and conceptually coherent factors that were independent of clinicians' theoretical orientation: 1) overwhelmed/disorganized, 2) helpless/inadequate, 3) positive, 4) special/overinvolved, 5) sexualized, 6) disengaged, 7) parental/protective, and 8) criticized/mistreated. The eight factors were associated in predictable ways with axis II pathology. An aggregated portrait of countertransference responses with narcissistic personality disorder patients provided a clinically rich, empirically based description that strongly resembled theoretical and clinical accounts.

## Conclusions

Countertransference phenomena can be measured in clinically sophisticated and psychometrically sound ways that tap the complexity of clinicians' reactions toward their patients. Countertransference patterns are systematically related to patients' personality pathology across therapeutic approaches, suggesting that clinicians, regardless of therapeutic orientation, can make diagnostic and therapeutic use of their own responses to the patient.

The results point to several conclusions. First, eight countertransference dimensions were identified as robust across extraction methods and rotations: 1) overwhelmed/ disorganized, 2) helpless/inadequate, 3) positive, 4) special/ overinvolved, 5) sexualized, 6) disengaged, 7) parental/ protective, and 8) criticized/mistreated. These dimensions are clinically and theoretically coherent, representing diverse reactions clinicians may have toward patients that likely reflect a combination of the therapist's own dynamics, responses evoked by the patient, and the interaction of patient and therapist. The factor structure offers a complex portrait of countertransference processes that is substantially more nuanced than global distinctions between positive and negative countertransference. What this study suggests,

however, is a way of transcending some of the limitations inherent in clinical theories derived from case studies, in which a single clinician attempts to classify countertransference experiences or constellations based on his or her own experience with a limited number of patients. By using an instrument that provides a “common language” for describing a subtle clinical phenomenon, Betan and colleagues can essentially pool the knowledge of dozens of clinical observers, identifying latent constructs (varieties of countertransference experience) that reflect patterns that individual observers themselves may not have recognized. Second, although every clinician and every therapeutic dyad is distinct, the significant correlations between the countertransference factors and personality disorder symptoms suggest that countertransference responses occur in coherent and predictable patterns. The associations between countertransference patterns and personality disorder characteristics support the broad view of countertransference reactions as useful in the diagnostic understanding of the patient’s dynamics, particularly those involving repetitive interpersonal patterns. To the extent that patients sharing diagnostic features on axis II have similar ways of thinking, feeling, and behaving interpersonally, one would expect them to evoke similar reactions from others, including therapists, and this appears to be the case. Third, data from clinicians of different theoretical orientations showed similar patterns vis-à-vis patients with particular kinds of pathology, suggesting that the results are not artifacts of clinicians’ theoretical preconceptions. What is striking about this finding is that coherent patterns of countertransference response emerge in treatments regardless of whether the clinician even “believes” in the concept of countertransference responses or has been trained to attend to them. Finally, the empirical portrait of countertransference responses toward patients with narcissistic personality disorder points to the way researchers can use this measure to create empirical prototypes of subtle countertransference constellations with patients presenting with specific types of personality disturbance. In principle, with a large enough sample, one could empirically map the terrain of countertransference patterns in response to multiple forms of personality pathology. One could also identify distinct constellations within diagnoses (e.g., different kinds of narcissistic patients) or to patients who share certain experiences (e.g., survivors of childhood sexual trauma) that may occur across treatments, at different points in therapy, or at different points in a single therapy hour. In working with survivors of childhood sexual abuse, for example, clinicians often face the opposite danger of pushing too much or too early for the patient to remember— and potentially recapitulating the patient’s subjective experience of unwanted penetration, abuse, or lack of boundaries—versus avoiding discussion of traumatic events in intimate detail for fear of traumatizing the patient— and potentially recapitulating the patient’s experience of unacknowledged but shared secrets or the inability or unwillingness of a caregiver who knew about the abuse to talk about it. Identification of such patterns as common constellations in the treatment of abuse survivors could be very useful in teaching clinicians about potential countertransference dangers inherent in working with abuse survivors in a way that is both clinically sensitive and empirically grounded.

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# Long-term effects of analysis of the patient–therapist relationship in the context of patients’ personality pathology and therapists’ parental feeling

Dahl, H.-S. J., Røssberg, J. I., Crits-Christoph, P., Gabbard, G. O., Hersoug, A. G., Perry, J. C., . . . Høglend, P. A. (2014). Long-term effects of analysis of the patient–therapist relationship in the context of patients’ personality pathology and therapists’ parental feelings. *Journal of Consulting and Clinical Psychology, 82*(3), 460-471.

## Summary

Transference work (analysis of the patient-therapist relationship) is considered a core active ingredient in dynamic psychotherapy. However, there are contradictory findings as for whom and under what circumstances working explicitly with the therapist-patient relationship is beneficial. This study investigates long-term effects of transference work in the context of therapists’ self-reported parental countertransference (CT), and patients’ level of personality pathology. Hence, we wanted to examine whether or not parental CT are associated with the specific long-term effects of transference work, and whether these associations change as a function of different levels of patients’ personality pathology. Transference work focus on the ongoing relationship between therapist and patient. We believe that this explicit focus will make CT affect the therapeutic process more than in the non-transference work group. Based on the sparse literature in the field we expected that transference work in the context of elevated parental CT might be beneficial for patients with more severe personality pathology, but possibly harmful for patients without personality pathology. The rationale for this differential prediction is as follows: When personality pathology is high, parental CT informs the therapist’s appreciation of the patient’s needs for protective (positive parental) engagement. However, when personality pathology is low, therapists are advised to be more neutral and adopt an “analytic” neutral stance. Parental CT may not be accurately attuned to these patients’ needs, and possibly impede exploration.

One hundred outpatients seeking psychotherapy for depression, anxiety, and personality disorders were randomly assigned to dynamic psychotherapy *with* a low to moderate level of transference work, or to the same type of therapy, but *without* transference work. Transference work was defined broadly, as all interventions that allude to the therapist or the therapy. The same therapists did both treatments after extensive training. Personality pathology was evaluated before treatment as the sum of fulfilled personality disorder criteria on SCID II. Countertransference feelings were assessed with the Feeling Word Checklist-58 (FWC-58), the therapists were asked to rate to what degree they had experienced 58 feeling states after each session. In this paper we study the Parental countertransference (CT) subscale which had the highest mean value of the subscales. The parental CT subscale included the words: Motherly, Affectionate, Dominating, and Important. The outcome variables were the Psychodynamic Functioning Scales and Inventory of Interpersonal Problems, measured at pre-treatment, mid-treatment, post-treatment, one year, and three years after treatment termination.

A significant treatment group (transference vs. no transference) by personality pathology by parental CT interaction was present. This indicates that parental CT had significantly different impact on the effect of transference work, depending on the level of personality pathology. In the context of low parental CT, transference work was positive for all patients. However, when parental CT increased, the specific effect of transference work was even more positive for patients with high levels of personality pathology, but negative for patients with low levels of personality pathology. These patients did not deteriorate, but the patients with little personality pathology in the non-transference

group did relatively better compared to the transference group, when parental CT was high. Patients with high levels of personality pathology was relatively better off in the transference group independent of parental CT, although they did even better when parental CT was high.

The therapist's parental countertransference and the level of patient's personality pathology strongly influenced the specific effect of transference work as measured three years after therapy.

## **Evaluation**

The study adds to an evolving body of literature suggesting that patient characteristics, technique variables, and therapist variables are all important. Examination of any one of these variables in isolation from the others may provide an incomplete understanding of their role in relation to outcome.

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## AAI predicts patients' in-session interpersonal behavior and discourse

Talia A., Daniel S.I.F., Miller-Bottome M., Brambilla D., Miccoli D., Safran J.D., & Lingiardi V. (2014). AAI predicts patients' in-session interpersonal behavior and discourse: A "move to the level of the relation" for attachment-informed psychotherapy research. *Attachment & Human Development, 16, 2*, 192-209.

### Brief Summary

There is currently little empirical evidence regarding how patients' attachment patterns manifest in individual psychotherapy. This study compared the in-session discourse of patients classified secure, dismissing, and preoccupied on the Adult Attachment Interview (AAI). Rather than focusing on content or form alone, this study analyzed how patients' discourse elicits and maintains emotional proximity with the therapist. The AAI was administered to 56 patients prior to treatment and one session for each patient was rated with the Patient Attachment Coding System (PACS) by four independent raters, blind to patients' AAI classification. Significant differences were found in the discourse of patients with different attachment patterns. Namely, secure and preoccupied patients showed more contact-seeking behavior than dismissing patients, who avoided emotional proximity more, while preoccupied patients resisted therapists' help more than did secure and dismissing patients. These results suggest that the different attachment patterns may have distinctive manifestations in the psychotherapy process that can be tracked by external observers.

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## Therapists' professional and personal characteristics as predictors of working alliance and outcome in psychotherapy

Knekt, P., Laaksonen, M., Härkänen, T., Maljanen, T., Heinonen, E., Virtala, E., & Lindfors, O. (2012). The Helsinki Psychotherapy Study: effectiveness, sufficiency, and suitability of short- and long-term psychotherapy. In R. A. Levy, S. Ablon & H. Kächele (Eds.), *Psychodynamic Psychotherapy Research. Evidence-Based Practice and Practice-Based Evidence* (pp. 71-94). New York: Humana Press.

Heinonen, E., Lindfors, O., Laaksonen, M. & Knekt, P. (2012). Therapists' professional and personal characteristics as predictors of outcome in short- and long-term psychotherapy. *Journal of Affective Disorder*, *138*, 301-312.

Heinonen, E., Knekt, P., & Lindfors, O. (2014). Therapists' professional and personal characteristics as predictors of outcome in long-term psychodynamic psychotherapy and psychoanalysis. *European Psychiatry*, *29*, 265-274.

### Summary

This study investigates therapists' professional and personal characteristics and identity as predictors of the therapist-patient working relationships, the psychotherapy process, and patient therapy outcomes in two short-term and two long-term therapies (Knekt et al. 2012). Both quantitative and qualitative methods will be used to meet these aims. The study is based on a cohort design and the data is coming from the Helsinki Psychotherapy study. The participants are 367 outpatients from psychiatric services in the Helsinki region having long-standing depressive or anxiety disorder causing work dysfunction. Patients with psychotic disorder, severe personality disorder, adjustment disorder, bipolar disorder or substance abuse were excluded. Solution-focused therapy included 12 and short-term psychodynamic psychotherapy 20 therapy sessions, both therapies lasting about half a year. The long-term therapies were open-ended, psychodynamic psychotherapy lasting about 3 years with about 240 sessions and psychoanalysis lasting about 5 years, with about 650 sessions. Treatments were provided by 71 volunteering psychotherapists who had an average of 9 years work experience in the short-term and over 15 years in the long-term therapies. The patient outcome assessment covers different measures of psychiatric symptoms and recovery, need for treatment, work ability, personality functioning, social functioning, and lifestyle. These outcome measures are administered longitudinally: prior to start of treatment and at 14 pre-chosen time points during a 10-follow-up from start of treatment. Working alliance was rated by both patient and therapist at the third therapy session, and 9 times during a 5-year follow-up. Information on the psychotherapy process is collected four times during the follow-up.

Original contributions have been published (Heinonen et al. 2012, 2013, 2014) from this sub-study and one study is ongoing (see cited our homepage).

### Evaluation

The results of this study may have implications improving the quality and flexibility of therapist training programs and supervision, and help in accommodating clinicians' personal qualities with therapy models for optimizing effective training, learning, and therapy practice.

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# Stockholm Outcome of Psychotherapy and Psychoanalysis Project (STOPPPP): Therapeutic identity

Sandell, R., Carlsson, J., Schubert, J., Broberg, J., Lazar, A., & Grant, J. (2004). Therapist attitudes and patient outcomes: I. Development and validation of the therapeutic attitudes scales (tasc-2). *Psychotherapy Research, 14*, 469-484. doi: 10.1093/ptr/kph039

Sandell, R., Lazar, A., Grant, J., Carlsson, J., Schubert, J., & Broberg, J. (2006). Therapist attitudes and patient outcomes. III. A latent class analysis of therapists. *Psychology and Psychotherapy: Theory, Research and Practice, 79*, 629-647.

Sandell, R., Lazar, A., Grant, J., Carlsson, J., Schubert, J., & Broberg, J. (2007). Therapist attitudes and patient outcomes: II. Therapist attitudes influence change during treatment. *Psychotherapy Research, 17*, 201-211.

The therapist has been found a most important factor determining therapy outcome, even in manualized treatments. The Therapeutic Identity (ThId) questionnaire was developed in the Stockholm Outcome of Psychotherapy and Psychoanalysis Project (STOPPPP; Sandell et al., 2000; Sandell et al., 2004) with the aim to evaluate therapists' professional background and experience, their therapeutic attitudes and style, as well as the private theories and meta-theoretical assumptions. The Therapeutic Attitudes Scales (TASC) is the part of the questionnaire that concerns therapists' therapeutic values and beliefs. The ThId has versions in English, German, Spanish, and Portuguese.

Using the TASC in a national sample the Stockholm group (Sandell et al., 2000; Sandell et al., 2004) was able to identify four clusters of therapists. These were interpreted primarily on the basis of their associations with variables related to the therapists' training. One was a cognitive/behavioural cluster, which scored high in adjustment, supportiveness and kindness, and another one consisting of therapists with classic psychoanalytic attitudes, which scored low on these variables and high on neutrality and insight. The two remaining clusters were interpreted as consisting of therapists with more eclectic attitudes, high on scales where the cognitive/behavioral cluster was high but also high on scales where the psychoanalytic cluster was high. Considering their profiles across the TASC scales one of them was interpreted as a psychodynamic cluster, generally closer to the psychoanalytic cluster, whereas the other reflected a more cognitive perspective, with a profile closer to the cognitive/behavioural cluster. In subsequent studies the TASC has been found significantly to correlate with patients' outcome in psychodynamic therapy and psychoanalysis.

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# The therapeutic attitude: Negotiating a “dark continent”

Klug, G., Henrich, G., Kächele, H., Sandell, R. & Huber, D. (2008). Die Therapeutenvariable: immer noch ein dunkler Kontinent? [The therapist variable: is it still an unknown factor?] *Psychotherapeut*, 53, 83-91.

## Summary

There is broad consensus in the scientific community that the therapist matters. The therapeutic attitude, conceived as the therapist’s personal backdrop against which the therapeutic process is unfolding during treatment, is a salient curative factor. The present study aimed at further elucidating the therapeutic attitude. In order to more subtly differentiate the person of the “healer“, psychoanalysts, psychodynamic psychotherapists, and cognitive-behavioral therapists were investigated. We hypothesized that there are significant differences between therapists of different therapeutic orientations according to their differential training and technique.

The Therapeutic Attitude Questionnaire (ThAt), the German translation of the Therapeutic Identity Questionnaire, developed by Sandell and co-workers, was applied to explore the therapist variable. The questionnaire comprises therapists’ demographics, academic and professional training, professional experience, personal therapy or training analysis and therapist’s theoretical orientation. Therapist’s attitude is captured by items of therapist’s belief in curative factors, individual technique and basic assumptions, condensed into the Therapeutic Attitudes Scales (TASC): Adaptation, Insight, Kindness, Neutrality, Supportiveness, Self-doubt, Irrationality, Artistry and Pessimism. Furthermore, therapists described in free-text format their strengths, limitations, aims and difficulties in therapy.

We investigated a total sample of 451 psychotherapists: 208 psychoanalysts, 81 psychodynamic psychotherapists and 162 cognitive-behavioral therapists; response rate was 52 %.

The central finding of the ANOVA for TASC variables was that adaptation and insight differentiate the groups in the theoretically expected way: cognitive-behavioral therapists believed that the patient’s adaptation to the environment is the most essential curative factor, whereas psychoanalysts believed that insight into problems is the most essential curative factor; psychodynamic psychotherapists took an intermediate stance. CHAID analysis of the TASC variables showed that adaptation contributes the most to the therapists’ differentiation. Thus, we concluded that psychoanalysts, psychodynamic and cognitive-behavioral therapists work in empirically distinguishable ways and as theoretically expected.

## Evaluation

This study is limited because it does not address the therapist’s effectiveness as a correlation with the outcome of the therapy is lacking.

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# Studying psychotherapy process with the PQS: Therapists' techniques in psychoanalysis and short-term and long-term psychoanalytic psychotherapy: are they different?

Seybert, C., Desmet, M., Erhardt, I., Hörz, S., Mertens, W., Ablon, S., Levy, R., Kächele, H. (2010). Therapists techniques in psychoanalysis and short-term and long-term psychoanalytic therapy: Are they different? *Journal of the American Psychoanalytic Association*, 59(3) (3), 592-602.

## Summary

Therapeutic techniques represent a significant part of the therapist's contribution to the therapeutic process.

This study compares the therapeutic techniques used in recorded sessions of 13 psychoanalyses, 15 long-term (LTDP) and 30 short-term (STDP) psychodynamic psychotherapies. Two hundred two therapeutic sessions were analyzed with the Psychotherapy Process Q-Set (PQS; Jones, 2000). In regards to the techniques defined and presented in the research literature, we identified 25 suitable PQS items among the total 100 items from the PQS. These therapeutic techniques are compared among the PA, LTDP and STDP samples and at different points in time of the therapeutic process. The correlation of each sample with the PQS analytic prototype (Ablon & Jones 1998) identifies therapeutic techniques characteristic for psychoanalytic oriented therapies. The study addresses three questions: (1) whether there are differences between PA, LTPD, and STPD at the level of therapeutic technique, (2) whether PA and LTPD show more resemblance to the PQS psychoanalytic prototype than STPD, and (3) whether interpretation (among other techniques) differs between STPD and LTPD.

Overall more similarities than differences could be found within these samples.

The most significant differences regarding therapeutic techniques, identified through *t* tests, were found on seven techniques. For example, psychoanalysts were observed to be more empathic toward their patients than were STDP therapists. No significant differences could be found between PA and LTDP therapists.

All three samples achieved a correlation of .50 or higher with the PQS psychoanalytic prototype. When correlating only the technique items of the samples and the PQS prototype, the technique items of the STDP sample achieve the highest correlation of .76 followed by the correlation of .70 for the LTDP sample and .58 for the PA sample.

## Evaluation

Despite limitations regarding sample size and heterogeneity the results indicate little dimensional differentiation in the techniques used in PA, LTDP, and STPD. In accounting for these differences, the length of treatment was more important than the lying down vs. face-to-face distinction.

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## Therapist variables and patient outcome

Berghout, C., & Zevalkink, J. (2011). Therapist variables and patient outcome after psychoanalysis and psychoanalytic psychotherapy. *Journal of the American Psychoanalytic Association, 59*, 577-583.

### Summary

Evidence from studies that have focused on the effects of therapist variables on treatment outcome suggests that a moderate amount of variance in patient outcomes is attributable to therapist differences, regardless of the type of treatment practiced. In the literature, researchers have considered gender of the therapist, therapists' experience and training, therapists' treatment attitudes, and self-reported attachment style to be relevant therapist variables (e.g., Beutler et al. 2004). In the present study, we investigated whether these therapist variables are related to patient outcome in a group of patients after psychoanalysis and a group of patients after psychoanalytic psychotherapy.

The patient sample (N = 97) originated from a project, with participants from four mental health care organizations in the Netherlands, designed to study the effectiveness of long-term psychoanalytic treatment. For the present study, we focused on patients who had ended long-term psychoanalytic treatment. One group of patients had received psychoanalysis (PA; n = 40); the other group had received psychoanalytic psychotherapy (PP; n = 57). Patient outcome was assessed by using the three outcome factors that were found in the PCA factor analyses: General distress, Introversion, and Disadaptation and disorganization (see Berghout, Zevalkink, and de Jong 2010).

All therapists (N=53) in the project were licensed clinicians (psychiatrist-psychotherapists or psychologist-psychotherapists)

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# To become a psychotherapist – a clinical challenge for students and a pedagogic challenge for teachers

Ögren, M.L., Bertling, U., Boalt-Boëthius, S., Werbart, A., Hau, S. (2012). Professional development and psychotherapy supervision. *Nordic Psychology*, 64, 3, 147-149.

Hau, S., Jacobsson, G., Lindgren, T. (2012). Rites of passage – novice students' experience of becoming psychotherapists. *Nordic Psychology*, 64, 3, 46-56.

## Aim

Postgraduate psychotherapy education combines teaching of theoretical knowledge, applied clinical experience as well as clinical practice under supervision. In an ongoing naturalistic study, the interplay between learning declarative and procedural knowledge and the development of a professional identity as a psychotherapist are investigated.

## Methods

Two educational programs, both located at the Department of Psychology, Stockholm university, are evaluated: A postgraduate psychotherapy education program and the psychotherapeutic training taught during the later part of the MSc Psychology education program. Much of the skills formed during the training concerns acquiring a procedural clinical knowledge. At the same time the process of developing a psychotherapeutic identity is very much linked to the capacity to form working alliances with patients, supervisors, and teachers. However, these complex interactive processes have to be studied systematically in order to improve the effectiveness of education programs. The processes of learning procedural knowledge and the communicative aspects of the education are investigated by means of interviews, questionnaires, student written summing-ups after psychotherapies and performance measures. Students, supervisors, teachers, and patients are studied before, during and after the educational programs. Conclusions can be drawn on how to further develop the education for becoming a competent psycho-therapist by comparing the groups at two different levels of education program.

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# Development of an adherence-scale for differentiation between psychodynamic psychotherapy and psychoanalysis

Huber, D., Henrich, G., Gastner, J., & Klug, G. (2012). The Munich Psychotherapy Study: Must all have prizes? In R. Levy, S. Ablon & H. Kächele (Eds.), *Psychodynamic Psychotherapy Research* (pp. 51-69). New York: Humana Press.

## Summary

The aim is to provide an adherence scale of high discriminant ability for differentiation between the psychoanalytic pole and the psychodynamic pole of psychotherapeutic technique. In this study, the psychoanalytic pole is represented by psychoanalytic psychotherapy and the psychodynamic pole by psychodynamic psychotherapy according to the nomenclature of German guidelines for psychotherapy. The assessment of treatment integrity is an essential quality criterion for outcome and process outcome studies. Adherence to a treatment manual in RCTs as well as in effectiveness studies is viewed as a strategy to assure internal, statistical and construct validity. The problem of differentiation between the psychoanalytic pole and the psychodynamic pole follows from the broad overlap between them, both in theoretical conceptualizations and practical implementation. Therefore, the scale development is performed in a bilateral way by integrating both a theoretical and an empirical approach.

The development of the adherence instrument is embedded in a theoretical and empirical framework by applying the literature about psychodynamic versus psychoanalytic techniques and by also applying real-world therapy sessions. Audiotaped psychodynamic and psychoanalytic therapy sessions are sampled from the Munich Psychotherapy Study (MPS; Huber, Henrich, Clarkin, & Klug, 2013; Huber, Zimmermann, Henrich, & Klug, 2012) within which unmanualized treatment conditions (psychodynamic psychotherapy, psychoanalytic psychotherapy, cognitive-behavioral therapy) were compared.

First step was an extensive literature research which provides the ground for item formulation. In total 36 items were formulated reflecting therapist's techniques and attitudes prototypical either for psychodynamic psychotherapy or for psychoanalytic psychotherapy (e.g. "Therapist encourages to free association" or "Therapist intervenes supportive [commending, approving, and advising]"). These items are to be regarded as dimensional in the sense of "rather psychodynamic" or "rather psychoanalytic" and not as categorical.

In a second step a group discussion was performed to discuss the discriminating power of all items. Six experts (three female and three male training analysts) participated in the discussion. Three chairmen focused the discussion to extract those items which presumably present prototypical therapist's technique or attitude of one of the therapeutic approaches and furthermore can discriminate between them reliably. The discussion resulted in 22 items, 11 presented the psychodynamic pole and 11 presented the psychoanalytic pole.

In a third step "expert therapy sessions" were selected. Twelve blinded experts (seven training analysts and five training psychodynamic therapists) after having carefully listened to audiotaped therapy sessions, rated whether it was a psychoanalytic or a psychodynamic session. Sessions were sampled from the middle part of the treatment. We choose two consecutive sessions to enhance assessment of aspects of the treatment process itself. Thus, five middle part sequences of psychodynamic and five psychoanalytic psychotherapy middle part sequences were rated. Each sequence was listened to and assessed by varying pairs of expert raters. Sessions are defined as "expert therapy sessions" if the two raters and the therapy label of the MPS were identical.

The fourth step involves a structured expert rating by applying the 22 items to the “expert therapy sessions”. A further group of about 9-12 experts (psychodynamic therapists and psychoanalysts with 5 years clinical experience at least) will be divided into six varying rater groups (three raters in each group). Ratings are based on three psychodynamic and three psychoanalytic “expert therapy sessions” (middle part sequences). Each expert listened to one or more sequences of “expert therapy sessions” and assessed each item of the therapist’s attitudes and interventions on a 4-point rating scale (0 = “not at all characteristic” to 3 = “extremely characteristic”). The most consensually rated items, both within raters’ groups and within treatment approach, are the most discriminative items and are appropriate for the adherence measure.

## **Evaluation**

To date an empirically robust adherence measure to discriminate between psychodynamic psychotherapy and psychoanalytic psychotherapy is still lacking. The majority of the currently used adherence scales are suitable for discriminating cognitive-behavioral and psychodynamic approaches but fail to provide reliable discrimination between different psychoanalytic approaches. Because of an increasing interest in effectiveness studies of high external validity of unmanualized long-term treatments, the measurement of adherence is of major importance for psychotherapy research of high scientific standard.

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## Change in defense mechanisms and coping over the course of short-term dynamic psychotherapy for adjustment disorder

Drapeau, M., de Roten, Y., Perry, J.C. & Despland, J.-N. (2003): A study of stability and change in defense mechanisms during a brief psychodynamic investigation. *Journal of Nervous and Mental Disease*, 191(8), 496-502.

Perry, J.C. (2001): A pilot study of defenses in psychotherapy of personality disorders entering psychotherapy. *Journal of Nervous and Mental Disease*, 189, 651-660.

Perry, J.C., Beck, S.M., Constantinides, P., & Foley, J.E. (2009): Studying a change in defensive functioning in psychotherapy, using the Defense Mechanism Rating Scales: Four hypotheses, four cases. In R.A. Levy & J.S. Ablon (Eds.), *Handbook of Evidence-based Psychodynamic Psychotherapy* (pp. 121-153). New York: Humana Press.

### Summary

In this study, we explored the role of overall defensive functioning by comparing it on the process level with the neighbouring concept of overall coping functioning. A total of  $N=32$  patients, mainly presenting adjustment disorder, were included in the study. The patients underwent STDP up to 40 sessions; three sessions per psychotherapy were transcribed and analyzed by using two observer rating-scales: Defense Mechanism Rating Scales (Perry, 1990) and Coping Action Patterns (Perry, Drapeau, Dunkley and Blake, 2005). Hierarchical linear modeling was applied to model the change over the course of therapy and relate it to outcome. Results suggest that SDTP has an effect on the target variable of overall defensive functioning, which was absent for overall coping functioning. Links with outcome confirm the importance of the effect.

### Evaluation

The aim of our study was to describe change in defense mechanisms and coping explore links between their evolutions over the course of STDP, on the one hand, and the therapeutic outcome, on the other. Our first hypothesis postulated a greater increase in the target variable of defenses than in coping over the course of STDP. The results were in line with the assumption: Coping remained unchanged, whereas defenses traded up towards more mature functioning (see also Drapeau et al., 2003; Perry, 2001; Perry et al., 2008). Our methodology, being process-oriented, remains anchored in categorical systems operationalizing defenses and coping. Alternative conceptions of adaptational processes are proposed by Sampson and Weiss (1989), where the focus of attention is the individuals increasing capacity to regulate his or her defenses, without them being necessarily more mature, reflects therapeutic change. This is a sample with a fairly low level of symptomatology; in particular, for CAP, more studies are needed to show its relevance on sticker samples (Kramer, Drapeau et al., 2009; Perry et al., 2008).

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## Trauma, dream, and psychic change in psychoanalyses

Fischmann, T.; Russ, M.; Baehr, T.; Stirn, A.; Leuzinger-Bohleber, M. (2012). Changes in dreams of chronic depressed patients: the Frankfurt fMRI/EEG study (FRED). In: Fonagy, P., Kächele, H., Leuzinger-Bohleber, M., & Taylor, D. (Eds.): *The Significance of Dreams: Bridging Clinical and Extraclinical Research in Psychoanalysis* (pp. 157-181). London: Karnac Books.

Fischmann, T., Leuzinger-Bohleber, M., Kächele, H. (2012). Traumforschung in der Psychoanalyse: Klinische Studien, Traumserien, extraklinische Forschung im Labor {Dream research in psychoanalysis: clinical studies, dream series, extra-clinical research}. *Psyche – Zeitschrift für Psychoanalyse*, 66, 833-861.

Fischmann, T., Russ, M., Leuzinger-Bohleber, M. (2013). Trauma, dream, and psychic change in psychoanalyses: a dialogue between psychoanalysis and the neurosciences. In: *frontiers in Human Neuroscience*, Vol 7, Article 877

### Summary

To many psychoanalysts dreams are a central source of knowledge of the unconscious—the specific research object of psychoanalysis. The dialogue with the neurosciences, devoted to the testing of hypotheses on human behavior and neurophysiology with objective methods, has added to psychoanalytic conceptualizations on emotion, memory, sleep and dreams, conflict and trauma. To psychoanalysts as well as neuroscientists, the neurological basis of psychic functioning, particularly concerning trauma, is of special interest. In this article, an attempt is to bridge the gap between psychoanalytic findings and neuroscientific findings on trauma and depression.

We then attempt to merge both approaches in one experimental study devoted to the investigation of the neurophysiological changes (fMRI) associated with psychoanalytic treatment in chronically depressed patients in the so called FRED Study (**F**runkfurt- **f**MRI **E**EG- **S**tudy of **D**epression). We also applied a method to quantify psychoanalysis-induced transformation in the manifest content of dreams developed by Moser and von Zeppelin in Zürich in the 1990 and further developed by our research group in Frankfurt (together with Susanne Doell and others).

In this study focused on some single case studies we used three independent methods. First, dreams reported during the psychoanalysis of chronic depressed analysands were assessed by the treating psychoanalyst. Second, dreams reported in an experimental context in the sleep laboratory of the Sigmund-Freud-Institute were analyzed by an independent evaluator using a standardized method to quantify changes in dream content (Moser method).

Thirdly, we also investigated the analysands by fMRI. The fMRI results regarding changes in brain activation patterns when confronted with conflictladen dream material (dream-words) elucidate the brain areas involved. These preliminary results point to the Precuneus and Left Parietal Lobe when conflict is still acute. The changes found clinically have thus found their neurobiological resonance and validate them furthermore. This is further supported by the finding that the MFC – usually involved when conflictladen information and control of affective signals is being processed – is no longer contrastingly active after one year of treatment.

In combination these results give impressive evidence in a psychoanalytical treatment on an empirical, clinical and neurobiological base.

We also illustrated the differences between the clinical use of dreams as an indicator for changes in the inner (traumatic) object world in psychoanalyses and the systematic, „scientific“ investigation of laboratory dreams by the so-called „Moser-method“ and by showing that these changes are also evident on a neurobiological level. The case report focused on the importance of the psychoanalytic context of dreams, the observation of transference and countertransference reactions, the associations of the patient and the analysand etc. necessary to unravel the unconscious meaning of the dream (Leuzinger-Bohleber, 2012). One great advantage of the psychoanalytical clinical „research“ on dreams continues to be the understanding of the meaning of a dream in cooperation with the dreamer—the patient. His association, and conscious and unconscious reactions to a dream interpretation still are the criteria in order to evaluate the „truth“ of the interpretation (see. e. g. Leuzinger-Bohleber, 1987, 1989, 2008). To make a long story short: the transformation of the unconscious world (like dreams) – and as products of it the maladaptive emotions, cognitions and behaviours („symptoms“) of the patient – still remain the final psychoanalytical criteria for a therapeutic „success“ based on „true insights“ of the patient in his unconscious functioning.

## Evaluation

Ongoing studies at the Sigmund-Freud-Institut, Frankfurt, show promising results combining clinical and experimental dream studies. The careful investigation of dreams in the psychoanalytical situation as well as of dreams reported in the sleep laboratory show parallel findings concerning the transformation of dreams in psychoanalyses. The preliminary results suggest that psychoanalysis-induced transformation can be assessed in an objective way.

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# The Zürich-Ulm Study of dreams: Aggregating single cases (USD)

Leuzinger-Bohleber, M. (1989). Veränderung kognitiver Prozesse in Psychoanalysen. Bd 2: Eine gruppenstatistische Untersuchung (Change of Cognitive Processes in Psychoanalyses. Vol. 2 A Group-statistical Study). Berlin: Springer.

Kächele, H., & Leuzinger-Bohleber, M. (2009). Dream series as process tool. In H. Kächele, J. Schachter & H. Thomä (Eds.), *From Psychoanalytic Narrative to Empirical Single Case Research* (pp. 266-278). New York: Routledge.

## Summary

This study initially 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.

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, 1989). 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.

An extension study was performed on material from one of the patients (Kächele & Leuzinger-Bohleber, 2009). In this study, all dreams were subjected to an analysis of changes in relationship pattern, dream atmosphere and problem solving. There was an impressive change of the dream atmosphere from negative to more positive affects and to more variation in affects 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. The careful investigation of transformations of dreams has also been one major tool for studying changes in psychoanalyses and psychoanalytic longterm therapies in the frame of the LAC depression study (main investigator: M. Leuzinger-Bohleber).

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## Posttraumatic dreams and symbolisation

Varvin, S., Fischmann, T., Jovic, V., Rosenbaum, B., & Hau, S. (2012). Traumatic dreams: symbolization gone astray. In: P. Fonagy, H. Kächele, M. Leuzinger-Bohleber & D. Taylor (Eds.): *The Significance of Dreams. Bridging Clinical and Extraclinical Research in Psychoanalysis* (pp. 182-211). London: Karnac.

Varvin, S., Jovic, V., Fischmann, T., Rosenbaum, B., & Hau, S. (2012) Traumatische Träume: Streben nach Beziehung[Traumatic dreams: quest for relations]. *Psyche – Zeitschrift für Psychoanalyse*, 66, 937-967

Jovic, V., Hau, S., Varvin, S., Fischmann, T., & Rosenbaum, B. (in press). Sleep and dream studies in Serbian victims of torture. In E. Vermetten, T. Neylan, S. R. Pandi-Perumal & M. Kramer (Eds.), *Sleep and Combat-related Post-Traumatic Stress Disorders*. New York: Springer.

### Aim

The study aims to combine the investigation of the content of the dreams, the dream work process and trauma. With a better understanding of the influence of trauma on dream work we hope to further develop psychoanalytic understanding of dreams and the clinical work with dreams.

### Methods

In the frame of a larger study on psychological and physiological parameters of PTSD (financed by the EU during 2005-2008) a group of 25 war veterans with PTSD related to traumatic war experiences during the last Balkan war were investigated in the sleep laboratory. They were selected from the larger group (N=100) as they all reported having repetitive war-related dreams at least twice per week. More than 70 spontaneous dream reports were collected under laboratory conditions. The standardized interviews – performed by psychoanalysts in Belgrade - were tape recorded, transcribed and translated into English. Two research groups, consisting of psychoanalysts from Germany, Norway, Denmark, and Sweden are in the process of investigating the manifest dream narratives with two sophisticated evaluation methods in order to describe symbolizing activity and relational interactions in the dreams. At the same time, psychoanalysts from Belgrade will compare these results with psychological measures such as: clinical symptomatology, personality structure, stressful life events (prior to war and war-related), pre-war adjustment, and cognitive and neuropsychological parameters.

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# Posttraumatic dreams and symbolisation: A follow up study

## Purpose and objective

The study aims to combine the investigation of the content of the dreams, the dream work process and trauma. So far we were able to gather abundance of data (including narratives of dreams) from two groups of subjects, and we were able to provide some evidence that their dreaming process differs in respect to several dimensions (symbolization, affect regulation, attachment to others etc.). With a better understanding of the influence of trauma on dream work we hope to further develop psychoanalytic understanding of dreams and the clinical work with dreams.

In this moment we have an access to the first group of subjects, i.e. individuals who were exposed to severe war-related stressors (torture, imprisonment, severe combat, injury, etc.), and to assess their psychological and physiological state seven or eight years after the initial assessment. In that sense we will be able to have a longitudinal perspective of their psychological status (development of posttraumatic sequela, possible changes in the clinical picture), social variables that could have impact on the outcome of the disorder, and more importantly, we will have a chance to analyze elements of their dream processes (indirectly via dream narratives) and to compare them with the results of analyses almost one decade before. It is reasonable to assume that we will have dispersion of possible outcomes of the posttraumatic processes (from the resolution to the chronic form) and that these differences would be recognizable at the level of dream structures.

This research started as a sub-component of the research project entitled “Psychobiology of PTSD” (PPTSD), that is approved and financed by European Commission (Contract number: FP6-509213) and has been implemented through international cooperation of research centers in Serbia, Croatia, Holland, Italy and England. PPTSD Project’s general objective is to better understand the biological basis of psychophysical profiles of PTSD patients. The study is focused on establishing multiple correlations of different PTSD subtypes with relevant psychological, biochemical, endocrinological, genetic, physiological and anthropometric parameter. Our subjects were 25 men, exposed to various war related stressors (combat, imprisonment, torture), with the current diagnosis of PTSD and with the specific characteristic – frequent nightmares related to war experiences (established criteria was at least two nightmares during the two week period prior to psychological assessment). Objectives of our study were to: 1) perform polysomnographic identification of two parasomnic events - nightmares and night terrors in subjects and to 2) record narratives of dreams during the night and upon awakening, and to record narratives on recurrent war-related dreams that will subsequently be submitted to psychoanalytical analyses.

Second part of the research was entitled „Posttraumatic dreams and symbolisation“ and was supported by the IPA Research Advisory Board. The main purpose of that second part was to investigate referential group of men, who were exposed to war-related stressors but who did not have PTSD at the time of assessment. They were selected to match the experimental group according to age, education and level of exposure to war-related stressors.

With both groups, procedure of collecting the narratives in the morning was similar: in the early morning subject was interviewed by one of two of Serbian colleagues, both psychoanalytic researchers, and interviews were recorded, transcribed, and translated into English. Material has been analyzed by two different methods: Psychoanalytical Enunciation Analysis (PEA) and by a method introduced by Moser & v. Zeppelin. Both methods and their utilization for the analysis of traumatic dream narratives have been presented in conferences and papers published so far.

Currently two research groups are in the process of evaluating the dream reports.

## Methods of analysis.

We used two different methods for qualitative analysis of narratives of dreams that are related to two different theoretical backgrounds and have relatively strict rules for application which limit possible subjective interpretations. Both methods have earlier been applied for analyzing different clinical phenomena (e.g. psychosis, suicide, depression). They proved to be useful for the systematic evaluation of traumatic dreams as well as for evaluating processing of memories and affects with intrusive re-experiencing and reactive avoidance – observable in dream narratives – phenomena that can be understood as the core of the clinical dynamics of the posttraumatic stress disorder.

**„Replica dreams“.** Most of our subjects did report dreams and all those dreams were at some extent related to traumatic (war-related) experiences. This was the case for subjects from the experimental group (individuals with current PTSD at the time of assessment) as well as for the referential group (healthy individuals who were exposed to war-related stressors). But one of important results was that in all narratives (except one, which could be understood as an artifact) traumatic material was transformed by the dream work. This speaks against the view of traumatic dreams as „pure replicas“ of the past presenting un-integrated memories and brings us closer to the understanding of traumatic dreams as complex processes which more or less successfully aim at integrating traumatic experience into the mind's normal communicative and problem-solving way of working.

**Positive and negative outcome.** One of the aims of our research was to explore the differences in the structure of dreaming of two groups (subjects with and without current PTSD). We are in the process of finalizing analysis of all dreams collected during the research. By the April 2013 we will be able to report the summary of main differences and probably will be able to describe main trends, qualitatively and quantitatively. Currently, we were able to demonstrate (19) that the referential group dream specimen is characterized by higher level of symbolic and relational quality than the dream specimen of the experimental group, and that they differ in security regulation, capacity to solve problems, and involvement with others (good feelings, positive relations).

**Affect regulation and involvement with others.** By looking at the dreams of the traumatized subjects in light of the results of the Moser method, disturbances of affect-regulation become apparent. Those disturbances reflect the dreamer's inability to get involved with others in the dream scenario because of anxieties, especially annihilation anxiety, evoked by such involvement. The Moser dream coding method reveals that, the security principle overrules the involvement principle in these dreams. This finding could be further elaborated to help us understand one of the basic features of PTSD – detachment from others, as a defensive strategy to avoid overwhelming affects.

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## Assessment methods for psychoanalytic observation

Löffler-Stastka, H., Stigler, K., (2011). Der Affektwahrnehmung und Affektregulation Q-sort-Test (AREQ): Validierung und Kurzform. [The Affect Experience and Affect Regulation Q-Sort Test (AREQ): validation and short version] *PPmP - Psychotherapie · Psychosomatik · Medizinische Psychologie*, 61, 225-232. DOI: 10.1055/s-0030-1263146

Löffler-Stastka, H. & Blüml, V. (2010). Assessment tools for affect regulation and quality of object relations in personality disorders: The predictive impact on initial treatment engagement. *Bulletin of the Menninger Clinic*, 74(1), 29-44. DOI: 10.1521/bumc.2010.74.1.29

Löffler-Stastka, H., Blüml, V. & Jandl-Jager, E. (2009). Voraussagekraft für die Therapie-Inanspruchnahme bei Persönlichkeitsstörungen: SWAP-200 und SKID-II im Vergleich [Predictive Power on therapy engagement in personality disorders: SWAP – 200 versus SCID-II]. *PPmP - Psychotherapie · Psychosomatik · Medizinische Psychologie*, 60, 342-349. DOI: 10.1055/s-0029-1238299

### Brief Summary

Use of Q-sort assessment methods for diagnostic purposes and in treatment evaluation Objectives: Does quantifying psychotherapy research do justice to its subject matter? Methods: Q-sort techniques are presented for the assessment of personality pathology, mental and interpersonal problems, as well as for quantifying the psychotherapeutic process.

### Results:

In studies on psychotherapy planning we identified mechanisms characteristic of nonresponders which could be efficiently captured with q-sort methods. From these clinically relevant intervention techniques can be derived. In psychoanalytic process research we operationalized relevant microelements in the patient-therapist interaction. Conclusions: Q-sort methods are efficient and helpful for studying research questions that are clinically relevant but often difficult to grasp as well as for dismantling studies. First, we investigated the validity of the prototype-matching, empirically based 200-item Shedler-Westen Assessment Procedure (SWAP-200) and its clinical utility for describing underlying dimensions of psychostructural organization and functioning. Patients (n = 306) from two psychoanalytic out-patient departments were included. Replicatory and exploratory factor analysis, correlation and discriminant validity statistics, and canonical correlation analysis were performed. Standard factor analysis revealed an eight-factor solution displaying a dimensional description of psychostructural personality organization (high functioning - neurotic/inhibited - borderline/emotionally dysregulated - psychotic/dissocial). Discriminant validity exists across the sample owing to high/poor psychological functioning. Canonical correlation analysis does not support the replacement of the Structured Clinical Interview for DSM-IV, but provides relevant implications for refining DSM-IV axis II. Support is given for the SWAP instrument in describing dimensional higher-order personality organization and psychostructural functioning. On the road to DSM-V, instruments are demanded that provide clinically meaningful information, for example, predictions about psychotherapy utilization. Comparison of five different instruments in a sample of 297 patients with personality disorders showed that the Structured Clinical Interviews for DSM-IV (SCID), SWAP-200, and the Inventory of Interpersonal Problems (IIP) lead to predictive models concerning initial therapy engagement. The Affect Experience and Affect Regulation Q-sort (AREQ) provided information concerning therapy rejection. The findings point to the importance of interpersonal, affective, and psycho-structural functioning in the diagnostic procedure of personality disorders. Concerning affect regulation, the empirically defined factors used in the Austrian sample of our study

showed correspondences and an overlap with the factors derived from the psychoanalytic theory and the original factors of Westen and colleagues. This study confirms the importance of investigating the applicability of psychometric instruments in various clinical samples. The AREQ test can be used in the diagnostics and during the assessment of treatment. Special features of the sample (diagnostic interviews and therapy process data) as well as the raters' theoretical background are probably able to influence the resulting factor structure. The outcome of this study might be helpful for building up core concepts for the construction of new instruments.

Currently, the conceptualization and treatment of personality pathologies are mainly theory driven. The resulting categorical classification of personality disorders leads to inaccurate diagnoses and is therefore being criticized by many researchers and clinicians. A consensus exists that in the upcoming edition of the DSM (DSM 5), the classification of personality disorders should rather adopt a dimensional approach, where patients are assessed depending on their character traits, inner-defense mechanisms, and interpersonal functioning. However, the basis (theoretical or empirical) of this classification-system is still a topic of dispute. This study presents assessment methods based on both theoretical and empirical assumptions.

### **Objective:**

To determine whether psychodynamic instruments employed in psychoanalytic settings are also useful for measuring changes in personality pathology in psychiatric inpatient settings. Matched pairs between two groups of patients, one receiving outpatient psychoanalytic care, the other inpatient social-psychiatric treatment, were created and subsequently analyzed (mean observation period  $20 \pm 11$  days). Patients were assessed using psychodynamic instruments measuring changes in quality of object relations (QORS) and affect regulation and experience (AREQ). To allow conclusions concerning the respective mechanisms of change, the influence of the therapeutic relationship, measured by using instruments evaluating transference (PRQ) and countertransference (CTQ) patterns, was also assessed. The instruments aforementioned were shown to be suited for both psychoanalytic and psychiatric patients. Typical short-term developments of the distinctive therapeutic procedures were evident; however, in both settings a positive working alliance was shown to be crucial for therapeutic progress. The psychodynamic instruments introduced in this study proved to be effective in measuring personality pathology in psychiatric inpatients and in helping clinicians throughout the indication and recommendation process during transition from inpatient to outpatient treatment. Since components of such assessment methods are being considered for DSM 5, their practical utility is shown in this study.

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# The mechanisms of change in the treatment of borderline personality disorder with Transference Focused Psychotherapy

Levy, K.N., Clarkin, J.F., Yeomans, F.E., Scott, L.N., Wasserman, R.H., Kernberg, O.F. (2006). The mechanisms of change in the treatment of borderline personality disorder with Transference Focused Psychotherapy. *Journal of Clinical Psychology*, 62(4), 481-501.

## Summary

The authors address how Transference Focused Psychotherapy (TFP) conceptualizes mechanisms in the cause and maintenance of borderline personality disorder (BPD) as well as change mechanisms both within the patient and in terms of specific therapists' interventions that engender patient change.

Mechanisms of change at the level of the patient involve the integration of polarized representations of self and others; mechanisms of change at the level of the therapist's interventions include the structured treatment approach and the use of clarification, confrontation, and "transference" interpretations in the here and now of the therapeutic relationship. In addition, the authors briefly review evidence from their group regarding the following hypothesized mechanisms of change: contract setting, integration of representations, and changes in reflective functioning (RF) and affect regulation.

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# Relatedness and differentiation in the therapeutic dyad – an empirical investigation of psychoanalytic and psychotherapeutic change processes

Erhardt, I. (2014). *Bezogenheit und Differenzierung in der therapeutischen Dyade. Eine empirische Untersuchung von psychoanalytischen und psychotherapeutischen Veränderungsprozessen* {Relatedness and Differentiation in the Therapeutic Dyad. An Empirical Study of Psychoanalytic and Psychotherapeutic Change Processes}. Gießen: Psychosozial-Verlag.

## Summary:

Process-outcome research investigates not only treatment effectiveness; rather, what is really happening in the sessions and to which extent the captured patient-therapist interactions impact outcome. Therapeutic alliance was found to demonstrate the strongest association between process and outcome (Orlinsky et al. 1994; Norcross & Wampold 2011). The relevance on pre-treatment patient variables were emphasized in order to investigate differential treatment response (Blatt & Felsen 1993; Blatt & Shahar 2004; Clarkin & Levy 2004) and the importance of therapist variables for treatment outcome was demonstrated empirically (Luborsky et al. 1997; Wampold, 2001; Beutler et al. 2004).

The present study is a process-outcome study on psychodynamic and psychoanalytic long-term psychotherapy in which 29 audio-taped treatment processes from three psychotherapy archives were investigated. Empirical rater-based research instruments were applied at four measure points (four sessions) in each treatment. The *Psychotherapy Process Q-Set* (PQS; Jones 2000; Ablon et al. 2012) was used to capture therapeutic process and treatment adherence, therapeutic alliance was measured with the *California Psychotherapy Alliance Scales* (CALPAS; Gaston & Marmar 1993), and psychic structure was assessed with the *Differentiation-Relatedness-Scales* (DR-S; Diamond et al. 2012). The latter was also used to capture therapeutic change in terms of level of self- and object-representations with repeated measurements. Pre-treatment patient variables were identified based on Blatt's personality theory of psychological dimensions "relatedness" and "self-definition" which defines the distinction between anaclitic (dependent) and introjective (self-critical) personality configurations (Blatt & Ford 1994). A therapist variable was introduced in order to assess therapeutic style through differentiating between a „relational-oriented“ and a „differentiation-oriented“ style according to the same dimensions. Through matching patient and therapist variables, different dyads of "therapeutic match" were captured.

The main research questions were, whether there are differences in therapeutic process, alliance and outcome between treatments of anaclitic and introjective patients. In addition, hypotheses assume that alliance quality is associated with and predicts therapeutic change. Hypotheses suggest that there are process variables which distinguish between treatments with and those without clinical significant change overall patients and that specific therapeutic techniques are related to positive outcome. We assumed that a more complementary therapeutic match in terms of therapeutic stance and patient personality facilitate therapeutic change better than those which demonstrate more similarity.

## Evaluation:

Although, there is a small sample size, the findings are consistent with Blatt's theory (Blatt 2008). Results suggest e.g. that anaclitic patients feel more comfortable in relying upon therapists than introjective patients and that dealing with their self-image is very characteristic for introjective and not for anaclitic patients. No differences were found in terms of outcome between patient groups and between treatment groups. An association between therapeutic alliance and therapeutic change was

found as well as a moderating effect of alliance. It seems that a better quality of therapeutic alliance leads to better patient working capacity and which is also associated with positive therapeutic change. More than a dozen process variables were identified which distinguish between treatments with and those without positive outcome overall patients, such as the degree of therapist's empathy and patient's compliance. Furthermore, only two therapeutic techniques were identified which are associated with therapeutic change. Therapeutic match seems to impact therapeutic outcome if there is a complementary match (e.g. anaclitic patients with differentiation-oriented therapists as well as introjective patients with relatedness-oriented therapists) than concordant matches (patient and therapist variables which are related to the same psychological dimension within each dyad). Clinical implications are discussed in terms of interaction between patient personality and therapist variable and therapeutic alliance. Limitations of the study amongst others are the small sample size and diagnostic heterogeneity of the patients. Further studies should replicate the objectives with bigger samples and include not only rater-based perspective but also other outcome measures.

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# Moderators of change in psychoanalytic, psychodynamic, and cognitive-behavioral therapy

Huber, D., Henrich, G. & Klug, G. (2013). Moderators of change in psychoanalytic, psychodynamic, and cognitive-behavioral therapy. *Journal of the American Psychoanalytic Association*, 61, 585-589.

## Summary

The present study focuses on the examination of moderators of change during psychotherapy. Outcome research in psychotherapy has proceeded remarkably, and that the effects of psychotherapy are statistically and clinically significant is empirically well founded. But “much more research needs to be conducted before the exact relationship between the process of the therapy and its outcome will be known” (Lambert and Ogles 2004). For that reason, the focus of psychotherapy research has shifted from investigating outcome to a process-outcome approach. A moderator is “a characteristic that influences the direction or magnitude of the relationship between an independent and a dependent variable” (Kazdin 2007). Moderators precede treatment and are not correlated with it. Identifying them helps in the prognosis of a course of therapy and in matching different patients to treatments.

The empirical basis of the process-outcome study is the Munich Psychotherapy Study (MPS), a prospective, comparative process-outcome study that evaluates the effectiveness and course of three different long-term psychotherapies: psychoanalytic (PA), psychodynamic (PD), and cognitive-behavioral (CBT) for a diagnostically homogenous sample of depressed patients. Patients seeking treatment for unipolar depression, single-episode or recurrent, and meeting the inclusion criterion were asked to participate in the study. The inclusion criterion was a primary diagnosis of a moderate or severe episode of major depressive disorder (ICD-10 F 32.1/2 or DSM-IV 296.22/23); a recurrent depressive disorder, current episode moderate or severe, without psychotic symptoms (ICD-10 F 33.1/2 or DSM-IV 296.32/33); or a double depression. Thirty-five patients were assigned to PA, 31 to PD, and 34 to CBT. Psychoanalytic therapy (PA) was operationalized as a therapy with a session frequency of three times a week, with the patient lying on the couch. Psychodynamic therapy (PD) was operationalized as a therapy with one session a week, in a face-to-face setting. Cognitive-behavioral therapy (CBT) was operationalized as a therapy with one session a week.

For this study, the outcome measure battery included the Beck Depression Inventory (BDI) on a symptomatic level, the Inventory of Interpersonal Problems (IIP) on an interpersonal level, and the Scales of Psychological Capacities (SPC) on an intrapsychic level. Outcome measurement points were pre-treatment and post-treatment. The following independent variables considered as putative moderators were assessed at pre-treatment: age, sex, partnership status, duration of depressive disorder since onset, and prior therapies, as well as observer-rated motivation for therapy and diagnosis of personality disorder during a clinical intake interview. Also included were the patient-rated Emotional Lability and Extroversion scale of the Freiburg Personality Inventory (FPI) and the therapist-rated subscale HAQ2: satisfaction with therapeutic relationship of the Helping Alliance Questionnaire (HAQ).

To show that the independent variables listed above are moderators of treatment effects, they were entered into a stepwise logistic regression analysis. Treatment modality (PA, PD, CBT) was included as the first step. The analysis was repeated with the dependent variables BDI, IIP, and SPC. The treatment effect was assessed as “clinical significance”.

The results are presented as odds ratios (ORs). Stepwise logistic regression analysis yielded that the Emotional Lability scale of the FPI (OR = 1.47) and diagnosis of a personality disorder (OR = 3.82) both negatively predicted outcome in the BDI. Partnership status (OR = 3.52), therapy dose (OR = 1.02) and satisfaction with therapeutic relationship (OR = 3.84) predicted positive outcome when

assessed with the IIP. Only PA positively predicted outcome (OR = 4.1) when structural change (SPC) was the target variable.

## **Evaluation**

Symptom improvement was negatively predicted by both self- and observer-rated personality impairment. Treatment parameters were the predominant predictors of positive outcome beyond symptoms. When structural change was the target variable, only PA predicted positive outcome. These findings lend support to the hypothesis that more intense and time-consuming therapies are needed to accomplish benefits on the interpersonal and intrapsychic level.

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# Interactive regulation processes and their relationship with psychotherapeutic changes - Chilean Millennium Nucleus: “Psychological intervention and change in depression” Process Study 1.

Tomicic, A., Martínez, C., & Krause, M. (2015). The sound of change: A study of the psychotherapeutic process embodied in vocal expression. *Laura Rice ideas revisited. Psychotherapy Research, 25* (2), 263-267.

Martínez, C., Tomicic, A., Medina, L., & Krause, M. (2015). A microanalytical look at mutual regulation in psychotherapeutic dialogue: Dialogic Discourse Analysis (DDA) in episodes of rupture of the alliance. *Journal Research in Psychotherapy: Psychopathology, Process and Outcome (RIPPPPO)*, in press.

Martínez, C., Tomicic, T., Salas, C., Rivera, M. J., & de la Cerda, C. (2015). Función Reflexiva en Primeras Entrevistas de Psicoterapia: Un Estudio Exploratorio. *Revista Argentina de Clínica Psicológica*, in press.

Martínez C., Tomicic, A., & Medina, L. (2014) Psychotherapy like discursive genre: A dialogic outlook to a time-limited psychotherapy. *Culture & Psychology, 20* (4),501-524.

## Background

This research line is based on the evidence from infant development psychodynamic research, relational neuroscience and attachment theory.

We have assumed “Regulation” as a core concept because the regulatory processes are involved in all types of interactions, but within significant relationships, like psychotherapy, these are reshaped changing the problematic ways we used to relate with the others and ourselves.

We consider the regulatory process (a) as a permanent phenomenon, (b) that occurs with different degrees of consciousness, (c) that involves different psychological abilities (vg. mentalizing), and (d) which is related with phenomena like coordination, synchrony, attunement and fit. This research line is interested in comprehending mutual regulatory processes involved in the construction, development and maintenance of the psychotherapeutic relationship.

## Research questions

How is related the mutual regulation between the participants and the psychotherapeutic change?  
What kind of changes occurs and in which dimensions during the psychotherapeutic process?

How “the change” develops within the patient-therapist interaction and through the psychotherapeutic process? Which are the temporal dynamics of each kind of change?

What kind of problems and/or negotiations occurs between therapist and patient? How do patient and therapist balance their own needs with those of the therapeutic relationship?

of its performative dimension in the interaction: A study with borderline personality disorder.

## Design and method

The different studies of this research line have in common the use of mixed designs that combined qualitative techniques and quantitative analysis. Additionally, all the studies are of longitudinal nature since we adhere to the Dynamic Systems Theory (DST), in which the regulatory processes are conceived as complex and temporally determined phenomena.

## **Sample**

In all the studies the sample structure is like a Russian nesting doll where we analyze relevant episodes taken from therapeutic sessions belonging to complete individual psychotherapies that have been audio and video recorded all the times.

## **Treatment**

Psychotherapies with psychodynamic and cognitive focus in a context of outpatient treatment. The therapists males and females with more than five years of practical professional experience.

## **Results**

-Verbal dimension of regulation: We have identified three discursive positions applicable to patients and two discursive positions for therapists. The triadic model in patients includes a meta-position role that could keep the alliance and therapeutic work.

-Non verbal dimension of regulation: We have established differences in the type of vocal qualities and facial gestures that patients and therapists use in their interactions, as well as, the associations of these differences with the interactional scenario within which they occur (change and rupture episodes).

-Characterization of the brain activity of patient and therapist: We have advanced in the development of an observation device and analytic method of the neurodynamic of the psychotherapeutic interaction.

## **Evaluation**

This is an ongoing research line in a developing stage. Thus its limitations have to do with the different levels of advance of each subproject. In a whole its different studies are contributing to develop an emergent and multidimensional theory of the regulatory processes in the psychotherapeutic interaction.

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# Analysis of depressive patients' verbal expressions throughout the psychotherapeutic process - Chilean Millennium Nucleus: "Psychological intervention and change in depression". Process research 2:

Valdés, N. (2012). Analysis of verbal emotional expression in change episodes and throughout the psychotherapeutic process: Main communicative patterns used to work on emotional contents. *Clínica y Salud, 23*, 153-179.

Valdés, N., Krause, M., Tomicic, A., & Espinosa, D. (2012). Expresión emocional verbal durante episodios de cambio: análisis de los patrones comunicacionales utilizados por pacientes y terapeutas para trabajar contenidos emocionales [Verbal emotional expressions during Change Episodes: analysis of the communicative patterns used by both patients and therapists for working emotional contents]. *Revista Argentina de Clínica Psicológica, 21*, 217-246.

## Background

A person's speech makes it possible to identify significant indicators which reflect certain characteristics of his/her personality organization, but also can vary depending on the relevance of specific moments of the session and the symptoms type. The work of contents associated with the patient's emotional experience during the conversation involves 3 communicative patterns (CPs) used to work on emotional content during change episodes: *affective exploration*, *attunement*, and *resignification*. Simultaneously, underlying cognitive processes during the therapy show a specific effect in breaking the link between affect and cognition in depressed patients, so that negative mood induction is less likely to reactivate negative beliefs and assumptions

## Methods/Design

Therapeutic outcome was estimated using the Outcome Questionnaire (OQ-45.2). Both patients displayed a significant degree of change during the therapy, even though Patient A started below the cut-off score and Patient B above it. But also, both therapies displayed a positive evolution from the point of view of Generic Change Indicators (GCI), considering the number of change moments during the session (A=14, B=24), but especially due to their level in the hierarchy of indicators. The Therapeutic Activity Coding System (TACS-1.0) was used for manually coding patients' and therapists' verbalizations in each speaking turn segment during Change and Stuck Episodes. The words uttered by patients and therapists during their speaking turns in CEs and SEs were analyzed using the Spanish version of the Linguistic Inquiry and Word Count (LIWC). Each speech segment text was analyzed to identify words referencing three cognitive mechanisms: (a) *cause*: words reflecting the presence of a basic cognitive skill involving the speaker's attempts to explain something through an underlying logical pattern to connect the reasons behind certain phenomena or processes and their effects; (b) *insight*: words revealing the speaker's increased awareness or deeper understanding of the central aspects of the meaning ascribed to a certain content previously inaccessible but now experienced as novel; (c) *tentativeness*: words showing the speaker's consideration of different alternative meanings for certain contents; and (d) *certainty*: words revealing the speaker's increased assurance about something that he/she regards as true and which he/she does not doubt.

## Treatment

Two short weekly individual psychodynamic therapies conducted by male psychoanalysts with a vast clinical experience, were analyzed. Both patients were female and had a similar reason for seeking help, and gave their informed consent to participate in the present study. All sessions in both therapies were included (N=39), during which 38 change episodes were identified, delimited, transcribed, and analyzed (A=14, B=24).

## First Results

The analysis of the behavior of Communicative Patterns (CPs) throughout the therapeutic process, regardless of the participant's role, revealed an association between the Communicative Patterns (CPs) used to work on emotional contents during Change Episodes and the therapeutic phase, which means that there was a larger proportion of *Affective Explorations* during the initial phase of the therapeutic process and a larger proportion of *Affective Resignifications* during its final phase. No associations were observed between the *Affective Attunement* displayed and the phase of the therapy. The patients' *Affective Explorations* during the initial phase displayed more words reflecting both *cause* and *tentative* than in the middle phase, while patients performed a larger proportion of *Affective Resignifications* during the final phase, in comparison with the initial phase. No differences were observed between the initial and the middle phases, as well as between the middle and the final phases in terms of *Affective Resignifications* with words revealing *insight*. However, in comparison with the initial phase, the following was observed: (a) words reflecting *cause* were more frequent during the middle phase; (b) words reflecting *tentative* were more frequent during the middle phase; and (c) words reflecting *certainty* were more frequent during the middle phase.

## Discussion

Therefore, CPs are a relevant element in the psychotherapeutic process, because they make it possible to characterize the verbalizations of patients and therapists during therapeutic dialog. The study confirmed the notion that meaning is not something static contained in the words that a person uses, but a product of the way in which words are employed to regulate communication. This is why patients' and therapists' verbalizations were analyzed in terms of the semantic contents present during their use of Communicative Patterns, that is, considering the context in which such verbalizations were performed.

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# Patients' perception about termination in psychoanalytic treatments: A qualitative research study

Olivera, J., Braun, M., Gómez Penedo, J. M., & Roussos, A. (2013). A qualitative investigation of former clients' perception of change, reasons for consultation, therapeutic relationship, and termination. *Psychotherapy, 50*(4), 505–516.

## Abstract

From a sample of 50 former psychotherapy patients from Buenos Aires, Argentina; 16 participants identified the psychotherapy process as psychoanalysis. Those 16 cases have been analyzed, in terms of how they experienced the termination process using a grounded theory approach. Results show that most therapies came to an end when the patient's decided it, and half of the participants reported that their therapist didn't agree with termination. Those patients whose termination has been agreed referred more satisfaction with the therapeutic process than those who didn't. (lo taché porque aparentemente no se requiere abstract)

## Aims and rationale of the study

The aim of this study is to describe how private-practice patients in Buenos Aires, Argentina, have experienced the termination of psychoanalytic psychotherapy. Psychoanalytic authors agree that termination is a critical phase of treatment (Shane, 2009; Zilberstein, 2008). Premature termination is one of the most salient problems psychotherapy portrays (Nuetzel & Larsen, 2012; Swift & Callahan, 2011) and patient-initiated premature termination poses many problems both for patients and therapists (Ogrodniczuk, Joyce, & Piper, 2005). It is necessary to continue analyzing how termination takes place in real psychoanalytic treatments and how psychoanalysts may facilitate the positive resolution of therapy.

Although there are studies about patient's perspective of termination in other countries (eg: Hyman, 1990; Knox et al., 2011; Roe, Dekel, Harel, Fennig, & Fennig, 2006), the experience of therapy in different cultures may vary. In a cross-cultural study Jock et al. (2013) found "great many and noteworthy" differences between former patients experience of therapy in Argentina and the United States (Jock et al., 2013).

## Methods

Subjects were 16 former psychoanalytic psychotherapy private practice patients. Semistructured qualitative face-to-face interviews were conducted. A first open ended question: "Tell me about your therapeutic experience" allowed participants to talk freely, afterwards specific questions about termination and other significant psychotherapeutic variables were asked in order to assess the most relevant aspects of the study. Also, patients were asked to rate their therapeutic process (in a scale from 1 to 10, ten being totally satisfied). To analyze the interviews, researchers conducted a qualitative approach, based on CQR (Hill et al., 2005) and described in a former article (Olivera, Braun, Gómez Penedo, & Roussos, 2013).

## Results

The majority of terminations were proposed by patients (14; 87.5%); while only two therapists initiated the termination process. Only three patients (18.75%) reported having set goals with their

therapist at the beginning of therapy and, likewise, three patients (18.75%) reported having discussed therapy length with the therapist. Half of the sample (eight patients; 50.0%) indicated having agreed on termination with their therapist (agreement group). Agreement on termination included the two cases in which therapists proposed termination and six cases where patients brought the issue to therapy and their therapist agreed on termination. The other half of the sample, reported either to have dropped out or to have met with opposition from their therapist when proposing termination (disagreement group). These two halves will be referred to as “agreement/disagreement” groups. Reasons for termination were varied and included both positive reasons, such as goal accomplishment; and negative reasons: lack of new topics; difficulties in the therapeutic relationship; and not perceiving new changes, among others. All participants gave more than one reason for termination; typically the agreement group reported more positive reasons, while the disagreement patients reported more negative reasons for termination.

Although all patients expressed having changed due to therapy, patients with agreement on termination gave better scores of satisfaction ( $M=8.25$ ;  $SD=.46$ ) than the disagreement group ( $M=6.65$ ;  $SD=1.6$ ). Also, patients valued those therapists that proposed termination and/or referred that they would have liked their therapist to be more active by proposing termination.

## Discussion

Most of our findings go in line with prior research in the area given that termination is more often proposed by patients than therapists (Olivera et al., 2013); positive terminations are related to good outcome and satisfaction with the therapy (Knox et al., 2011; Roe, Dekel, Harel, & Fennig, 2006) and motives for termination can be grouped in “positive” and “negative or conflictive” (Renk & Dinger, 2002). The unique value of this study is that it identifies a trend in psychoanalytic treatments in Buenos Aires in which most therapists do not talk about goals, length or termination of the therapeutic process and wait for the patients to address the issue. Whether they can agree with their patient about termination or not, will have an impact on the patient’s satisfaction with therapy and how the whole process will be remembered.

## Limitations

The most salient limits of this study are that it has a small and nonrepresentative sample; it is based on retrospective recall; and there is no information about the therapists’ aside from what patients said. Nevertheless, this kind of research opens the window to how patients experience their termination and what they value most from the psychoanalytic therapy. It is of major importance to continue in this line of work in order to improve the psychoanalytic practice.

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# Changes in object relations following intensive psychoanalytically oriented inpatient treatment

Porcerelli, J.H., Shahar, G., Blatt, S.J., Ford, R.Q., Mezza, J.A., Greenlee, L.M. (2005). Changes in object relations following intensive psychoanalytically oriented inpatient treatment. *Abstracts of the 2005 Poster Session of the American Psychoanalytic Association Winter Meeting: Journal of the American Psychoanalytic Association*, 53,1323-1325.

Considerable advances have been made in recent years in the assessment of mental representations. One of the most reliable and valid measures of mental representations is the Social Cognition and Object Relations Scale (Westen et al. 1990). The present study used data from the Riggs-Yale Project (Blatt and Ford 1994) to assess changes in mental representations following intensive inpatient psychoanalytically oriented treatment of severely disturbed, treatment-resistant patients.

## Participants and Procedures

The study included 84 patients (mean age = 21). Patients received, on average, 1.5 years of psychoanalytically oriented treatment and had undergone psychological testing at admission and at the end of the study period. Most patients were at least middle-class, with at least average IQs. Approximately 30% were diagnosed with a DSM-III psychotic condition. Object relations were coded from six TAT cards (1, 5, 12 M, 13 MF, 14, 15).

The Social Cognition and Object Relations Scale (SCORS) includes four dimensions of object relations, each scored on a 5-point scale with scores of 5 being healthy. Complexity of Representations (CR) assesses degree of differentiation, integration and complexity. Affect-tone of Relationships (AT) assesses malevolence (vs. benevolence) of relationships. Capacity for Emotional Investment (EI) assesses the degree of need-gratifying vs. mutual relatedness. Understanding Social Causality (SC) assesses the degree to which social attributions are logical, accurate, and psychologically minded.

## Discussion

Significant changes in object relations were demonstrated following psychoanalytically oriented inpatient treatment. Following treatment, descriptions of relationships were less malevolent, idiosyncratic, and illogical and showed more mutuality, complexity, and psychological mindedness. Overall, these results suggest structural changes could occur in a population of severely disturbed, treatment-resistant patients following intensive psychoanalytically oriented inpatient treatment.

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# Dyadic affective interactive patterns in the intake interview as a predictor of outcome

Rasting, M., Brosig, B., Beutel, M.E., (2005) Alexithymic characteristics and patient-therapist-interaction: a video-analysis of facial affect display. *Psychopathology*, 38, 105-111.

Rasting, M. & Beutel, M. E. (2005). Dyadic affective interactive patterns in the intake interview as a predictor of outcome. *Psychotherapy Research*, 15, 188-198.

## Summary

The study aimed at testing predictions regarding the relationship between affective display and feeling states and between affective interaction patterns and clinical outcomes. The issues of this study were: (1) How do affect displays of patients and therapists differ in the intake interview? (2) How are affect displays of patients and therapists related to each other's affect displays and respective feeling states? (3) Are specific dyadic interaction patterns predictive for the outcome of inpatient psychotherapy? (4) Are there indicators of higher affective involvement of the therapist in the unsuccessful dyads?

We assumed that facial affect displays could serve as indicators of patients' neurotic relationship offers and therapists' affective involvement in these interactive patterns in a clinical situation. Facial affect display would be primarily used in its symbolic and relationship regulating function. Therefore, we did not expect a close overall correspondence between feeling states and facial affective display. However, we assumed that hedonic facial affective display might have a regulating effect on the feeling state of the interaction partner. With respect to therapeutic outcome, we hypothesized that unsuccessful dyads were characterized by high involvement of the therapist in reference to reported feeling states and facial affective display. In these dyads, we expected a reciprocal facial lead affect.

For the purpose of the study, we recruited ten "successful" and ten "unsuccessful" patients from an inpatient psychotherapy ward. Over a period of 12 months, each patient's intake and discharge interviews with the two therapists participating in the study were videotaped. According to our hypothesis, we found a strong relationship between dyadic facial affective patterns and outcome of psychotherapy. Reciprocal dyadic lead affect was related to a less favorable outcome. On the basis of the dyadic lead affect (reciprocal or nonreciprocal), 75% of the patients could be classified correctly as being part of the successful or the unsuccessful group. These findings also support the more general hypothesis that relationship patterns between patients and therapists emerge in a very early phase of treatment and have a critical impact on the course and outcome of treatment. Consensual communication, as indicated by reciprocal lead affect, may restrict the potentialities of working through neurotic conflicts in the psychotherapeutic relationship and limit corrective emotional experiences. Especially hedonic facial affects have a high probability of being reciprocated because almost 50% of the dyads with reciprocal lead affect showed a hedonic dyadic lead affect (happiness, social smile).

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# Patient and therapist perspective on therapeutic action in psychoanalysis and psychoanalytic psychotherapy: Helpful and hindering factors

Lilliengren, P., & Werbart, A. (2010). Therapists' view of therapeutic action in psychoanalytic psychotherapy with young adults. *Psychotherapy: Theory, Research, Practice, Training*, 47, 570–585.

Palmstierna, V., & Werbart, A. (2013). Successful psychotherapies with young adults: An explorative study of the participants' views. *Psychoanalytic Psychotherapy*, 27, 21–40.

Werbart, A., & Levander, S. (2006). Two sets of private theories in analysands and their analysts: Utopian versus attainable cures. *Psychoanalytic Psychology*, 23, 108–127.

Werbart, A., & Levander, S. (2011). Vicissitudes of ideas of cure in analysands and their analysts: A longitudinal interview study. *International Journal of Psychoanalysis*, 92, 1455–1481.

## Summary

This research program aims to explore patient and therapist views of helpful and hindering factors in psychoanalysis and psychoanalytic psychotherapy, applying rigorous qualitative methods. A series of studies was based on periodical interviews with seven analysands and their analysts (Werbart & Levander, 2006, 2011). Double sets of private theories of cure were found among analysands and their analysts. Ideas of utopian cure involved a profound transformation of the personality by way of deep regression. Ideas of an attainable and more limited cure included new ways of managing old problems and new ways of thinking and reflecting. The ongoing treatment was then seen as the 'next-best solution'. Both parties' mourning of the preferred but abandoned utopian theories of cure seems to be an important ingredient in the psychoanalytic process. Furthermore, the utopian fantasy of creating 'the new person' by means of 'proper' psychoanalysis or analytic training has far-reaching consequences for psychoanalytic education and supervision.

Further studies focused on young adults in psychoanalytic psychotherapy. Patients experienced as curative talking openly in the context of a safe relationship, which led to new relational experiences and expanding self-awareness. Hindering factors included difficulties "opening up," experiencing the therapist as too passive and that something was missing in therapy. According to the therapists, the core curative factor was the development of a close, safe and trusting therapeutic relationship, while patients' fear about close relationships emerged as the sole hindering factor from the therapists' perspective (Lilliengren & Werbart, 2010). In a study of overcoming depression, positive changes experienced by young adult psychotherapy patients extended beyond symptom relief and included finding out how they wanted to live and forming their lives in that direction. Dissatisfied psychotherapy patients described abandonment by a therapist felt to be insufficiently flexible, a therapy lacking intensity, and links missing between therapy and everyday life. They lacked confidence in their relationship with the therapist, wanted more response from the therapist, and concluded that their therapies lacked direction. Conversely, the most successful cases described a secure therapeutic relationship where growth could take place. The patients and their therapists experienced the therapeutic work in a strikingly similar way, worked actively towards joint goals, overcame obstacles to their collaboration, explored what was painful and actively promoted the use of new skills after termination (Palmstierna & Werbart, 2013).

In a two-stage mixed-method study of clinically nonimproved patients, "Spinning One's Wheels" emerged as a core category. The patients described the therapeutic relationship as distanced and

artificial. While they saw active components in therapy and their own activities in life as beneficial, therapy itself was experienced as overly focused on problem insight and past history. The phenomenon of ongoing therapy without symptom reduction was interpreted as a product of imbalance between the three components of therapeutic alliance, with a good-enough emotional bond, but no shared understanding of goals and tasks in therapy. A number of current studies further examine patients' view of the therapeutic relationship three years post termination, as well as the therapists' view of psychotherapy processes in longitudinally clinically significant improved cases, and in cases of non-improvement in psychoanalytic psychotherapy.

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# Changes in mental representations and personality configurations after psychoanalysis and psychoanalytic psychotherapy

Arvidsson, D., Sikström, S., & Werbart, A. (2011). Changes in self- and object representations following psychotherapy measured by a theory-free, computational, semantic space method. *Psychotherapy Research, 21*, 430–446.

Levander, S., & Werbart, A. (2012). Personality related responses to the psychoanalytic process: A systematic multicase study. *Psychoanalytic Psychology, 29*, 1–16.

Werbart, A., in collaboration with Grünbaum, C., Jonasson, B., Kempe, H., Kusz, M., Linde, S., Lundén O’Nils, K., Sjövall, P., Svenson, M., Theve, C., Ulin, L., & Öhlin, A. (2011). Changes in the representations of mother and father among young adults in psychoanalytic psychotherapy. *Psychoanalytic Psychology, 28*, 95–116.

Werbart, A., & Forsström, D. (2014). Changes in anaclitic–introjective personality dimensions, outcomes, and psychoanalytic technique: A multi-case study. *Psychoanalytic Psychotherapy* (in press).

## Summary

Treatment goals in psychoanalysis often include changes in underlying dynamic mental structures, such as self- and object representations, or personality configurations. The aim of this ongoing research program is to study changes in self- and object representations, and in the anaclitic-introjective personality configuration following psychoanalysis and long-term psychoanalytic psychotherapy. Furthermore, we investigate personality related responses to the psychoanalytic process, as well as patients’ experiences of changes in dynamic mental structure. This research program combines quantitative and qualitative methods, and integrates theory-neutral and empirically-driven, inductive approach with a theory-driven, deductive approach.

Twenty-five women and 16 men from the Young Adult Psychotherapy Project (YAPP) were interviewed according to Sidney Blatt’s unstructured Object Relations Inventory prior to psychoanalytic psychotherapy, at termination and at the 1.5-year follow-up. Typologies of representations of self, mother and father were constructed by means of ideal-type analysis for male and female patients separately, and the changes were studied from prior to psychotherapy through long-term follow-up. The clusters of self-representations could be depicted on a two-dimensional space with the axis Relatedness (anaclitic personality style) – Self-definition (introjective personality style) and the axis Integration – Non-integration. The most common descriptions of the parent were the emotionally or physically absent parent, and the parent with his or her own problems. In most cases, the descriptions of the parent changed over time. There was a movement towards more integrated self-descriptions and a better balance between relatedness and self-definition. However, most of the parental representations were negative. There were important improvements in the quality of the self- and parental descriptions, and the changes continued after termination of psychotherapy (Werbart et al., 2011; Werbart, Brusell, & Widholm, 2013). These findings were further corroborated in a study applying a theory-neutral, computational and data-driven method for assessing changes in semantic content of self- and object representations (Latent Thematic Analysis). Young adults in psychotherapy are compared with an age-matched, non-clinical sample at three time points. In the psychotherapy group, all representations changed from baseline to follow-up, whereas no comparable changes could be observed in the comparison group. The semantic space method supported the hypothesis that long-term psychoanalytic psychotherapy contributes to sustained change of affective-cognitive schemas of self and others (Arvidsson, Sikström, & Werbart, 2011).

In a study of personality related responses to the psychoanalytic process, 7 analysands and their analysts were repeatedly interviewed at the beginning, during and after the analysis about the analysands' problems and helpful/hindering factors in the analytic process. The analysands were categorized as initially anaclitic or introjective according to Blatt's personality model. The introjective group expected improved emotional control and ability to regulate interpersonal distance in addition to better understanding the roots of their problems. The anaclitic group believed that the analyst's strength and empathy would help them handle their need of support and love. The introjective group saw their own problems as the main hindrance in analysis but also directed critique to the analyst as a person. Their analysts' experienced that the analysands wanted to do the work by themselves and were difficult to engage in the analytic process. The analysands in the anaclitic group were more occupied by hindrances in the psychoanalytic frame and attitude. Their analysts, on the other hand, sometimes found the work difficult and frustrating. These findings underline the importance of being aware of personality differences in analysands' response to specific dimensions of the analytic process (Levander & Werbart, 2012).

Changes in the anaclitic-introjective personality configuration were investigated in relation to outcomes in 14 cases of publicly financed psychoanalysis. The method of prototype matching was adapted for personality assessment and multiple outcome measures were applied. We found a moderate increase in the other polarity while still maintaining the basic character structure with which the patients started treatment. Both groups developed more mature and integrated expressions of relatedness and self-definition. For the anaclitic cases symptom reduction was accompanied by more mature integration of anaclitic and introjective personality dimensions, while the introjective cases could show symptom reduction without such improvement. This could indicate that sustainable change in latent mental structures is more difficult to achieve in introjective than in anaclitic patients. Both groups described their experienced changes in terms of complementary personality orientation, but the introjective group described more benefits from psychoanalysis. Several patients expressed their ambivalence to these changes and a feeling of loss of their previous personality orientation. The patients' view of their analysts and the analytic method were congruent with the patients' primary focus on relationship or self-definition. In order to reactivate developmental processes in psychoanalysis, the psychoanalytic technique has to be adjusted to the anaclitic and introjective patients' different needs and defenses.

A number of current studies further examine the relationship between patient characteristics (gender, personality configurations), psychotherapy process, changes in dynamic mental structures, and the participants' subjective experiences of change processes.

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# The Inventory of Personality Organization (IPO): Its validity in Argentine populations through non-clinical and clinical samples comparison groups

Persano, H.L. (2002): Inventario de organización de la personalidad (IPO), Spanish translation. Mental Health Department, School of Medicine, University of Buenos Aires, 2002.

Quiroga, S.; Castro Solano, A.; Fontao, M. I. (2003): La evaluación de la estructura de la personalidad: Adaptación argentina del inventario de organización de la personalidad (IPO). *Subjetividad y procesos cognitivos*, 3, 188-219.

Silva de Oliveira, S.E.; Ruschel Bandeira, D. (2011): Linguistic and cultural adaptation of the Inventory of Personality Organization (IPO) for the Brazilian culture. *J. Depress Anxiety*, 1:1. <http://dx.doi.org/10.4172/2167-1044.1000105>.

## Aim

The aim of this research is to validate the validity of the IPO, 83 items, in Argentine populations.

The IPO is an instrument which was designed to operationalize Otto Kernberg's ideas concerning borderline personality organization (BPO) diagnosis (Lezenweger, M. et al. 2001). The IPO is a multidimensional research tool which is used to differentiate dimensions of personality organization. For Otto Kernberg, primitive defenses, identity diffusion and distortions in the relation with reality are common disturbances in BPO, and they became the three specific variables used for the structural diagnosis (Kernberg, O, 1984).

The IPO was validated previously into Spanish but onto 155 items format (Avila Espada, A. et al. 2000), and this 155 items format was also adapted into an Argentinean version (Quiroga, S. et al. 2003). As a consequence of several reviews that took place, in 2001 the IPO was modified into a shorter version, with an 83-item questionnaire. It is still used to explore five main dimensions of the psychic level of functioning: primitive defenses (PD), identity diffusion (ID), reality testing (RT), aggression (A) and moral values (MV). The IPO 83 items was translated into Spanish by Humberto Persano under Otto Kernberg supervision (Persano, H. 2002) under IPA grant for a broader research on defense mechanisms.

The IPO was validated and adapted in different countries: Chilean version (Ben-Dov, P. et al. 2002), Dutch version (Berghuis, J. et al. 2009), Japanese version (Brazilian version (Silva de Oliveira, S.E. et al. 2011), German version (Dammann, G et al. 2012) and also there are European Portuguese and Italian versions unpublished.

For validation purpose in Argentine a comparison study was designed in order to test the strength of the IPO in differentiating between clinical and non-clinical samples.

## Methods

The five dimensions of the IPO were tested in this trial to compare two groups: non-clinical and clinical sample. The aim of the present study was to apply the IPO on a large sample of university students. The IPO was administered to students from different universities and regions of Argentine, and to compare this non-clinical sample with a BPD clinical sample. The clinical sample was recruited from both inpatients and outpatients sample which fulfill BPD diagnosis according to DSM-IV TR.

The aim of this research design was developed to validate the IPO 83 items in Argentine. IPO 2001 was administrated to non-clinical sample in a voluntary and anonymous way. Also it was applied to a clinical sample after approval of The Ethical Independent Committee of The Hospital Colonia Domingo Cabred, where the clinical sample was recruited.

The subjects involved in the non-clinical sample were recruited from both public and private universities from different regions of the country (n=1068) and it was carried out on 2003-2004; distribution gender (66,8% female and 33,2% male); age median 22, SD (5,2). The clinical sample was recruited from both inpatients and outpatients sample at the Colonia Domingo Cabred Hospital in Buenos Aires, which fulfill BPD diagnosis according to DSM-IV TR (n= 169); distribution gender (female, 60,4%, male 39,6%), age median 28, SD (10,8).

Statistical comparison was made using non parametric tests. Statistical differences were confirmed through Mann-Whitney Test, Two-Sample Kolmogorov-Smirnov Test and Kruskal-Wallis Test for independent variables.

## Results

Level of personality organization was significant different in both samples through five variables studied in this research. Primitive defense mechanisms (PD,  $p<0.001$ ), identity diffusion phenomena (ID,  $p<0.001$ ), impairment in reality testing (RT,  $p<0.001$ ), aggression (A,  $p<0.001$ ) and disturbances in moral values (MV,  $p<0.001$ ) are more present in BPD patients recruited from clinical sample than in non-clinical sample. The statistical analysis through three nonparametric tests mentioned above has shown that all five variables represent significant different values in both samples. Another interesting result is no gender differences were found both in clinical and non-clinical samples.

## Conclusions

The IPO self report format interview would help interviewers to explore these three dimensions through the PD, ID and reality testing (RT) items. It is generally accepted that a lower level of defense mechanisms is present in severe psychopathology, as well as the identity diffusion phenomena. Disturbances in reality testing expressed by difficulties in clearly differentiating self from non-self representations are common in the borderline realm, as well are the oscillating representations of the social common sense of reality. It is very common to observe that borderline patients often behave under the aggression domain: impulsivity, self-injuries and suicidal attempts and gestures. These symptoms are explored by the aggression (A) subscale of the IPO. It is also very well known that these patients have disturbances in the integration of the superego structure and the IPO format interview can reveal these characteristics through the moral values (MV) subscale.

Although the IPO is not used as a clinical diagnostic tool, it would allow experts to distinguish between severe psychopathology and healthy people, while exploring these three main subscales (PD, ID, RT) of the IPO which reveal the structure of the psychic function, and the others (A and MV) subscales reveal aggression control behavior and superego structure.

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# The patient-therapist interaction and the recognition of affects during the process of psychodynamic psychotherapy for depression.

Ahola P, Valkonen-Korhonen M, Tolmunen T, Joensuu M, Lehto SM, Saarinen PI, Tiihonen J, Lehtonen J. (2011). The patient-therapist interaction and the recognition of affects during the process of psychodynamic psychotherapy for depression. *American Journal of Psychotherapy*, 65, 355-379, 2011.

## Method

The perceptions of patients (n=25) and their therapists of the process of psychodynamic psychotherapy for depression were assessed during the first treatment year using 23 scales: Formation of the treatment contract, emergence of a rational treatment alliance, recognition of depression and hopelessness within treatment setting, emergence of affective relationship between the patient and the therapist, current self experience, intimate object relationships (state and dealing with them), social object relationships (state and dealing with them), dealing with aggressions, work and other occupational problems (state and dealing with them), reactivation of negative and withdrawn affects within the therapeutic relationship, object ambivalence (positive and negative affects and thoughts), working with depressive mental contents and hopelessness, experiences of being understood and mirrored in therapy, recognition of changes therapy has made possible.

## Findings

Patients and therapists independently evaluated the impact of these subjects on the therapeutic experience of the patients during the one-year long treatment period. The estimations by the patients and therapists were concordant in the majority of the scales, reflecting mutual tuning and working alliance within the therapeutic couple. The roles of affects and frustrating subjects in the treatment relationship were, however, evaluated significantly differently by the patients and therapists. The results highlight the importance of working on the expression of affects, especially with those of aggressive contents in the psychotherapy of depression.

The validation of the findings by factor analysis in relation to the treatment outcome is in progress.

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# Psychological intervention and change in depression. Depression, a complex phenomenon: Understanding the syndrome and treatment response

## Background

Investigators from different theoretical positions have discussed two major types of experiences that tinge psychopathology as depression: (1) disruptions of gratifying interpersonal relationships (for example, object loss), and (2) disruptions of an effective and essentially positive sense of self (for example, failure). From a psychoanalytic cognitive-developmental standpoint some depressed patients show a self-criticism personality trait (introjective) meanwhile others have a tendency to show a dependence personality trait (anaclitic).

## Subprojects

- Adult attachment, social network and personality traits: their relation with depression.
- Alliance evolution in two types of depression (anaclitic/introjective)

## Research questions

Anaclitic and introjective depression are the key elements of this research, from here, questions arise:- Can we describe thoroughly both types of depression (in terms of initial alliance, expectations, attachment, social support, etc.)?. How is the evolution of process variables for each type?

## Design and method

When applying psychological assistance in a private health center, participants are invited to be part of this study. Those who agree to participate, signed informed consent and completed some questionnaires (A) prior to the first psychotherapy interview, and during psychotherapy (B).

Sample: 99 patients have been included so far in this study that is still in progress.

Treatment: Therapies are held in a private outpatient clinic that delivers brief psychotherapies (8-12 sessions). Psychiatrists have diagnosed all patients.

Treatment is as usual in this natural setting, no manualization.

## Measures

Depressive symptoms: The Beck Depression Inventory (BDI-I-A, Beck et al., 1961)

Depressive Experience Questionnaire (DEQ, Blatt, D'Afflitti, & Quinlan, 1976)

Attachment in couples relationships: the Experience in Close Relationships Scale, (ECR, Brennan, Clark & Shaver, 1998)

Social Support Questionnaire (SSQ-6, Sarason, Sarason, Shearin & Pierce, 1987)

Psychotherapeutic Expectative (PATHEV, Schulte, 2005)

(A and B) Outcome Questionnaire (OQ-45.2, Lambert et al., 1996)

Cultural Variables (CMVC)

Session Evaluation Questionnaire (SEQ, Stiles, 1980)

Working Alliance Inventory (WAI, Horvath & Greenberg, 1986)

## Results

99 patients (77.8% women). Age X:43.12 years (DS:13.43). 50.0% married, 35.7% single, 4.1% widowed and 10.2% divorced. 36.7% have university studies, 22.4% have completed high school, 22.4% have technical studies.

BDI, 39.2% Severe depression, 32.0% Moderate, 21.6% Low and 7.2% Minimal depression. Types of depression (measured by DEQ), 32.9% Mixed depression, 17.6% Anaclitic, 17.6% Introjective and 31.8% Uncategorized.

In a sub-sample of 70 the results showed that both maladaptive attachment styles (anxious and avoidance) relates with self-criticism personality dimension. Also when looking at social networks, only avoidance attachment style relates inversely with this variable – in relation with size and satisfaction of the social network-.

Two mediational analyses were made; both models showed that self-criticism mediates the relation between the variables of attachment (anxiety and avoidance) and depressive symptomatology, not the same with dependency level. This means that patients that presents high levels of anxiety or avoidance have higher self-criticism in the interactions and that this relates with higher depressive symptoms.

The moderation analysis showed that when the level of satisfaction with the social network is low and the anxiety attachment level is high, meanwhile the avoidance increases, depressive symptoms increases as well.

## Evaluation

This study is still in progress and only preliminary results arise. One main limitation is that the study relies on depressed patients,; later specification a non clinical sample must be addressed.

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# Psychological intervention and change in depression: Exploring depressive experiences

## Research questions

- Which are the structural vulnerabilities of anaclitic and introjective depressive experiences?
- Which are the structural resources of anaclitic and introjective depressive experiences?
- What about the evolution of process variables for each type of depressive experience, considering their vulnerabilities?

## Design and method

Clinical sample: To 150 patients OPD-SQ will be applied, together with BDI and DEQ at the beginning of psychotherapy. Through the process OQ and WAI are applied. At the end of psychotherapy OPD-SQ and BDI are applied again.

Non clinical sample: 150 people without depression (BDI) will answer OPD-SQ and DEQ.

Treatment is as usual in different outpatient clinics. (natural settings)

## Measures

Operationalized Psychodynamic Diagnosis- Structure Questionnaire (OPD-SQ, Ehrenthal, Dinger, Horsch, Komo-Lang, Klinkerfug, Grande, & Schauenburg, 2012).

Depressive symptoms: The Beck Depression Inventory (BDI-I-A, Beck et al., 1961)

Depressive Experience Questionnaire (DEQ, Blatt, D'Afflitti, & Quinlan, 1976)

Outcome Questionnaire (OQ-45.2, Lambert et al., 1996)

Working Alliance Inventory (WAI, Horvath & Greenberg, 1986)

## Results

The study is just starting, so there are no results so far. The sample is being recruited and some questionnaires are being digitalized to further analysis.

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# Psychological intervention and change in depression: Failure in psychotherapy from the experience of patients diagnosed with depression. A qualitative comparative study.

## Background

Between 5% and 10% of patients get worse at the end of psychotherapy. Dropout rates in psychotherapy are estimated at 46.86%. However, there is a publication bias, in the sense that successful therapies are over-represented). Consequently, the failure of therapies has not received enough attention in literature. Additionally, the perspective of patients regarding failure of therapy has not been sufficiently considered. The aim of this study is to capture the meanings of negative evaluation of the psychotherapy, from the experience of Chilean patients diagnosed with depression, and compare it with patients that had successful experiences.

## Research questions

What are the meanings associated with a negative evaluation of the psychotherapy in Chilean patients diagnosed with depression from their experience in a psychotherapeutic process?

1. Explore the meanings associated with a negative evaluation of psychotherapy from the experience of Chilean patients diagnosed with depression, compared with patients that had successful experiences.
2. Identify causes attributed to a negative evaluation of psychotherapy from the experience of Chilean patients diagnosed with depression, compared with patients that had successful experiences.
3. Identify possible consequences of negative evaluation in psychotherapy, compared with patients that had successful experiences.

## Design and method

Qualitative methodology. A descriptive-analytic relational design. Data collection included follow-up semi-structured interviews performed with the clients after finished or dropped-out psychotherapy. Data analysis was carried out according to Grounded Theory procedures, including open, axial and selective coding.

Sample:

The study included patients diagnosed with depression and treated at semi-funded institution of mental health (6, 8 or 12 session pre-assigned, depending severity).

Sample: 40 patients follow up interviews.

## Treatment:

This study includes non-manualized brief psychotherapies aimed at the resolution of depressive symptoms, independent of psychotherapist theoretical model.

6, 8 or 12 psychotherapy session pre-assigned, depending severity, with the flexibility of extend a few sessions, case by case.

Measures: Semi-structured and narrative interview.

## Results:

Results allowed identify the criteria used by patients to determine when a psychotherapeutic process is unsuccessful and compare it with a successful process. Furthermore, they permit to develop a comprehensive model of negative evaluation of the psychotherapy from the patient's point of view.

In summary

- It was possible to distinguish 3 groups of patients in relation to the overall evaluation of psychotherapy from their subjective experience: 20 patients with positive evaluation, 13 patients with mixed, and 7 patients with negative evaluation.
- Patients are able to assess their differential effects attribute psychotherapy, other treatments or life situations.
- Patients did not only consider the lack of symptomatic relief when evaluating negatively their psychotherapy. Factors that stood out were:
  - Distrust and Misunderstanding
  - Absence of Focus working
  - Didn't have the experience of "Change in oneself" as opposed to successful cases
  - Didn't have a "transforming psychotherapy relationship" as opposed to some successful cases
- Patients with negative and mixed evaluation, didn't talk directly about their bad feelings to the therapist. They felt that wasn't appropriate.

## Conclusion

Even in many very brief psychotherapies (focused on symptomatic relief) patients feel that one of the most important factors of psychic change is the "transformative relationship" with the psychotherapist, relationship contrary to dysfunctional depressive pattern.

## Evaluation

This study is in progress. Still need to perform qualitative analysis. Later be incorporated into the analysis further comparison with quantitative instruments such as the BDI and OQ45.2, and therapist's interviews.

## Some limitations

- The study provides a specific frame of brief psychotherapies aimed at the resolution of depressive symptoms independent of the theoretical model of the psychotherapist.
- Are not manualized psychotherapies.

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## Facial affective relationship offers of patients with panic disorders

- Benecke, C. & Krause, R. (2005). Facial affective relationship offers of patients with panic disorders. *Psychotherapy Research*, 15, 178–187.
- Benecke, C. & Krause, R. (2005). Initial affective facial behaviour and outcome satisfaction in the psychotherapy of patients with panic disorder. *Zeitschrift für Psychosomatische Medizin & Psychotherapie*, 51, 346-359.

### Summary

The affective facial behavior of patients with anxiety-disorders and that of their psychotherapists was analyzed following specific hypothesis about the domination of dependency autonomy conflicts of these patients including an ambivalent need for a positive relationship toward a significant object and an incapacity to express negative feelings because of fear of losing this relationship. The authors investigated facial indicators of this conflict in 20 women with panic disorder in the first psychotherapy session. A preponderance of facial smile and a lack of negative affective facial signals were expected. This was not confirmed for the total sample. A cluster analysis identified two subgroups of panic patients. One group confirmed the assumptions precisely. The other did as well but only insofar as the patients smiled more often than a sample of a mixed clinical control group that excluded panic disorders. In addition, the panic patients of this cluster showed much negative affect. The patients of the two panic clusters did not differ in panic and other symptoms but did so in their descriptions of their interpersonal behavior.

Additionally the data of facial behaviour was correlated with outcome ratings at the end of the treatment. Therapists show less affective facial behaviour than panic patients; particularly, they smile less frequently. The frequency of smiling in the first session correlated negatively with outcome ratings. Therapists adapted their interactive behaviour to the relationship offers of their patients.

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## Metaphors and affect

- Fabregat, M., & Krause, R. (2008). {Metaphors and affect: their interrelation in the therapeutic process}. *Zeitschrift für Psychosomatische Medizin und Psychotherapie*, 54, 77-88.

This piece of research deals with the relationship between affect and its transference into language in “hidden ways” before it appears as purposefully verbalised meaning.

### Design

Using videotapes of 10 fifteen-hour short-term therapies by very experienced therapists treating an unselected group of patients, facial affect and metaphoric language of the therapist and the patient as well as the temporal distance between the two were recorded.

### Results

The density of metaphors was not significantly correlated with symptom reduction but with treatment satisfaction. However symptom reduction correlated significantly with the frequency of interactive metaphors used by both the therapist and the patient. It could be shown that there is an optimal time window between facial affect and metaphor production beyond the here and now, but not as a long term memory.

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## Fibromyalgia, facial expression and emotional experience

- Kirsch, A. & Bernardy, K. (2007). Fibromyalgia, facial expression and emotional experience. *Psychopathology*, 40, 203-208,

We studied the facial affective behaviour (facial expression) of female fibromyalgia (FM) inpatients which was compared to healthy woman (absence of mental/psychiatric disorder according to ICD-10). The facial affective behaviour was coded with the Emotiona Facial Action Coding System. Videotaped psychodynamic interviews of each of 15 female FM inpatients and healthy women were analyzed. The facial expression was related to gazing behaviour and emotional experience.

FM patients exhibited neither a reduction in total activity of facial expression nor in absolute frequency of primary affects compared to healthy women, who, however, in mutual gaze and eye contact showed a significantly higher proportion of “genuine joy” and a lower one of “contempt”. No congruence between the patient’s emotional experience and facial expression was found. We concluded that the absence of reduced total activity of facial expression is in contrast to the elaborate descriptions of complaints provided by the patients. Nevertheless, our analysis (amongst others) showed a lack of elements that stabilize a relationship. Especially genuine smiling stabilizes the relationship between two persons, it keeps the communication going on, which has also an impact on the countertransference of the therapist. The healthy women in our study hardly differed from the patient according to negative, distance inducing affects like anger and disgust. Contempt, however, was shown more than twice as often by the patients. Contempt is an affect that serves to abandon a relationship with another person or prevents it from establishing. Furthermore, it contains a devaluation of the interaction partner, in this case the therapist. The patient gives an impression of facial affective liveliness and “health”, at the same time stabilizing elements do not occur, and distance inducing ones are implemented.

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# Facial expression and experience of emotions in psychodynamic interviews with patients with PTSD in comparison to healthy subjects

- Kirsch, A. & Brunnhuber, S. (2007). Facial expression and experience of emotions in psychodynamic interviews with patients with PTSD in comparison to healthy subjects. *Psychopathology*, 40, 296-302.

The facial affective behaviour informs others of current emotions and evokes responses that shape social interactions, influences relationship satisfaction, and as we assumed, adjustment to traumatic events.

## Design

We videotaped 15 clinical interviews with traumatized patients in comparison to a healthy control group (absence of mental/psychiatric disorder according to ICD-10).

## Findings

As well as the FM inpatients, the traumatized did not show a reduction of overall facial expression nor a reduced frequency of facial affects in comparison to the healthy controls. The control group, however, showed significantly more “genuine joy”, the traumatized patients significantly more “anger”. We concluded that this indicates the importance of distance regulating interaction patterns of traumatized patients. Within a clinical dyadic patient-therapist setting, anger could lead to an unconscious relationship-pattern “object go away!”. In the countertransference of the therapist anger affects could enhance insufficient empathy, missing exploration of the traumatic event to the point of unconscious aversion of which the therapist has to become aware.

## Contact

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## Childhood-onset versus acute, adult-onset traumatized patients

- Kirsch A., Krause, R., Spang, J., Sachsse U. (2008) Childhood-onset versus acute, adult-onset traumatized patients in the light of amnesic tendencies and derealisation . *Z Psychosom Med Psychother* 54, 277-284

This research project related facial – affective behaviour in traumatized patients to dissociation including amnesic tendencies and derealisation.

Facial affective behaviour of acute adult-onset traumatized patients versus childhood-onset traumatized patients was analyzed with the Emotional Facial Acting Coding System, an instrument for the registration of facial movements with emotional relevance.

The facial affective behaviour of the patient's first and last EMDR sessions was compared. Childhood-onset and acute adult-onset traumatized patients showed the same amount of overall facial activity. Childhood-onset traumatized patients showed higher values of derealisation (FDS). The reduction remains constant over time. Also childhood-onset traumatized patients developed more psychic complaints and greater derealisation.

Using the same corpus of data it was investigated whether the facial affective behaviour of patients with posttraumatic stress disorder (PTSD) and borderline personality disorder (BPD) could be used to discriminate the two groups. Patients were assigned to clusters which were then compared for emotional numbing and dominant affects. In Cluster 1 the negative affects anger, contempt and disgust were dominant to the exclusion of other primary affects. Chief affects expressed in cluster 2 were disgust, social smiling and contempt. Clusters 3 displayed the full range of primary affects, with grief the most frequent. BPD as additional diagnosis was significantly more frequent in clusters 1 and 2 than in cluster 3. The finding that PTSD patients in Clusters 1 and 2 display a significantly more frequent co-morbidity with BPD than those in Clusters 3 is discussed against the background of the range of facial - expressive affects.

## Cost-offset effect of psychotherapy in reducing medical health service utilization.

- Kraft, S., Puschner, B., Lambert, M. J., & Kordy, H. (2006). Medical utilization and treatment outcome in mid- and long-term outpatient psychotherapy. *Psychotherapy Research*, 16 (2), 241-249.

This study examined service use and its relation to outcome in people receiving outpatient psychotherapy with a special focus on the possible cost-offset effect of psychotherapy in reducing medical health service utilization.

### Sample

Between September 1998 and February 2000 all adult insurees of a large private insurance company (“Deutsche Krankenversicherung”, DKV) who applied for reimbursement of their outpatient psychotherapy were asked to participate in the TRANS-OP study (see Open Door Review...). Due to the considerable time and effort for the collection and analysis of service use data, a randomized subsample of 200 participants who had applied either for cognitive behavioral therapy (CBT, N=100) or psychodynamic psychotherapy (PD, N=100), was drawn of the original sample (N=939). Medical utilization data were analyzed only for participants who had returned at least the baseline questionnaire (N=176).

### Measures

Information about medical utilization (outpatient and inpatient treatments) was made available by the DKV via computerized, aggregated records of insurance claims. Psychological distress was assessed with the German adaptation (EB-45; Lambert, Hannover, Nisslmüller, Richard, & Kordy, 2002) of the Outcome Questionnaire-45 (OQ-45.2; Lambert et al., 1996). Somatic distress was measured with the Giessener Complaints Questionnaire (GKB-24; Brähler & Scheer, 1995).

### Results

Mean medical costs continually increased before the start of outpatient psychotherapy and decreased thereafter. This pattern was more pronounced for hospital days, with a sharp decline immediately after the start of treatment. Medical costs during 6 months decreased from 2,183.36 € (SD= 2491.29) at start of psychotherapy to 1,609.44 € (SD=1,951.62) two years later (26.3%). During the same time, hospital days showed a 78.7% decrease from 3.33 (SD=10.35) to 0.71 (SD=4.11). However, these differences were not statistically significant.

Improvement in somatic well-being within the 18 months after start of therapy was significantly related to a reduction in medical costs, even when controlling for pretreatment medical costs. Furthermore, the reduction in health care costs was somewhat larger in younger patients, and cost reduction was somewhat larger in patients with fewer sessions. No difference in reduction of medical care utilization was found between the two forms of psychotherapy.

### Evaluation

This is one of the few studies which examined cost offset after mid- and long-term outpatient psychotherapy. To our knowledge, by then it was the first that analyzed the association of cost offset and mental health treatment outcome, and it was the only European study besides Sandell et al. (2001)

in which direct health care costs, and not only hospital or disability days, were obtained from objective data sources (i.e., insurance claims).

# Relational and Classical Elements in Psychoanalyses: An empirical Study with case Illustrations

- Høglend, P., Johansson, P., Marble, A., Bøgwald, K-P., & Amlo, S. (2007). Moderators of the effects of transference interpretations in brief dynamic psychotherapy. *Psychotherapy Research, 17*, 160–171. doi:10.1080/10503300701194206
- Waldron, S., Scharf, R. D., Hurst, D., Firestein, S. K., & Burton, A. (2004). What happens in a psychoanalysis: A view through the lens of the Analytic Process Scales (APS). *International Journal of Psychoanalysis, 85*, 443–466.
- Westen, D., & Shedler, J. (1999a). Revising and assessing Axis II: I. Developing a clinically and empirically valid assessment method. *The American Journal of Psychiatry, 156*, 258–272.
- Westen, D., & Shedler, J. (1999b). Revising and assessing Axis II: II. Toward an empirically based and clinically useful classification of personality disorders. *American Journal of Psychiatry, 156*, 273–285.

## Brief Summary

The first aim of this article is to report a newly developed measure of therapeutic process, the Dynamic Interaction Scales. When combined with the Analytic Process Scales (Waldron, Scharf, Crouse, et al., 2004; Waldron, Scharf, Hurst, et al., 2004), the two instruments permit a reliable and fine-grained assessment of technical and relational aspects of psychoanalytic and psychodynamic psychotherapeutic process. The Shedler-Westen Assessment Procedure and Psychological Health Index (Westen & Shedler, 1999a, 1999b; Waldron et al., 2011) permit a reliable and fine-grained assessment of the changes during treatment. The second aim is to demonstrate how combining results from these instruments permits exploring the relationships between processes and outcomes of treatment. We illustrate the utility of this approach by a demonstration project, applying the instruments to two treatments started 21 years apart. The results show different relational and classical approaches of the analysts and different outcomes. Both patients had a similar level of psychological functioning at the outset of treatment, but one made a much more extensive recovery than the other. The difference in outcomes may reflect different patient pathology, in spite of their initial level of functioning, but it may also reflect the impact in the better outcome case of a more relational approach, combined with a more extensive use of classical analytic interventions judged to be of higher quality. We then present quantitative results applying the same instruments to 11 additional patients. Technical and relational differences are found between good and poor outcome cases in this group, similar to those found in our two demonstration cases. Ongoing evaluation of an additional 18 cases will permit further study of these differences.

## Evaluation

Previous researchers on short-term or even medium-term psychotherapy outcomes have generally not found that therapists' varying technical contributions to treatment account for much of the differences in outcomes (e.g., Norcross, 2011; Wampold, 2001). By contrast, our findings, if further confirmed in a larger sample, affirm the importance of the therapist's contribution to benefit. We will have moved closer to confirming what most psychoanalysts have believed for a long time: that *both* the quality of the analyst's relationship with the patient *and* the ability to provide useful verbal communications are crucial therapeutic factors. In other words, the differing emphases of relational and classical theory each have a contribution to the course of treatment that exceeds the benefit of either the relationship alone or interpretation and insight alone. And it seems clear that if, on one hand, interpretations and insights are a function of and happen in the context of a human relationship, on the other hand, a

human relationship is shaped by the reciprocal understanding of the people in the relationship (Høglend et al., 2007).

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## Clinical and systematic clinical studies

## Research in child psychoanalysis: Twenty-five-year follow-up of a severely disturbed child

Tyson, P. (2009). Research in child psychoanalysis: twenty-five-year follow-up of a severely disturbed child. *Journal of the American Psychoanalytic Association* 57 (4): 919-45.

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.

### Summary

The history and current state of research at the Anna Freud Centre reports the evolution of a database that has methodically recorded and systematically organized data from over 750 cases of children referred to the Centre over a forty-five-year period. A long-term follow-up of a small sample of these children suggests the kinds of long-term benefits that can be gained when an individual is treated with intensive psychoanalysis as a child. As an example, the author presents clinical material from the analysis of an eight-year-old along with follow-up interview data twenty-five years later to demonstrate the efficacy and the outcome of a child psychoanalysis and critically discusses the value of distinguishing two different models of psychoanalytic treatments – the “classical model” and the “mental process model”.

The long tradition of research at the Anna Freud Centre, as well as the extensive Hampstead Index database<sup>2</sup> of methodically recorded and systematically organized observations from the analysis of children dating back to at least 1960 provided the material, technical, and epistemological support to respond to this challenge. Fonagy, Target and their colleagues at the Centre designed and systematically conducted an empirically sound study of the outcome and efficacy of child analysis (for a description of this study and its methodology, see Fonagy and Target 1996). This entailed a systematic file review of 763 cases treated in psychoanalysis or psychotherapy at the Anna Freud Centre. By studying the case records they sought to identify children who had had a successful psychoanalytic outcome and then determine the characteristics of the child or the analysis that contributed to that success. The children who seemed to gain the most from psychoanalysis, judging by their improved adaptive capacity at the completion of their analysis, were those who presented with severe social and emotional psychopathology, such as difficulties in relating to peers, problems with affect regulation, low frustration tolerance, distortions of self-image, fragile reality contact, and idiosyncratic and magical thinking. To support the impression that these more disturbed children had actually the most to gain from psychoanalysis, they designed and conducted a twenty-five-year follow-up study. In the course of their file review, the team at the Anna Freud Centre began to recognize that the children with serious pathology had in common a difficulty in differentiating other people’s thoughts and feelings from their own. Consequently they were unable to create representations of the self with specific thoughts and feelings and representations of others with thoughts and feelings separate from and different from their own. This limited them socially, as they were unable to reflect on or anticipate another’s response and so could not choose appropriate action. They could not empathize with others or imagine themselves in another person’s shoes.

In the course of this file review, the research team observed that the techniques that seemed to be effective with the more disturbed children differed from the standard defense and conflict interpretation techniques typically used with neurotic children. They realized that an implicit model of psychoanalytic treatment was often being used with these children instead of—or in addition to—the explicit classical model. This observation led them to delineate two discrete models for the

psychoanalytic treatment of emotional disturbance in children. The first, the classical model, involved insight and the modification of unconscious mental representations through interpretations of conflict, defense, and transference. The second, which they called the “mental process model,” focused primarily on what came to be known as mentalization, the process of reflecting on the thoughts, feelings, and mental states of self and others.

By presenting detailed material from the analysis of an eight-year-old named Peter along with follow-up interview data twenty-five years later, the author provides a convincing explication of the need for and effectiveness of psychoanalysis for some severely disturbed children. She describes her therapeutical challenge to find alternative strategies of intervention after she figured out that the classical model of treatment – interpretation of unconscious conflict aimed at promoting insight – was not helpful and did not lead to elaboration or the introduction of new material in this case. The strategy the author developed in treating Peter was to focus on verbalizing his feelings and mental states, using Katan’s notion (1961, p. 185) that verbalization of affect leads to some measure of control. This analysis predated Fonagy, Target, and their colleagues’ work on mentalization. The author maintained that such verbalization increases ego strength by enabling the individual to distinguish between wishes and fantasies on the one hand, and reality on the other. By consistently labelling Peter’s feelings, and making links to his actions and subsequent feelings, Peter might in time be able himself to label and think about his mental states. To enable Peter to feel that he could control his feelings instead of his feelings controlling him became the goal of therapy. Perhaps Peter was one of those cases that alerted the research team to the use of implicit treatment techniques and that led them eventually to differentiate the mental process model. The outcome of Peter’s treatment, examined by a follow-up interview twenty-five years later, can be described as a positive, considering the emotional state he presented as a seven-year-old.

## Evaluation

Although epistemological difficulties have discredited the case study as a research method for evaluating the efficacy of psychoanalysis, combining the richness of a case study with empirical research data shows how the two methods together can convincingly demonstrate the effectiveness of psychoanalysis with certain types of severely disturbed children. Child analysis requires a considerable investment of time and money but the cost is minuscule weighed against the cost of maintaining someone like Peter on lifetime disability, not an inconceivable trajectory for someone with the emotional challenges he presented. The Anna Freud Centre research team concluded that the effort and cost of early and intensive psychoanalytic treatment for children like Peter is particularly justified because they have the most to gain from psychoanalysis.

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# Psychoanalytic treatment of a patient with a neurotic depression. A systematic clinical single case study

Bruns, G. (2005): Zweifel am Dasein. Aus der Behandlung eines depressiven Patienten (Existential doubt. From the treatment of a depressive patient). *Psyche – Zeitschrift für Psychoanalyse*, 59, 816-842.

## Summary

The article describes the psychoanalytic treatment of a male patient suffering from a neurotic depression with symptoms of a desperate, depressive mood, conscious and unconscious self-destructive tendencies (suicidality, somatic and psychosomatic diseases, overly ascetical and self-restricted style of living) and sexual symptoms of erectile and libidinal disorder. The depression dates back to childhood and was exacerbated in adulthood by a separation and the psychic conflict connected with it. In the course of the analysis the etiological background emerges more clearly – between the age of 0,5 and 1,5 years of the patient his mother lost her husband, her only daughter, her father and a brother by dead and became depressive. A constellation of the kind described with the concept of the dead mother by André Green showed up. The emotional absence of the mother was made more severe by the complete absence of the father. The patient felt that his mother most intensely suffered from the loss of her daughter and that he had the unspoken and unconscious task to replace his dead elder sister together with comforting his mother. In this constellation he experienced doubts whether he was recognized by his mother as own person and whether he was seen by her at all. These early doubts laid the foundations for persisting doubts if he had the right to live and to follow own wishes or if he had to live for the benefit of another person, especially his mother or another woman substituting her in his mind.

In order to understand these existential doubts of the patient the author draws substantially on an interaction model taken from developmental psychology.

In analysis the existential doubt manifested itself as hunger for contact and confirmation. The psychosomatic symptoms played a special role for these needs: on the one hand they demanded care and attention from doctors, they reduced dependency from the analyst because there were more doctors than one, and they were an unconscious recapitulation of experiences of illness-conditioned abandonment in early childhood. In the course of treatment over five years, the patient was able to gradually overcome his symptoms and to establish a more mature and stable form of self/object differentiation.

## Evaluation

The sessions were recorded and based on the records evaluated with regard to the unconscious conflicts which changed during treatment, to transference and countertransference. The evaluation was done with a group of clinically working psychoanalysts in fixed intervals. Based on clinical data and the analyst's countertransference it was examined which psychoanalytical theory of depression and of mental functioning seemed to be most appropriate to understand the patient's symptoms and the intersubjective processes during treatment.

During four years after termination there were follow up meetings with the patient once or twice per year which showed the stability of the development during treatment.

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## Assessing change in analysis terminable

Josephs, L. (2000). Self-criticism and the psychic surface. *Journal of the American Psychoanalytic Association*, 48, 255-280.

### Summary

The current study systematically assesses the progress of a single patient during a four-year treatment episode. As a case study it centers a schizoid patient in her mid-sixties who had made in a lengthy analysis – for much of her adult life – significant clinical improvement. The treating analyst's impression of clinical improvement was independently verified through systematic analysis of transcripts of audiotapes of thirty-six sessions over a four-year period of treatment. The patient showed significant improvement in measures of character pathology, object relations, mentalization, and superego anxiety.

The presented traditional case study offers a special attention to the impact of taping and the supplemented analysis of verbatim transcripts of the whole period of treatment. The transcripts have been rated by external judges with good levels of interrater reliability ( $> .70$ ) on measures of character pathology, object relations, reflective functioning, and superego anxiety. Two types of measure were selected for the study. Measures of the first type were selected to assess personality variables such as character pathology and level of objects relations that are presumed to be fairly stable and resistant to change. The research question with these measures was whether long-term intensive treatment could significantly alleviate severe and entrenched character pathology.

Measures of the second type were selected to assess more fluid and psychodynamically significant process variables such as reflective functioning and superego anxiety. The research question with these measures was whether the patient would become more reflective and develop a milder superego over the course of treatment. If the patient did, future research could then examine how aspects of technique and the therapeutic interaction impact on variables that fluctuate quite a bit during sessions.

The results suggest that some patients with entrenched character pathology who seem to be in analysis interminable may still make clinically significant improvement.

In addition, the study demonstrates that the reflective functioning scale (Fonagy et al. 1998) can be fruitfully adapted for use with transcripts of psychoanalytic sessions and furthermore it offers that the SWAP (Shelder and Westen 1998) can generate a personality profile that is consistent with an established self-report measure, the MCMIII, so that it is a suitable measure for assessing change in character structure.

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# The „Medea-Fantasy“- An unconscious determinant of psychogenic sterility

- Leuzinger-Bohleber, M. (2012). The ‘Medea fantasy’: An unconscious determinant of psychogenic sterility. In P. Mariott (Ed.), *The Maternal Lineage. Identification, Desire, and Transgenerational Issues* (pp. 169-204). London/New York: Routledge.
- Leuzinger-Bohleber, M.; Teising, M. (2012): “Without being in psychoanalysis I would never have dared to become pregnant”: Psychoanalytical observations in a multidisciplinary study concerning a woman undergoing prenatal diagnostics. *International Journal of Psychoanalysis*, 93, 293-315.

## Summary

Based on systematic clinical case studies the author describes an important unconscious fantasy found in a specific group of female analysands who had unconsciously sought psychoanalytic treatment for the same symptoms: psychogenic frigidity and sterility. In the six psychoanalyses and four long-term therapies, the analyst and the analysands finally discovered that a central unconscious fantasy, hitherto unrecognised, had determined all these women’s experience of their femininity; with the Greek myth in mind, the author called it the ‘Medea fantasy’. Pivotal to this fantasy was the unconscious conviction that sexual passion carried the risk of existential dependence on their love partner and of eventual deception and abandonment by him. These women were unconsciously convinced that they would not be able to endure such an abandonment and would react to it with lethally destructive impulses constituting an existential danger to the self and the love object—as well as, in particular, to the products of the relationship with him: their children. For this reason it seemed to them psychically imperative to forgo any creative unfolding of their femininity and symbolically to ‘deaden’ themselves and their bodies. In their long and difficult treatments, it emerged that all these patients had sustained severe traumas in their early object relations, with consequent excessive stimulation of archaic fantasies about the female body and about characteristic modalities of the early relationship with the primary object. For example, it turned out that all these women shared the striking biographical fact that, during their first year of life, their mothers had suffered from severe depressions and been treated with antidepressants. As a result, the mothers had presumably lacked an adequate capacity to present themselves to their babies as helpful, reliable and indestructible objects that could thereby have come to their aid in, for example, the progressive integration of archaic destructive fantasies. These had consequently been preserved in the form of splitoff, unconscious ‘Medea fantasies’. While the traumatic quality of their early object relations had undoubtedly favoured the formation of this unconscious fantasy in the analysands, it has to be discussed whether the Medea fantasy might possibly constitute a ubiquitous unconscious fantasy of femininity.

## Evaluation

The systematic clinical case studies have been further discussed with clinicians at different conferences. The “Medea-fantasy” was one of the conceptual frameworks of a large empirical study “Ethical Dilemma Due to Prenatal and Genetic Diagnostics” systematically investigated in 82 psychoanalytical case studies applying the method of psychoanalytic expert validation (see Leuzinger-Bohleber, Engels, Tsiantis, 2008).

## Contact:

Prof. M. Leuzinger-Bohleber

# What do patients want?

Hill, C. (2010) "What do patients want?" *Psychoanalytic Perspectives from the Couch*. London: Karnac Books.

## Summary

This book, based on a doctoral thesis, provides an insight into patients' experiences of psychoanalysis as they describe the factors, which they considered facilitated or impeded their analytic treatment. It addresses the question "What do patients want?" and explores what led to their different outcomes. The context for this book is a psychoanalytic culture where very little is known or understood about what actually takes place between patient and analyst, from the patient's perspective. The field of literature on psychoanalytic process and outcome studies has generally privileged the practitioner or researcher's voice, whilst underutilizing rich published accounts of patients talking about their own experiences. This book was thus an attempt to provide an in-depth understanding of an experience usually mystified, and poorly understood, by those outside the analytic dyad.

## Method

A qualitative methodology was used to enable the exploration of this broad question and to provide rich and trustworthy data. The complexities inherent in psychoanalytic clinical work, carried out behind closed doors and influenced by unconscious phantasies and dynamics, presented challenges, which have been explored and discussed.

## Sample

Eighteen participants were interviewed, eleven women and seven men, ages ranging from 31 to 60, and living in four Australian states. The criteria for participating were that they had completed (or ended) an analysis, and it was with a professionally recognized psychoanalyst. The patients free-associated to an open question about their experiences, providing very rich accounts of their analyses, which they demonstrated with clinical material. Their stories generally indicated a sophisticated understanding of the analytic process.

## Evaluation

The chapters were arranged in a journey format, paralleling the analytic journey itself. A significant focus was the desire to be a 'patient-partner' not a 'patient-victim'. Major themes, which emerged spontaneously, related to choice of an analyst, procedures around the assessment and ending phases of analysis, the quality of engagement between both partners in the transference/counter-transference relationship, and issues to do with silences, authority and powers of negotiation. The patients delineated factors, which either facilitated liberating experiences and major life changes, or resulted in dissatisfying or 'failed' analyses. A surprising central theme emerged around a strong paternal transference, which is described in a separate chapter entitled "the analyst as father". Questions were raised and discussed as to the importance of this specific transference. The patients offered further personal reflections on what they considered as imperative for a 'good' analysis.

Significant findings are discussed in each chapter, then key conceptual issues are brought together at the end, highlighting implications for psychoanalysis, its training procedures, Institute policies and clinical practice.

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# A single-case study on the process and outcome

Szecsödy I & Stoker J (2009) A single-case study on the process and outcome of psychoanalysis. *Scand. Psychoanalytic Review* 31, 3139-3147

## Summary

The present study investigates one person's psychoanalysis over a period of five years during treatment and two and five years later at follow-up.

## Method

Both patient and analyst were interviewed with the AAI yearly and filled out questionnaires every year during the treatment.

## Findings

According to the interviews, the analysand found "a space for himself in himself" in which he could contain "sorrow, hopefulness, joy, remorse, anger and even desperation". The psychoanalytic relationship was stable and consistent, and the main complaints decreased significantly over time. RF scores rose from a sum-score of 5 before the beginning of treatment to 6/7 at the end.

Self-rating scales showed positive changes already in the first year of treatment and these gains were maintained throughout treatment and also at the two-year and five years follow-up.

Mental attachment representation before the treatment and at termination did show a shift from an insecure attachment representation to a more secure one.

## Evaluation

Further discussion and experiences are necessary to deepen our understanding of how to interpret the influence and impact of research on the treatment, on the analyst, the validity of "informed consent of the analysand" as well to the specificity of the treatment and the instrument used to study it.

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# Evaluation of psychic change through the application of empirical and clinical techniques for a 2-year treatment

López Moreno, C. M., Schalayeff, C., Acosta, S. R., Vernengo, P., Roussos, A. J., & Dorfman Lerner, B. (2005). Evaluation of psychic change through the application of empirical and clinical techniques for a 2-year treatment: a single case study. *Psychotherapy Research, 15*(3), 199-209.

## Summary

The authors present results obtained by a combination of clinical and empirical methods used in the evaluation of psychic change involving a single case study carried out during 2 years of nonmanualized psychodynamic psychotherapy.

## Method

A multidimensional definition of change that includes clinical (psychoanalytic) and empirical perspectives is provided. The authors used material from supervision sessions and clinical meetings to assess the psychodynamic diagnosis and evolution.

The following empirical techniques and instruments were used: core conflictual relationship theme (Luborsky & Crits-Christoph, 1990), Symptom Checklist-90-Revised

(Derogatis, 1983), and Differential Elements for a Psychodynamic Diagnostic (C. M. Lopez Moreno et al., 1998).

## Results

Several markers of psychic change along the therapeutic process were found. The instruments proved to be sensitive to the changes obtained during the psychotherapy. Used together, the instruments allowed an integrated evaluation of the patient's evolution during the treatment.

## Evaluation

This study is part of a research program (Lopez Moreno et al., 1999) that began with a project grant from the Research Advisory Board of the International Psychoanalytic Association.

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# A German specimen case of psychoanalysis

Kächele, H., Albani, C., Buchheim, A., Hölzer, M., Hohage, R., Jiménez, J.P., Leuzinger-Bohleber, M., Mergenthaler, E., Neudert-Dreyer, L., Pokorny, D. & Thomä, H. (2006) The German Specimen Case Amalia X: Empirical studies. *International Journal of Psychoanalysis* 87, 809-826

Buchheim, A., & Kächele, H. (2007). Nach dem Tode der Eltern. Bindung und Verlust {After the death of the parents. Attachment and loss}. *Forum der Psychoanalyse*, 23, 149-160.

Buchholz, M. B., Spiekermann, J., & Kächele, H. (2015). Rhythm and blues. Amalia's 152nd session. From psychoanalysis to conversation and metaphor analysis - and retour. *International Journal of Psycho-Analysis*, in press.

The paper provides a perspective on how psychoanalytic process research can be implemented. We detail the Ulm process research model and summarize the manifold empirical studies that were performed on a completely tape-recorded psychoanalytic therapy. The studies demonstrate the many modalities empirical process research has available to objectively study process and outcome phenomena.

## Method

The psychoanalytic treatment was first described by a systematic longitudinal description under a fixed set of headings performed by external observers based on the transcribed recordings.. Second topics of special importance were analyzed by external raters using manual based codings. The concepts of emotional insight, self-esteem, dream pattern, suffering, transference, plan analysis etc were studied using systematic time samples.

Using the AAI in a follow-up study after 25 years could show that after the death of both parents of the patient the treatment significant attachment issues came to the fore that had not been dealt with during the treatment (Buchheim & Kächele 2007).

Additional measures using computer-based textanalysis generated new approaches to the material.

Recently we have applied modern conversational analysis technique to highlight microprocesses that escape the naked eye of the clinician (Buchholz et al. 2015).

The case has been intensively studied by the Swiss dream research group of Prof. Boothe (see details under **dream**)

## Evaluation

The case is unusual insofar the complete tape recordings and the transcripts are available for the research community. The findings have been detailed in many other studies.

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# Verbal expression of emotions in the stage-wise progress of a case of long-term psychodynamic therapy

Gumz, A., Kästner, D., Geyer, M., Wutzler, U., Villmann, T., & Brähler, E. (2010). Instability and discontinuous change in the experience of therapeutic interaction: An extended single-case study of psychodynamic therapy processes. *Psychotherapy Research*, 20 (4), 398-412.

## Summary

The present study is intended to explore how change occurs in the psychotherapeutic processes. Even though current psychotherapy research has an important focus on this specific issue, there is a lack of studies that track the process of emotional change throughout therapy. In terms of making sense of the process of psychodynamic psychotherapy, it seems reasonable to place a primary focus on analysing mechanisms of change at the level of emotions, while recognising that other forms of change (e.g. cognitive, behavioural, physiological) are also important. Emotions are inextricably connected to psychopathological processes.

Our aim in the present study was to build on the findings of previous research by assessing changes in the verbal expression of emotions within the therapeutic dialogue in a psychodynamic long-term therapy by means of continuous measuring throughout a long and complete therapy period. We hypothesized that changes would occur in the form of transitions and discontinuous changes. A further aim was to verify and develop the applicability of the Clinical Emotions List (Leising et al., 2004) as a measuring instrument for use in this kind of research. Identifying changes at an emotional level opens up the possibility of using various quantitative and qualitative methods to investigate different sessions and therapy phases with regard to the relationship between emotional variables and factors that influence the development within the therapeutic process.

## Results

The number of verbalised emotions and the variability of the emotional profile increased during the course of the therapy. These developments occurred in three distinct phases. The proportion of positive emotions varied across each stage although there was no linear increase across the case as a whole. The presented results show that the Clinical Emotions List (CEL) is a suitable instrument for assessing changes in emotional expression within the therapy process.

## Conclusions

The findings of this study suggest that discontinuous transitions can be regarded as reflecting therapeutic progress (proximate outcomes) at an individual emotional level. Phases of therapy in which transitions occur can be systematically analysed in order to search for factors that influence the development of the therapeutic process. This methodological approach opens up a range of research issues of theoretical and practical importance. The rating instrument used in this study has the potential to be widely used in case study research as a means of identifying processes of emotional transition in individual therapy.

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# Chilean Millennium Nucleus: “Psychological intervention and change in depression”. Process-outcome research 1: Foci on psychotherapy.

- Dagnino, P., de la Parra, G., Jaramillo, A., Crempien, C., Padilla, O., Gómez-Barris, E., ... , & Rodríguez, S. (2014). El devenir del cambio: cómo es y hacia dónde se dirige. *Revista Argentina de Clínica Psicológica*, 23(1), 23–40.
- Dagnino, P., Krause, M., Pérez, C., Valdés, N., & Tomicic, A. (2012). The evolution of communicative intentions during change episodes and throughout the therapeutic process. *Research in Psychotherapy: Psychopathology, Process and Outcome (RIPPO)*, 15(2), 75–86.
- Echávarri, O., González, A., Krause, M., Tomicic, A., Pérez, J. C., Dagnino, P., ... Reyes, L. (2009). Cuatro terapias psicodinámicas breves exitosas estudiadas a través de los indicadores genéricos de cambio. *Revista Argentina de Clínica Psicológica*, 18, 5–19.

## Background

Brief dynamic psychotherapy has been increasingly important in the actual clinical practice. For its brevity focalization must be accomplished.

Although the usefulness and the necessity of the focus are accepted, there are many and different conceptualizations of focus. The Operationalized Psychodynamic Diagnosis System (OPD-2) was used for focus identification: relational pattern, internal conflictual configuration and structural vulnerabilities.

The study on foci and the relation between them becomes a research and clinical imperative. But also, the study of the process is of fundamental importance for advancing the science of psychotherapy, for this, change on foci must be considered. Focus can be expected to evolve, transform, or change during a therapeutic process and to have an effect on patient’s change according to the way the therapist and the patient interact.

More than studying the whole session, significant segments can be identified and researched upon. Therefore, the delimitation of episodes of change are necessary.

In sum, when considering the psychotherapy process research reflections about the study of relevant episodes within the session and throughout the process, it can be expected that the foci may evolve, transform, or change. No studies have been found that examine the foci, their relationship and their trajectory during the therapeutic process and not even their change during relevant episodes. Due to these observations and because of their importance for clinical practice, the foci will be studied in this thesis.

## Research questions

Which are the foci that therapist and patients work on in natural settings. Will the foci relate to each other and in what way? Do they change over the therapeutic process? In which way will the foci change over the course of the process? And will they relate to change?

## Design and method

Multiple single subject design. Change episodes are delimited and OPD Foci are identified for each patient. OPD foci presence is identified in each episode.

Sample: 10 brief dynamic therapies in natural settings

Treatment: Brief dynamic therapies as usual.

## Measures

Operationalized Psychodynamic Diagnosis (OPD-2, Task-Force, 2008)

Generic Change Indicators (GChI, Krause, et al., 2007)

Foci Presence Scale (FPS, Dagnino & de la Parra, 2010)

## Results

With only four processes analyzed, we have found that:

In general, foci presence concentrated more on the middle phase of psychotherapy in comparison to the initial and final phases.

The focus on the dysfunctional relational patterns had more presence during the initial phase. In the case of inner conflict focus its presence was stable during all the phases, and the structural vulnerabilities focus showed that its presence increased through the process.

Regarding the relationship among the types of foci and their subjective change, it was found that during the middle phase the presence of the relational pattern focus and the conflict focus relates to higher levels of subjective change.

## Evaluation

To examine the patient's foci as usual, that is the therapist without the knowledge of the OPD system, is of both clinical and research importance but the examination of the foci throughout the therapeutic process becomes even more important since the study of the process leads to really comprehend how therapy generates changes in patients' difficulties. Therefore, studying the process of foci change is of fundamental importance for advancing in the science of psychotherapy.

The results confronted us with the question about how foci would develop in unlimited dynamic psychotherapies.

Also no observations were made on other segments of the process that would function as control segments (e.g. stuck episodes) or in unsuccessful therapies.

And it would be interesting to identify the foci in patients with a different structural level, and study how the presence of the foci relates with other process variables (alliance, outcome, etc.)

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# An empirical investigation of analytic process: Contrasting a good and poor outcome case

Waldron, S., Gazzillo, F. (2015). Do the processes of psychoanalytic work lead to benefit? Studies by the APS Research Group and the Psychoanalytic Research. *Psychoanalytic Inquiry*. DOI: 10.1080/07351690.2015.987602

Gazzillo, F., Waldron, S., Genova, F., Angeloni, F., Ristucci, C., Lingiardi, V. (2014). An Empirical Investigation of Analytic Process: Contrasting a Good and Poor Outcome Case. *Psychotherapy*.  
<http://dx.doi.org/10.1037/a0035243>

Waldron, S., Gazzillo, F., Genova, F., & Lingiardi, V. (2013). Relational and classical elements in psychoanalyses: An empirical study with case illustrations. *Psychoanalytic Psychology*, 30, 567–600. doi:10.1037/a0033959

## Summary

The aim of this study was to assess the difference in the analytic processes between two patients with similar personality profiles, who were in analysis during the same time, by two analysts with similar training and working in a similar setting. The authors explored the patients' personality and changes with the Global Assessment of Functioning Scale (GAF) and the Shedler–Westen Assessment Procedure-200 (SWAP-200) applied by two pairs of independent raters in 16 sessions (8 sessions from the first month of treatment and 8 sessions from the last month of treatment). In addition, the research group assessed therapeutic processes with the Analytic Process Scales (APS) and the Dynamic Interaction Scales (DIS) applied by three independent raters to 20 sessions, as well as the Helping Alliance Rating Scale (HAR) applied to eight sessions from the beginning of each therapy. The results showed striking differences between the outcomes of these two psychoanalyses that are paralleled by differences in their therapeutic process, i.e. by a better use of classical interventions (clarifications and interpretations centered on conflicts, transference and problematic patterns of emotions and behaviors), together with a more relational approach to the patients (warmer, more straightforward, more subjectively connotated and more emotionally attuned communications). The authors provide verbatim clinical interactions to illustrate these differences and explore the potential implications of these findings.

## Evaluation

The study is based on only two cases and on the assessment of only 20 sessions from an average number of >600 sessions for each treatment, and the authors have not yet collected follow-up data. However, the results of the analysis of 22 additional cases seem to support the data presented (see also Gazzillo et al., 2013; Waldron, Gazzillo, Stukenberg, 2015), giving them greater reliability, and it is the authors' intention to collect follow-up data on most of the treatments considered in this research.

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## Department of Dynamic and Clinical Psychology, “Sapienza” University of Rome: Single cases and process-outcome

Lingiardi, V., Shedler, J., & Gazzillo, F. (2006). Assessing personality change in psychotherapy with the SWAP-200: A case study. *Journal of Personality Assessment*, *86*, 1, 23–32.

Lingiardi, V., Gazzillo, & Waldron, S. (2010). An empirically supported psychoanalysis: The case of Giovanna. *Psychoanalytic Psychology*, *27*, 2, 190-218.

Di Giuseppe M.G., Perry C.J., Petraglia J., Janzen J., & Lingiardi V. (2014). Development of a Q-sort version of the Defense Mechanism Ratings Scales (DMRS-Q) for clinical use. *Journal of Clinical Psychology*, *70*, 5, 452-465.

### Summary

The goal of the first two studies was to show how some empirical instruments for the assessment of personality, defense mechanisms and therapeutic process can be useful both for a more fine-grained and reliable description of the patients' personality and its changes and for a more detailed and precise comprehension of the process factors contributing to a good outcome of an analytic psychotherapy.

In the first study (Lingiardi, Shedler, Gazzillo, 2006) we assessed with the Shedler-Westen Assessment Procedure-200 (SWAP-200; Westen, Shedler 1999a, 1999b) the first ten therapy sessions and the last ten sessions after two years of the treatment of Melania, a patient in her thirties with a borderline personality disorder with histrionic traits and a substance-related disorder. Melania was having a three sessions per week on the couch for two year psychoanalytic psychotherapy. SWAP-200 is a Q-sort measure consisting of 200 jargon-free items describing both healthy and pathological personality traits. The treating clinician, or a trained rater who knows the patient well, has to sort all the SWAP-200 items in 8 different piles according to their level of descriptivity of the patient's personality, and in doing so has to follow a fixed distribution aimed at reducing the possible rater's biases (Block, 1978). An ad hoc computer program translates this assessment in two different personality diagnoses: 1) a PD scale diagnosis following the personality disorders of the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5; APA, 2013) redescribed with the SWAP items by a pool of expert clinicians, plus an high-functioning scale; 2) a Q-factor empirically derived taxonomy of personality pathology based on the SWAP description of real patient with personality disorders. Both the PD scale and Q-factor diagnosis are dimensional (the computer specifies in what measure the patient assessed shows the features of each disorder) and categorial (there is a cut-off for giving the full diagnosis of one or more disorders). Moreover, it is possible to use the 30 SWAP items more descriptive of the personality of the patient for developing his/her case formulation. Finally, the qualitative and quantitative comparison between the SWAP items that are more descriptive of the patient's personality in the different periods of a psychotherapy enables a fine-grained understanding of the personality dimensions more (and less) affected by the therapeutic process. The SWAP assessment of Melania conducted by two independent raters showed how her therapy facilitated a substantial improvement in her personality functioning: after two years of treatment, Melania showed no personality disorder and a dramatic increase of her high-functioning capacities, and her SWAP assessment enabled a sophisticated description of the changes of her personality facilitated by her psychotherapy.

The other empirically supported single case study (Lingiardi, Gazzillo, Waldron, 2010) is the case of Giovanna, a patient in her late twenties with obsessional traits and significant difficulties in intimate relationships. Giovanna, such as Melania, was having a three sessions per week on the couch psychoanalytic psychotherapy. In the case of Giovanna, we assessed 20 transcribed sessions: the first 4, 4 after 6 month, 4 after 12 months, 4 after 18 months and 4 after 24 month. The first 4 sessions, the 4 sessions from the 12<sup>th</sup> month and the 4 sessions after the 24<sup>th</sup> month were assessed with the SWAP-

200. Moreover, all the sessions were also assessed with other two instruments: the Defense Mechanism Rating Scale (DMRS; Perry, 1990) and the Analytic Process Scales (APS; Waldron et al., 2004a, 2004b). The DMRS provide a qualitative and quantitative profile of the defense mechanism more used by the patient and of her overall level of functioning according to a hierarchy of defense levels going from an action level to a mature level, passing for a denial, borderline, narcissistic, neurotic and obsessional level. The APS, finally, enable the assessment of both the patient and the therapist contributions to the therapeutic process and of the quality of their participation to the process itself. The application of these empirical tools to the case of Giovanna showed a substantial improvement in her personality functioning and defense maturity and suggested that this improvement could have been facilitated by the explorative interventions of the therapist (clarification and interpretation of conflicts) and by the overall quality of the analyst interventions and his being attuned to the patient's feeling.

Since 2011, in collaboration with the Analytic Process Scales Study Group and the Psychoanalytic Research Consortium (PRC) of New York directed by Sherwood Waldron, Francesco Gazzillo and Vittorio Lingiardi with their research group have started a broader study on the empirical assessment of process and outcome of psychoanalysis. This research project is based on the systematic assessment of 20 audiotaped and transcribed sessions of each of the 31 psychoanalytic treatments of the PRC: the first 4, 4 from the 6th month of treatment, 4 from the middle of the therapy, 4 from the 6th week before the termination and the last 4 sessions of each treatment. The first 4+4 sessions are assessed by two independent raters with the Helping Alliance Rating Method (HAR; Luborsky, 1976), the Global Assessment of Functioning Scale (GAF; APA, 2000), and by other two independent raters with the SWAP-200, as well as the Personality Health Index (PHI) and RADIO categories (two SWAP related indexes developed by the APS study group for assessing the level of personality health and some specific personality functioning domains; see Waldron et al., 2011). The last 4+4 sessions are assessed with the same instruments, but not with the HAR. All the sessions are assessed by three independent raters with the APS and the Dynamic Interaction Scales (DIS; Waldron, Gazzillo, Genova, & Lingiardi, 2013). The DIS are twelve rating scales aimed at the empirical assessment of relational and interactional features of patient, therapist and therapeutic couple contributions to the treatment.

In the study written by Waldron, Gazzillo, Genova, and Lingiardi (2013) we showed the inter-rater reliability of the DIS and the information obtained by their application to two psychoanalytic treatments: the first one is a poor outcome treatment delivered in the seventies by a therapist with an ego psychology orientation, and the second one is a good outcome analysis delivered thirty years later by a therapist with a relational orientation. DIS seem to differentiate correctly the two analytic approaches, and together with the APS seem to suggest that good outcome psychoanalyses are characterized by a more sophisticated use of classical analytic interventions (such as clarifications and interpretations of defenses and conflicts), and a more relational attitude of the therapist, i.e. her/his being more available to show her/his subjective thoughts and feeling, a greater contingency with patient's feelings, etc.

Given that the two patients involved in this first study had different personality profiles and that their treatments were delivered by different therapists, in different periods, with different theoretical orientations and different durations, in another study, written by Gazzillo, Waldron, Genova, Angeloni, Ristucci, and Lingiardi (2014), we compared two psychoanalyses delivered in the same period, with comparable lengths and frequency of sessions, by therapists of the same city, and with the same theoretical orientation, and to patient with a very similar personality profile. One of these treatments had a good outcome, and the second one a poor outcome. Our aim was to verify if the process differences between good and poor outcome psychoanalyses outlined in the 2013 study were confirmed also controlling factors such as the theoretical orientation of the therapist, the frequency of sessions, the length of treatment etc. The results of this study seem to confirm most of the differences highlighted in the first study, showing that good outcome psychoanalyses seem to be characterized by both better classical interventions and a more relational attitude, reducing the contrast between those theoretical and clinical models that stress the therapeutic relevance of an explorative work on

one hand, and those one which stress the therapeutic relevance of the patient-therapist emotional relationship. Moreover, in these two last studies, we have tried to bridge the gap between classical clinical case presentation and empirical assessment of patient and therapies using data derived by both the sources.

Finally, the last report, written by Di Giuseppe, Perry, Petraglia, Janzen, and Lingiardi (2014) is focused on the need to provide clinicians with a reliable and valid measure for detecting patient defense mechanisms “inside psychotherapy.” To avoid the limitations of existing methods, we designed a Q-sort based on the theoretical definitions and criteria of the Defense Mechanisms Rating Scales (DMRS-Q), but one that does not require transcripts of clinical interviews or sessions, and may be applied without specific training on defenses. The DMRS-Q is sensitive to changes in psychotherapy and its scores correlate significantly with various aspects of mental functioning, making it potentially available for the psychotherapy process and outcome research as well. We report the results of using the DMRS-Q on a systematic single case study with the aim of detecting changes in defense mechanisms during a long-term psychodynamic psychotherapy. The DMRS-Q reveals change both in quantitative scores and in the literary Defensive Profile Narrative.

## **Evaluation**

Our goals are identifying the process features of effective psychoanalyses and to outline diagnostic and therapeutic factors that can help us to identify, since the first month of treatment, the analyses that seem not to proceed well. We illustrated a new reliable and valid measure for detecting patient defense mechanisms “inside psychotherapy”; the DMRS-Q is used in the context of a systematic single case.

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# Beneath the surface of the therapeutic interaction: The psychoanalytic method in modern dress

Freedman, N., Lasky, R., & Hurvich, M. (2003). Two pathways towards knowing psychoanalytic process. In M. Leuzinger-Bohleber, A.U. Dreher & J. Canestri (Eds.) *Pluralism and Unity; Methods of Research in Psychoanalysis*, (pp. 207-22). London: International Psychoanalytic Association

Bucci, W. & Maskit, B. (2007) Beneath the surface of the therapeutic interaction; The psychoanalytic method in modern dress. *Journal of the American Psychoanalytic Association*, 55, 1355-1397.

## Summary

The study introduces a multi-perspective approach to the data of the analytic situation, including impressions of the treating analyst, ratings of complete sessions by clinical judges using psychoanalytic criteria, and objective linguistic measures. Our basic hypothesis is that successful analytic treatment involves repeated instances of the referential process, which includes *Arousal* of an emotional experience in the session, a *Symbolizing* phase involving vivid narratives or descriptions and a phase of *Reflection*, in which new emotional meanings may be found. Computerized measures of the referential process were applied to 16 recorded and transcribed psychoanalytic sessions of the third year of an analysis of a female patient with a female analyst. The clinical evaluations represent the impressions of the treating analyst and those of analysts who listened to the tapes or read the transcripts. The ratings were based on qualities referred to by the abstract terms 'A' and 'Z' (Freedman, Lasky & Hurvich, 2003): 'A' qualities are generally associated with productivity; Z qualities with disorganization.

The 16 sessions were run through the DAAP program using Referential Process measures including the Weighted Referential Activity dictionary (WRAD), Reflection (REF) and Disfluency (DF) dictionaries, several dictionaries representing categories of affect and sensory and somatic experience, and several derivative DAAP measures including covariations between pairs of variables. (See *Measures of the Referential Process*, ODR this edition for details of procedures.) Significant correlations with the difference score 'A - Z' were found in the expected direction, for several measures of patient speech, including Mean WRAD ( $r = .538$ ,  $p < .05$ ) and both the REF/WRAD ( $r = -.698$ ,  $p < .01$ ) and DF/REF ( $r = .523$ ,  $p < .05$ ) covariations. Results were also found for analyst speech and for the relation between analyst impressions and session language.

## Evaluation

The claim of this approach is that process research including multiple perspectives has the potential to unite the values of empirical research with a modern version of the psychoanalytic method. The results suggest that computerized referential process measures can be used on session transcripts to gain an overall sense of the productivity of the session. However the study covers only part of a year of a single analysis, so the results, while promising must be considered preliminary. Several studies involving other cases and different sampling procedures are under way applying this approach to other treatments and including outcome assessment.

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# A metasynthesis of published case studies through Lacan's L-schema: Transference in perversion

Willemsen, J., Inslegers, R., Meganck, R., Geerardyn, F., Desmet, M., Vanheule, S. (2015). A metasynthesis of published case studies through Lacan's L-schema: transference in perversion. *International Journal of Psychoanalysis*, in press

This study was produced by members of the Single Case Archive ([www.singlecasearchive.com](http://www.singlecasearchive.com)) and using data from this archive. The Single Case Archive compiles clinical and empirical single case studies on psychoanalytically oriented psychotherapies that were published in ISI-ranked journals.

## Sample

The sample consisted of 11 case studies on the psychoanalytic treatment of sexual perversion, all published in international scientific journals. Case studies on character perversion were not included. All case studies involved adult male subjects between 25 and 49 years old at the start of treatment (in two case studies age was not reported).

## Treatment

The treatment provided in the 11 case studies is individual treatment from various psychoanalytic orientations. For 9 out of 11 case studies treatment duration exceeded 18 months (up to a maximum of 15 years). For one case study treatment duration was 6 months and for another one treatment duration was not mentioned.

## Method

The manuscripts of the published case studies were screened for passages in which the author explicitly discusses an aspect of the transference. These passages were read and re-read and thematically coded. These codes were descriptive and stayed close to the manuscript. Then codes were assigned to the Imaginary or the Symbolic dimension of Lacan's L-schema. In the next step, the codes from the Imaginary and Symbolic axis separately were rearranged into overarching themes. While the formulation of the initial codes was rather descriptive, the final themes were closely adapted to the theoretical terms of the L-schema. A credibility check was performed by the co-authors.

## Results

With regards to the Imaginary axis of transference (i.e., transference as resistance) the results reveal three different ways in which the perverse patient draws the therapist in an unconscious bond against the analytic process: (1) by identifying with the image of child in relation to analyst-mother or analyst-father, by identifying with the image of sexual partner, (2) through fusion with the analyst or by pulling the analyst into the perverse world, and (3) by rivalry as manifested in a power struggle or aggression. In this respect, the treatment of perverse patients is difficult for the analyst, and requires a great deal of tolerance and tenacity.

With regard to the Symbolic axis of transference (i.e., transference as a necessary condition for analytical work), we found that the perverse subject is able to formulate a request for help, is able to suspend the satisfaction derived from the symptom in order to talk about it, question motives for thoughts, feelings and actions, his products of the unconscious and his identity. In terms of the L-schema, this indicates that the analyst can function as a representative of the otherness in the Other in the treatment of such patients.

## Evaluation

This study is among the first metasyntheses of psychoanalytic case studies. This method has great potential when it comes to empirical research in psychoanalysis, especially for psychoanalytic concepts that resist operationalization in quantitative terms. However, the methodology also suffers from several shortcomings. The method is qualitative and descriptive rather than predictive with regard to the treatment of sexual perversion. In other words, based on our results we cannot conclude that focusing on the Symbolic dimension will be effective in the treatment of perversion, or that treating perversion through psychoanalysis will result in a positive outcome. The scientific method of metasynthesis suffers from some limitations. The data of this metasynthesis are accounts and interpretations made by the authors of published case studies. The case studies used alternate between detailed descriptions of therapeutic processes and more abstract elaborations. As a result, our study is based on clinical data from different levels of abstraction. Moreover, the case reports greatly varied in writing style, psychoanalytic orientation and level of detail. While some case studies provide almost no information on transference, others contained abundant information. These different levels of abstraction and quality of information constitute a drawback to this study.

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## A review of basic characteristics of patient, therapist, therapy and research method

Desmet, M., Meganck, R., Seybert, C., Willemsen, J., Geerardyn, F., Dclercq, F., . . . Kächele, H. (2013). Psychoanalytic single cases published in ISI-ranked journals: The construction of an online archive. *Psychotherapy and Psychosomatics*, 82, 120-121.

Single case studies are quintessential for psychoanalytic theory, research and practice. At this moment, however, the field of single case research deals with a lack of surveyability, which hampers the full exploitation of its potentials. This letter presents a review of clinical and empirical single case studies on psychoanalytically oriented psychotherapies that were published in ISI-ranked journals. Briefer psychoanalytic single cases published in journals contrast with longer, book-format cases both at the level of number and vicissitudes. The number of longer cases is limited to a few dozen, the number of smaller cases runs up to a few thousand (cfr. infra); longer cases often surprise us with an almost timeless impact on theory and training, smaller cases tend to disappear in the mass of psychoanalytic literature without noticeable impact. The clinical richness typical for single case data in combination with their large number nevertheless constitutes a unique resource. As in no other data-base, the totality of smaller cases offers an opportunity to study the therapeutic experiences of large numbers of patients and therapists in their full clinical complexity. As such, systematic accumulation of quantitative and qualitative data across homogeneous sets of cases could be an invaluable supplement to classical process-outcome research.

The present state of the field of single case research, however, is characterized by a lack of surveyability and accessibility which hampers every effort to accumulate data across cases. Smaller cases are usually published in journal articles, sometimes as the focus of the article, other times as illustrations in the course of conceptual or technical accounts. Abstracts of these articles frequently lack detailed information about the case. They often only mention that a clinical case is presented, without giving further specification. Even if the case is the focus of the article, authors are often unable to compile all relevant information in the limited format of an article abstract. Consequently, researchers and clinicians that apply standard search procedures in electronic databases are at risk of missing a substantial portion of the single cases relevant to their research questions or clinical issues. Under these conditions, screening of full article texts becomes necessary for selection of a comprehensive set of single cases. This state of affairs makes the search for smaller cases a time-consuming and discouraging enterprise, which is usually neglected or left incomplete. Thus, a fertile field of empirical data is left fallow.

This article therefore presents a tool that facilitates access to the field of smaller single cases. We first selected all single cases published in ISI ranked journals that met a set of inclusion/exclusion criteria; subsequently, basic characteristics of patient, therapist, therapy and research method were screened in every case study. A summary of this screening is presented in this paper. Full results of the screening for all cases separately is presented in an online and permanently updated archive, which also contains the single cases themselves ([www.singlecasearchive.com](http://www.singlecasearchive.com)). The online overview allows the quick identification of relatively homogenous sets of cases in function of specific research question.

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# Clinician reports of personality pathology of patients beginning and patients ending psychoanalysis

Cogan, R., Porcerelli, J.H. (2005). Clinician reports of personality pathology of patients beginning and patients ending psychoanalysis. *Psychology and Psychotherapy: Theory, Research and Practice*, 78, 235-248.

Shedler, J., & Westen, D. (1998). Refining the measurement of Axis II: A Q-sort procedure for assessing personality pathology. *Assessment*, 5, 333-353.

## Summary

The purpose of this work was to use a clinician Q-sort procedure to describe the personality pathology and adaptive functioning of patients beginning and ending psychoanalysis. With a cross-sectional design, Cogan and Porcerelli compared a group of patients beginning and a group of patients ending psychoanalysis. This was the first comprehensive assessment of the personality of patients beginning and patients ending psychoanalysis with a measure that (a) is consistent with Axis II of DSM-IV, (b) includes commonly observed Axis I symptoms which often co-occur with Axis II psychopathology, (c) draws on the expertise of clinicians; and (d) has been psychometrically evaluated in published studies of reliability and validity.

Twenty-six psychoanalysts described a patient beginning psychoanalysis and twenty-eight described a patient ending psychoanalysis using the Shedler–Westen Assessment Procedure 200 (SWAP-200). The SWA-200 is clinically sensitive, reliable, and valid measure of personality disorders, traits, and strengths which harnesses clinician judgments about patients and is consistent with DSM-IV personality disorder categories (Shedler & Westen 1998).

Each clinician also completed questions about themselves, the patient, and the treatment. The most characteristic SWAP-200 items describing patients beginning and patients ending psychoanalysis provide a meaningful picture of the two groups. Among patients at the end of psychoanalysis, scores were significantly lower on the SWAP-200 Paranoid, Schizotypal, Borderline, Histrionic, and Dependent scales and scores were significantly higher on the SWAP-200 High functioning scale and the DSM-IV GAF scale. At the beginning of psychoanalysis, of the 15 most descriptive items, 10 items concerned internal struggles (afraid of rejection or abandonment, guilty, feels inadequate, unhappy, self critical, anxious, competitive, ashamed, submissive, and creates situations that lead to unhappiness). In contrast, at the end of psychoanalysis, of the 15 most descriptive items, four concerned positive aspects of work (satisfaction in pursuing long-term goals, pleasure in accomplishing things, able to use talents effectively, and contentment in life's activities), three concerned positive relationships with others (fulfilment in mentoring, empathic, able to assert appropriately), and three concerned resilience (resolution of painful experiences from the past; can hear and benefit from hearing emotionally threatening information, and able to recognize alternative viewpoints even when strong feelings are involved).

## Evaluation

The findings demonstrate the usefulness of a clinician report measure for the study of psychoanalytic psychotherapy and psychoanalysis. The SWAP-200 allows for the assessment of personality pathology and strengths and also allows for a rank ordering of both pathological and adaptive characteristics.

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# Department of Dynamic and Clinical Psychology, “Sapienza” University of Rome: Single cases and process-outcome

Lingiardi, V., Gazzillo, & Waldron, S. (2010), An empirically supported psychoanalysis: The case of Giovanna. *Psychoanalytic Psychology*, 27, 2, 190-218.

Waldron, S., Gazzillo, F., Genova, F., & Lingiardi, V. (2013). Relational and classical elements in psychoanalysis: An empirical study with case illustrations. *Psychoanalytic Psychology*, 30,4, 567-600

Gazzillo, F., Waldron, S., Genova, F., Angeloni, F., Ristucci, C., & Lingiardi V. (2014). An empirical investigation of analytic process: Contrasting a good and poor outcome case. *Psychotherapy*, 51, 2, 270-282.

Di Giuseppe M.G., Perry C.J., Petraglia J., Janzen J., & Lingiardi V. (2014). Development of a Q-sort version of the Defense Mechanism Ratings Scales (DMRS-Q) for Clinical Use. *Journal of Clinical Psychology*, 70, 5, 452-465.

## Summary

The goal of the first two studies was to show how some empirical instruments for the assessment of personality, defense mechanisms and therapeutic process can be useful both for a more fine-grained and reliable description of the patients' personality and its changes and for a more detailed and precise comprehension of the process factors contributing to a good outcome of an analytic psychotherapy.

In the first study (Lingiardi, Shedler, Gazzillo, 2006) we assessed with the Shedler-Westen Assessment Procedure-200 (SWAP-200; Westen, Shedler 1999a, 1999b) the first ten therapy sessions and the last ten sessions after two years of the treatment of Melania, a patient in her thirties with a borderline personality disorder with histrionic traits and a substance-related disorder. Melania was having a three sessions per week on the couch for two year psychoanalytic psychotherapy. SWAP-200 is a Q-sort measure consisting of 200 jargon-free items describing both healthy and pathological personality traits. The treating clinician, or a trained rater who knows the patient well, has to sort all the SWAP-200 items in 8 different piles according to their level of descriptivity of the patient's personality, and in doing so has to follow a fixed distribution aimed at reducing the possible rater's biases (Block, 1978). An ad hoc computer program translates this assessment in two different personality diagnoses: 1) a PD scale diagnosis following the personality disorders of the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5; APA, 2013) redescribed with the SWAP items by a pool of expert clinicians, plus an high-functioning scale; 2) a Q-factor empirically derived taxonomy of personality pathology based on the SWAP description of real patient with personality disorders. Both the PD scale and Q-factor diagnosis are dimensional (the computer specifies in what measure the patient assessed shows the features of each disorder) and categorial (there is a cut-off for giving the full diagnosis of one or more disorders). Moreover, it is possible to use the 30 SWAP items more descriptive of the personality of the patient for developing his/her case formulation. Finally, the qualitative and quantitative comparison between the SWAP items that are more descriptive of the patient's personality in the different periods of a psychotherapy enables a fine-grained understanding of the personality dimensions more (and less) affected by the therapeutic process. The SWAP assessment of Melania conducted by two independent raters showed how her therapy facilitated a substantial improvement in her personality functioning: after two years of treatment, Melania showed no personality disorder and a dramatic increase of her high-functioning capacities, and her SWAP assessment enabled a sophisticated description of the changes of her personality facilitated by her psychotherapy.

The other empirically supported single case study (Lingiardi, Gazzillo, Waldron, 2010) is the case of Giovanna, a patient in her late twenties with obsessional traits and significant difficulties in intimate relationships. Giovanna, such as Melania, was having a three sessions per week on the couch psychoanalytic psychotherapy. In the case of Giovanna, we assessed 20 transcribed sessions: the first

4, 4 after 6 month, 4 after 12 months, 4 after 18 months and 4 after 24 month. The first 4 sessions, the 4 sessions from the 12<sup>th</sup> month and the 4 sessions after the 24<sup>th</sup> month were assessed with the SWAP-200. Moreover, all the sessions were also assessed with other two instruments: the Defense Mechanism Rating Scale (DMRS; Perry, 1990) and the Analytic Process Scales (APS; Waldron et al., 2004a, 2004b). The DMRS provide a qualitative and quantitative profile of the defense mechanism more used by the patient and of her overall level of functioning according to a hierarchy of defense levels going from an action level to a mature level, passing for a denial, borderline, narcissistic, neurotic and obsessional level. The APS, finally, enable the assessment of both the patient and the therapist contributions to the therapeutic process and of the quality of their participation to the process itself. The application of these empirical tools to the case of Giovanna showed a substantial improvement in her personality functioning and defense maturity and suggested that this improvement could have been facilitated by the explorative interventions of the therapist (clarification and interpretation of conflicts) and by the overall quality of the analyst interventions and his being attuned to the patient's feeling.

Since 2011, in collaboration with the Analytic Process Scales Study Group and the Psychoanalytic Research Consortium (PRC) of New York directed by Sherwood Waldron, Francesco Gazzillo and Vittorio Lingiardi with their research group have started a broader study on the empirical assessment of process and outcome of psychoanalysis. This research project is based on the systematic assessment of 20 audiotaped and transcribed sessions of each of the 31 psychoanalytic treatments of the PRC: the first 4, 4 from the 6<sup>th</sup> month of treatment, 4 from the middle of the therapy, 4 from the 6<sup>th</sup> week before the termination and the last 4 sessions of each treatment. The first 4+4 sessions are assessed by two independent raters with the Helping Alliance Rating Method (HAR; Luborsky, 1976), the Global Assessment of Functioning Scale (GAF; APA, 2000), and by other two independent raters with the SWAP-200, as well as the Personality Health Index (PHI) and RADIO categories (two SWAP related indexes developed by the APS study group for assessing the level of personality health and some specific personality functioning domains; see Waldron et al., 2011). The last 4+4 sessions are assessed with the same instruments, but not with the HAR. All the sessions are assessed by three independent raters with the APS and the Dynamic Interaction Scales (DIS; Waldron, Gazzillo, Genova, & Lingiardi, 2013). The DIS are twelve rating scales aimed at the empirical assessment of relational and interactional features of patient, therapist and therapeutic couple contributions to the treatment.

In the study written by Waldron, Gazzillo, Genova, and Lingiardi (2013) we showed the inter-rater reliability of the DIS and the information obtained by their application to two psychoanalytic treatments: the first one is a poor outcome treatment delivered in the seventies by a therapist with an ego psychology orientation, and the second one is a good outcome analysis delivered thirty years later by a therapist with a relational orientation. DIS seem to differentiate correctly the two analytic approaches, and together with the APS seem to suggest that good outcome psychoanalyses are characterized by a more sophisticated use of classical analytic interventions (such as clarifications and interpretations of defenses and conflicts), and a more relational attitude of the therapist, i.e. her/his being more available to show her/his subjective thoughts and feeling, a greater contingency with patient's feelings, etc.

Given that the two patients involved in this first study had different personality profiles and that their treatments were delivered by different therapists, in different periods, with different theoretical orientations and different durations, in another study, written by Gazzillo, Waldron, Genova, Angeloni, Ristucci, and Lingiardi (2014), we compared two psychoanalyses delivered in the same period, with comparable lengths and frequency of sessions, by therapists of the same city, and with the same theoretical orientation, and to patient with a very similar personality profile. One of these treatments had a good outcome, and the second one a poor outcome. Our aim was to verify if the process differences between good and poor outcome psychoanalyses outlined in the 2013 study were confirmed also controlling factors such as the theoretical orientation of the therapist, the frequency of sessions, the length of treatment etc. The results of this study seem to confirm most of the differences highlighted in the first study, showing that good outcome psychoanalyses seem to be characterized by

both better classical interventions and a more relational attitude, reducing the contrast between those theoretical and clinical models that stress the therapeutic relevance of an explorative work on one hand, and those one which stress the therapeutic relevance of the patient-therapist emotional relationship. Moreover, in these two last studies, we have tried to bridge the gap between classical clinical case presentation and empirical assessment of patient and therapies using data derived by both the sources.

Finally, the last report, written by Di Giuseppe, Perry, Petraglia, Janzen, and Lingiard (2014) is focused on the need to provide clinicians with a reliable and valid measure for detecting patient defense mechanisms “inside psychotherapy.” To avoid the limitations of existing methods, we designed a Q-sort based on the theoretical definitions and criteria of the Defense Mechanisms Rating Scales (DMRS-Q), but one that does not require transcripts of clinical interviews or sessions, and may be applied without specific training on defenses. The DMRS-Q is sensitive to changes in psychotherapy and its scores correlate significantly with various aspects of mental functioning, making it potentially available for the psychotherapy process and outcome research as well. We report the results of using the DMRS-Q on a systematic single case study with the aim of detecting changes in defense mechanisms during a long-term psychodynamic psychotherapy. The DMRS-Q reveals change both in quantitative scores and in the literary Defensive Profile Narrative.

## Evaluation

The aims of the first two studies were to show how it is possible and useful to bridge the gap between the classical descriptions of the clinical cases developed from the perspective of the therapists and their empirical assessment with well validated dynamic empirical tools. This integrative strategy may have several advantages: clinically sensitive empirical tools may help the therapist to have a more precise picture of what happens in the therapeutic process and how the process affects – or do not affect – patients; on the other hand, nuanced clinical descriptions may help the researchers to identify relevant dimensions of psychopathology and psychotherapy yet uninvestigated or underinvestigated from an empirical perspective. In the other two studies, which are part of a research project that will be completed in 2015, we have expanded this strategy applying it to a larger sample of recorded therapies with both good and poor outcomes. Our goals are identifying the process features of effective psychoanalyses and to outline diagnostic and therapeutic factors that can help us to identify, since the first month of treatment, the analyses that seem not to proceed well. The fifth study illustrated a new reliable and valid measure for detecting patient defense mechanisms “inside psychotherapy”; the DMRS-Q is used in the context of a systematic single case.

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# Assessing personality change in psychotherapy with the SWAP–200: A case study

Lingiardi, V., Shedler, J., Gazzillo, F. (2006). Assessing personality change in psychotherapy with the SWAP–200: A case study. *Journal of Personality Assessment*, 86(1), 23–32.

Westen, D., & Shedler, J. (1999a). Revising and assessing Axis II, Part I: Developing a clinically and empirically valid assessment method. *American Journal of Psychiatry*, 156, 258–272.

Westen, D., & Shedler, J. (1999b). Revising and assessing Axis II, Part II: Toward an empirically based and clinically useful classification of personality disorders. *American Journal of Psychiatry*, 156, 273–285.

## Brief Summary

Many studies document the efficacy of psychotherapy for acute syndromes such as depression, but less is known about personality change in patients treated for personality pathology. The Shedler–Westen Assessment Procedure (SWAP–200; Westen & Shedler, 1999a, 1999b) is an assessment tool that measures a broad spectrum of personality constructs and is designed to bridge the gap between the clinical (idiographic) and empirical (nomothetic) traditions in personality assessment.

In this single case study, Lingiardi, Shedler and Gazzillo demonstrate the use of the SWAP–200 as a measure of change in a case study of a patient diagnosed with borderline personality disorder.

A total of 10 consecutive therapy sessions from early in the treatment and 10 consecutive therapy sessions from late in treatment were tape recorded and transcribed. Two clinical judges reviewed transcripts of the first 10 psychotherapy sessions and provided SWAP–200 descriptions of the patient based on the information available in the transcripts. After 2 years of psychotherapy, the assessment procedure was repeated.

## Evaluation

The findings illustrate the personality processes targeted in intensive psychotherapy for borderline personality. Those findings are highly suggestive and point the way toward research strategies that can reliably address a wide range of clinically relevant personality constructs. The methods the authors described in this article represent one step in the direction of integrating the clinical and empirical traditions in personality assessment.

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# Outcomes of psychoanalytical crisis interventions after prenatal diagnostics

Leuzinger-Bohleber, M., Belz, A., Caverzasi, E., Fischmann, T., Hau, S., Tsiantis, J., & Tzavaras, N. (2008). Interviewing women and couples after prenatal and genetic diagnostics. In M. Leuzinger-Bohleber, E.-M. Engels & T. Tsiantis (Eds.), *The Janus Face of Prenatal Diagnostics. A European Study Bridging Ethics, Psychoanalysis, and Medicine* (pp. 151-218). London: Karnac Books.

Leuzinger-Bohleber, M. (2013). The Medea fantasy: An evitable burden during prenatal diagnostics? Psychoanalysis, gender and medicine in dialogue. In I. Moeslein-Teising & F. Thomson Salo (Eds.), *The Female Body. Inside and Outside* (pp. 129-151). London: Karnac Books.

## Summary

In the frame of a large EU wide study we developed a specific form of crisis interventions and studied their outcome:

First a short summary of the complete study: Achievements in genetic research produce ethical and moral dilemmas which need to be the subject of reflection and debate in modern societies. Moral dilemmas are seen as situations in which a person has a strong moral obligation to choose each of two alternatives for action, but cannot fulfill both. Denial of ambivalences that moral dilemmas arouse constitutes a threat to societies as well as to individual persons. The EU wide study "*Ethical Dilemmas Due to Prenatal and Genetic Diagnostics*" (016716-EDIG), which was performed from 2005-2008, tried to investigate these dilemmas in detail in a field which seems particularly challenging: prenatal diagnostics (PND). The existence of PND confronts women and their partners with a variety of moral dilemmas: Should they make use of this technique at the risk of hurting the fetus by the technique itself or by being possibly confronted with the decision for or against the termination of pregnancy? Once they have undergone PND, data regarding abnormalities confront women and their partners with moral dilemmas regarding the decision on the life or death of the unborn child, the responsibility for the unborn child, for its well being even with abnormalities and its possible suffering and so on. An important aspect is the conflict of individual beliefs and obligations and those of society's specific cultures. These dilemmas have not received full attention in our societies and often remain latent, creating a source of distress for women (and partners) and may be a burden on the relationships. Some couples show better coping capabilities, particularly if support by competent professionals is available. However, more research is needed to identify those with vulnerability to psychopathology as a consequence to abortion after PND results or to giving birth to severely handicapped children. Pathology sometimes appears not until years after the decision. Our study was a step in this direction.

The study described existing care systems across participating centres in Germany, Greece, Israel, Italy, Sweden and the United Kingdom. Data was collected in 2 sub-studies. All results were integrated into a discourse on ethical dilemmas. Study (A) recruited two groups of couples (positive or negative PND, total n= 1687). Experiences with PND and connected dilemmas have been explored (questionnaires, interviews). Results have been discussed in interdisciplinary research groups. Study (B) interviewed psychoanalysts and their long-term patients who showed severe psychopathologies as reactions to the dilemmas mentioned. Results of the study help to discuss possible protective and risk factors for women/couples undergoing PND. The results and perspectives for training have been discussed with participating couples, experts, the general public, and politicians in order to develop culturally fair connected clinical practice in this field within the EU, taking into account cultural and religious differences.

The EDIG study offered a unique chance for a multidisciplinary dialogue between ethicists, psychoanalysts, medical doctors, philosophers and cultural anthropologists. Another innovative aspect was the possibility that relatively detailed interviews with women/couples after PND as well as the empirical findings based on large scale questionnaire data could be used by different authors looking at them from different disciplinary and cultural perspectives.

We also could show that women/couples who accepted psychoanalytical crisis interventions during the decision phase after a positive finding of prenatal diagnostics showed less frequently depressions after 8 months (measured e.g. by the Hospital Anxiety and Depression Scale, HADS) than those who had not accepted any help (see Fischmann et al, 2008).

As for the counselling aspect in prenatal diagnostics, one important finding in our study was that the majority was pleased with the fact that professionals left the decision to them, thus stressing that a non-directive approach is preferable. Nevertheless, our data showed that the processing of the decision they made does not end with the act itself, but reminders catch up with them continuously, even though none of the participants thought she had made a wrong decision. So, what one can see here is the ambivalence, and one might go further and say a dilemma, caused by a simple prenatal test, seen in the predominant answer given: “there is no right decision to make in a situation like this”. Individuals are left alone with this and one has to respect their wish to decide by themselves, but support should be offered and given on an individual basis and not programmatically, taking each and every personality into account.

## **Evaluation**

In this European wide large interdisciplinary study an outcome study of psychoanalytical crisis interventions was included. Women who had accepted such a crisis intervention before deciding for an abortion of their handicapped embryo less frequently developed a serious depression 8 months after the interruption of the pregnancy (according to HADS).

These results motivated us to develop a liaison service with a large gynaegological clinic in Frankfurt offering women/ couples psychoanalytical crisis interventions mostly directly in the hospital during the decision phase after a positive finding in prenatal diagnostics (see Leuzinger-Bohleber, in press).

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# Systematic case studies of psychoanalyses with chronic depressed within the frame of the LAC Depression Study

Leuzinger-Bohleber, M. (in press): Working with severely traumatized, chronic depressed patients. International Journal of Psychoanalysis

Leuzinger-Bohleber, M. (2014): Depression and trauma: the psychoanalysis of a patient suffering from chronic depression. In: Altmann, M.(Ed.) Time for Change. London: Karnac, p.122 ff.

## Summary

Surprisingly often in the psychoanalyses of chronically depressed patients, depression represents an unconscious attempt to psychically cope with unbearable psychic pain following severe traumatisation: dissociative states, a chronified psychic state of shock, a disappearance of emotions, an emptying of the self and the object relationships, as well as a disappearance of the psyche in the body are among the possible consequences. The treatment of these difficult groups of analysands can also frequently bring analysts to the limits of the endurable. Often related to this is the repeated danger of denying the trauma, and a re-traumatisation of the analysand in the analytic situation.

This systematic clinical case study discusses the fact that in comparison with other therapeutic approaches, psychoanalysis disposes over a highly differentiated conceptualisation of the psychic determinants and the treatment of chronic depression. However, in order to retain its creativity and innovation as a scientific discipline and to be thus perceived in the non-psychoanalytic world, it must constantly further develop its conceptualization by way of systematic and extra-clinical research as is witnessed in the insufficient conceptual account of severe traumatisation during the genesis of

chronic depression. In this connection, several exemplary examples from extra-clinical studies in the sphere of psychotherapeutic research, neurobiology, epigenetics and embodied cognitive science will be accounted for. As will be treated in the final part of this paper, of no less importance are the conceptualizations in *clinical* research on psychoanalysis, which are based on meticulous, careful analyses of trauma reactivation in the transference, and understanding and working through them in the psychoanalytic relationship.

This systematic clinical case study is based on expert validations within the frame of the LAC Depression Study (see psychoanalytical expert validation, LAC Depression study). Similar expert validated systematic clinical case studies are in preparation.

## Evaluation

The systematic clinical case studies within the frame of the large extraclinical LAC Depression Study have proven to be fruitful to communicate the clinical experiences with this difficult to treat group of patients. Book publications with several case studies in German and English are in preparation.

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## Further psychoanalytical studies

## The Geneva Early Childhood Stress Project: The effects of maternal interpersonal violence-related posttraumatic stress on the parent-toddler relationship and subsequent child social-emotional development

Schechter, D. S., Suardi, F., Manini, A., Cordero, M., Sancho Rossignol, A., Gex-Fabry, . . . Rusconi Serpa, S. (2014). How do maternal PTSD and alexithymia interact to impact maternal behaviour? *Child Psychiatry and Human Development*.

Moser, D.A., Aue, T., Favez, N., Kutlikova, H., Suardi, F., Cordero, M.I., Rusconi, S., Schechter, D.S. (2014 epub July 25). Violence-related PTSD and neural activation when seeing emotional male-female interactions. *Social, Cognitive, and Affective Neuroscience*.

Schechter, D.S., Moser, D.A., Reliford, A., McCaw, J.E., Coates, S.W., Turner, J.B., Rusconi, S., Willheim, E. (2015 epub Feb 20). Negative and distorted attributions towards child, self, and primary attachment figure, among posttraumatically stressed mothers: What changes with Clinical Assisted Videofeedback Exposure Sessions (CAVES)? *Child Psychiatry and Human Development*, 46(1), 10-20.

Schechter, D.S., Rusconi-Serpa, S. (2014). Understanding how traumatized mothers process their toddlers' affective communication under stress: Towards preventive intervention for families at high risk for intergenerational violence. In Emde R, M & Leuzinger-Bohleber (Eds). *Early Parenting Research and Prevention of Disorder: Psychoanalytic Research at Interdisciplinary Frontiers* (pp. 90-118). London: Karnac Books..

The Geneva Early Childhood Stress Project (GECS-Pro) Phase 1 was officially launched in 2010 at the Research Unit of the Child and Adolescent Psychiatry Service, Department of Pediatrics, University of Geneva Hospitals and Faculty of Medicine. The GECS-Pro is funded by the Swiss National Science Foundation as part of the National Center for Competence in Research on the Synaptic Bases of Mental Disorders (NCCR-SYNAPSY) as well as the Gertrude von Meissner, Prim'Enfance and the Oak Foundations. The GECS-Pro is a prospective longitudinal study that in Phase I (2010-2014) has included over 100 mothers of children ages 12-42 months. The study focus is to understand how maternal interpersonal violence exposure and related posttraumatic stress disorder (PTSD) affects the mother-child relationship particularly with respect to mutual affect regulation and the development of self-regulation of affect, arousal, and aggression in the child. The project examines psychological, behavioral physiologic, neuroimaging, and epigenetic data of both mother and children individually and in interaction in an effort to identify potential endophenotypic differences that contribute to the intergenerational transmission of violence and related psychopathology. A second focus of the GECS-Pro is to understand how child displays of negative affect, helplessness, and dysregulation impact the traumatically stressed parent, her mental representations of the child marked by her attributions to the child's personality, and her caregiving behavior. Related to this second focus, we have further developed an experimental intervention technique the Clinician Assisted Videofeedback Exposure Session(s) or « CAVES » that had been developed as part of the principal investigators prior IPA-funded research in New York. This intervention is being further developed into a 12-16-session manualized brief psychotherapy the Clinician Assisted Videofeedback Exposure-Approach Therapy or « CAVEAT ». While the GECS-Pro Phase 1 will be ending recruitment in December, 2014, Phase 2 will be beginning in the spring, 2015 which will focus on longitudinal follow-up the children from Phase 1 at ages 5-9 years in an effort to identify individual differences with respect to aggressive versus anxious-depressed behaviors and symptoms. A second planned project within Phase 2 involves a controlled trial of the CAVEAT with a new cohort of 30 mothers and children ages 12-42 months.

## Methods/design

In Phase 1, Each mother-child pair was evaluated and videotaped over the course of a screening session plus 2 evaluation sessions and the CAVES session.

## Measures included

Screening visit : Geneva Socio-Demographic and Treatment History Questionnaire, Traumatic Life Events Questionnaire, Brief Physical and Sexual Abuse Questionnaire, Symptom Checklist-90

Maternal interview : Working Model of the Child Interview with Reflective Functioning Probes (WMCI-RF), Clinician Administered PTSD Scale (CAPS), Structured Interview for the DSM-IV (SCID) Mood Disorders Module, PTSD Symptom Checklist-Short Version, Beck Depression Inventory-II, Hopkins Dissociative Symptom Checklist

Mother-child visit : Modified Crowell Parent-Child Interaction Procedure with serial salivary cortisol and DNA sampling and coding via the CARE-Index (done) and AMBIANCE (planned), Infant-Toddler Social-Emotional Assessment (ITSEA), Disturbances of Attachment Interview, Parenting Stress Index—Short Form, Ages and Stages Questionnaire

CAVES : CAVES Semi-structured Interview, Maternal Attributions Rating Scale (MARS), WMCI-RF selected items, the Personality Disorders Questionnaire-4 (PDQ-.4)

The majority of mothers were eligible for and participated also in an fMRI scanning session that included a Hamilton Anxiety Scale and a Post-MRI Interview about their reaction to fMRI silent film stimuli.

All mothers were recontacted one year after their participation in the study to complete the Reflective-functioning Questionnaire and the Child Behavior Checklist

Methods/design : In Phase 2, Each child will be evaluated and videotaped over the course of 2 evaluation sessions. Measures will included : The MacArthur Story-Stem Battery with Mentalization Subscale, the Test for Emotional Comprehension, the Traumatic Events Screening Inventory—Child Version (TESI-C), the Schizophrenia and Affective Disorders Schedule—Child Version (K-SADS), the Child Dissociative Checklist, the Trier Social Stress Test for Children with salivary cortisol and DNA sampling, EEG with affect matching task, the Victim-Bullying Questionnaire

## Results of GECS-Pro Phase 1

Most recently, the Geneva Early Childhood Stress Project (Schechter et al., 2014; Moser et al., 2014 ; Schechter & Rusconi-Serpa, 2014) has found the following:

1. maternal IPV-PTSD severity is correlated with maternal alexithymia and that both are positively correlated with parenting stress and negatively correlated with maternal sensitivity (Schechter et al., 2014).
2. both maternal IPV-severity and parenting stress are negatively correlated with the mean percentage of methylation of the NR3C1 gene for the glucocorticoid receptor (Schechter et al., submitted).
3. low cortisol baselines in mothers and low cortisol reactivity to laboratory stressors (i.e. separation and exposure to novelty) in the children (ages 12-42 months) (Preliminary analyses reported: Schechter DS. Understanding how traumatized mothers process their toddlers' affective communication under stress: Towards preventive intervention for families at high risk for intergenerational violence. Symposium on Attachment and Psychopathology in Families at Risk (Ute Ziegenhain, Chair; Klaus Schmeck, discussant). European Congress of Developmental Psychology, Lausanne, 6-9-2013. Final analyses are pending.

4. IPV-PTSD mothers' toddlers show a significantly lower stress response than those of non-PTSD mothers (ref). And IPV-PTSD mothers' neural activity in response to a) child-parent separation vs. play and b) adult male-female interactions that are menacing vs. neutral vs. prosocial both reflect cortico-limbic dysregulation with less ventro-medial prefrontal cortical activity among PTSD mothers than non-PTSD mothers (Moser et al., submitted; Moser et al., 2014).

5. children of IPV-PTSD mothers vs. non-PTSD mothers from 12-42 months and then from 24-54 months, show a) greater attachment disturbances, and b) less cooperativeness during play with mother on observational measures, and c) greater internalizing and externalizing behavior on maternal report measures. (Preliminary analyses reported: Schechter DS. Understanding how traumatized mothers process their toddlers' affective communication under stress: Towards preventive intervention for families at high risk for intergenerational violence. Symposium on Attachment and Psychopathology in Families at Risk (Ute Ziegenhain, Chair; Klaus Schmeck, discussant). European Congress of Developmental Psychology, Lausanne, 6-9-2013. Final analyses are pending.

6. maternal PTSD severity is correlated significantly with negativity of maternal attributions towards her child, her primary attachment figure from childhood, and herself with only a significant decrease in negativity of attributions towards her child over the course of the 3-session evaluation that includes a CAVES (single-session) (see Schechter et al., 2014)

## Discussion

We are using an approach towards evaluating violence and maltreatment-exposed mothers and their children from early childhood on that involves an integration of psychoanalytically-informed, psychiatric, and developmental neuroscientific measures in order to characterize risk and resilience with respect to the intergenerational transmission of violence and related psychopathology and determinants of individual differences. We are also developing and evaluating parent-child videofeedback-based interventions that are targeted to supporting maternal affect regulation and reflective functioning upon clinician-assisted exposure to child negative affect, helpless states, and distress that in the context of maternal PTSD might well otherwise have been avoided. Outcomes include change of the quality of maternal attributions

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# The Montevideo study of attachment and narratives

Altmann de Litvan, M. (2015) Underlying structures of mother-infant interaction at brief psychotherapeutic processes. (Estructuras relacionales subyacentes en procesos psicoterapéuticos breves madre-infante). En prensa.

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Altmann de Litvan, M.; Procopio, R.; & Szteren, L. (2014). Intervenciones en psicoterapia madre-bebé tendientes a disminuir el riesgo de un apego inseguro. En Torres, B.; Causadioas, J.; & Posadas, G. (2014). La teoría del apego: investigación y aplicaciones clínicas. Psimatica Editorial S.L. ISBN: 9788488909879.

## Brief Summary

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.

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. 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 behavior with emotions and by verbal expressing of emotions. 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. The analysis of the text material utilizes the Cycles Model Program (CM, available from the Ulm Textbank website). 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, following the word block segmentation. Subprojects were:

The study of risk in attachment

The study of productivity in the session according to clinical and empirical criteria

The validation of the Therapeutic Cycles Model into Spanish language

The study of the impact of interventions in the developmental process

The implementation of training programs for health care groups and mothers in the topic of attachment

The Underlying structures of the mother-infant interaction at brief psychotherapeutic processes

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. Patterns of mother-baby interaction for each dyad were found using Box & Jenkins times series analysis. The interchanges that are repeated during the interpersonal communications and can be conceptualized as patterns of interaction –automatic procedures of how to relate with others and the world. These patterns constitute ways of organizing experience; schemes to coordinate affects, ideas, actions, which together with fantasies activate our unconscious processes. The relevance of these patterns for psychotherapy roots in that they are the ports of entry to therapeutic action, to “moments of meeting” that constitute the way to change the mental organization at a procedural level. One year old cases were analyzed in depth at empirical and clinical levels. The authors found that each dyad has a particular and unique pattern of interaction.

## **Evaluation**

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 of 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.

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 vocalize and to touch the baby and also to avoid using abstract words as a means of communicating with the baby.

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## Uruguayan Psychoanalytic Association Research Department: High and low frequency in our psychoanalytic practice today

Altmann, M., Garbarino, A., de Barbieri, A. M., de León, B., Frioni, M., Lamónaca, J., . . . Bernardi, R. (2002). Alta y baja frecuencia en nuestra práctica analítica actual {High and low frequency in our psychoanalytic practice today}. *Revista Uruguaya de Psicoanálisis*, 95, 152-192.

Bernardi, R., Altmann, M., de León, B., De Barbieri, A. M., Garbarino, A., Frioni, M., . . . Telleria, E. (1996). Cambios de la interpretación entre 1960 y 1990 en el psicoanálisis uruguayo. ISSN 1688-7247 (1996). *Revista Uruguaya de Psicoanálisis*, 84-85, 89-102.

### Summary

The most significant change we have discovered is that frequency does not have the central place that it used to. In relation to this we found two tendencies among analysts: One that establishes a direct relation between high frequency and analytic process. This is produced in high frequency treatments and it is a necessary condition and another one that places frequency as a factor in the definition of the analytic process, but does not determine it. It is not a necessary condition. For both tendencies of opinion, high frequency does not determine the production of the analytic process. It is also important to remark that both tendencies coexist many times in the discourse of an analyst. The hypothesis that analytic process is favored by high frequency was confirmed, so did the work with the transference.

The ideal model in our work is still the high frequency one, while the real model tends to low frequency in the sessions. Analysts point out and/or think that other parameters are important (transference, regression, neutrality) when we want to define an analytic process.

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# Psychoanalytic Practice in Latin America

Parada Franch, N., & Altmann de Litvan, M. (2006). La formación analítica y la actividad analítica profesional en América Latina. [The relation between analytical training and professional activity in Latin America]. *Sub-comité de Educación Investigación de FEPAL*.

Marucco, N., Devoto, T., Altmann de Litvan, M., Mion, C., Yamhure, E., Passos, M., . . . Baptista Franca, J. (2012-2014). Cómo ven los analistas el futuro del psicoanálisis en América Latina. Estudio cualitativo. {How do psychoanalysts see the future of psychoanalysis in Latin America?}. *Comité de Educación de FEPAL*.

## Summary

Psychoanalysts and candidates (more than 200) from all Latin American societies and groups participated on a survey (representative sample) that aimed to gather their opinions and experiences about several aspects of their training and their professional practice.

This study found that in some Latin American countries, psychoanalysts –more than candidates- had a negative perspective of the future of psychoanalysis in their country.

This finding was the root to develop the qualitative study “How do psychoanalysts see the future of psychoanalysis in Latin America?” The aim of this project, developed by the Education Committee of FEPAL was to know the vision, perceptions and evaluation of Latin American analysts about the difficulties they find in their real professional practice and how they see the future of psychoanalysis.

30 young psychoanalysts and former Training Directors from all Latin American countries were interviewed.

We found 4 positions or perspectives about the future in the interviewees: (1) a good and better future, (2) a good future if psychoanalysts and psychoanalytic institutions are able to make some changes, (3) good and will stay as it is, and (4) a difficult future.

The study deepens in the analysts perspectives in each country.

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# Scenic memory of the Shoah – on the transgenerational transmission of extreme trauma in Germany

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## Summary

The research project in the Frankfurt Sigmund-Freud-Institut pursues the goal of comprehending the transmission of Jewish survivors' persecution experiences to their sons and daughters, under the specific circumstances which apply in the "land of the perpetrators".

The study focusses on the way in which the Shoah is recalled through a process of *scenic memory* rather than in a primarily verbal manner and on its effect on the next generation. Our basic assumption here is that it conveys those central aspects of the trauma, which excluded language from the start. This approach is based on the concept of *scenic understanding* proposed by Alfred Lorenzer, which is similar to the concept of *enactment*. For Lorenzer the most significant access to unconscious memories is obtained by the scenic approach, for his initial question is: "How can the non-verbal be grasped in language?" With the *scenic understanding* he wants "to understand [...] the incomprehensible".

## Method

A particular characteristic of the study consists of a specific mode of research corresponding to the "multi-sited ethnography" approach (George Marcus): the Holocaust survivors living in Germany are not observed in a single "field" but in various contexts, including analyses, psychotherapies, psychotherapeutic self-experience groups, in video interviews, house visits, or at the "Meeting-Place for Survivors of the Shoah", so that the study includes observations from both clinical and non-clinical settings. We will be presenting vignettes based on these sources.

The processes of the scenic memory of the Shoah are at first investigated from the different perspectives of the two research analysts, who supervise each other. The non-Jewish German psychoanalyst and the Jewish analyst in Germany belong to different generations. Their different research perspectives are important because the transmission configurations diverge and because the contrasting views expand and deepen the study of the treatment processes. In terms of the Freudian notion of "Healing and Research" the treating analyst is the starting point and basis for the study of trauma transmission. In addition, external supervisors who also examine the psychosocial effects of the Holocaust in Germany, Austria, Israel and the United States, are included in the research process.

As the transmission of the trauma is not directly observable, it must be interpreted hermeneutically. Firstly relevant scenes or vignettes are selected and described phenomenologically. The subsequent analysis of these scenes follows the basic idea formulated by Lorenzer, "to understand all the material on the model of dream interpretation". The transference and counter-transference processes which occur in the analytic work with Holocaust survivors and their descendants, play a central role.

The transmission of trauma is investigated from working with survivors of the Holocaust and members of the Second and Third Generation. In each setting the analysts enter into a relational process. With "evenly hovering attention" they observe how the survivors shape the scenic memory of the Shoah. The decisive criterion for determining the character of such a scene is founded in the analysts' countertransference reaction: that is, when their feelings and fantasies indicate a "getting-in-touch" with the extreme trauma. This may be a hint of something catastrophically intolerable, a sense of annihilation, anxiety, pain, compassion, powerlessness, despair, hopelessness, senselessness, depression and mourning, but also bodily sensations such as shuddering, tears and paralysis. The inner eye may show images of menace and persecution from concentration camps; the inner experience is about surviving, self- or object-loss, about non-verbal expression of the place "where language cannot reach" (Hans Keilson).

In the next step of the evaluation, the experts are involved in the investigation process. The expert supervision will be carried out by psychoanalysts and psychologists, sociologists and cultural studies specialists who are familiar with hermeneutic approaches and analytic methods. Following the model of psychoanalytic case-supervisions the clinical and non-clinical material will be worked on with the aim of achieving a consensual conceptualization of scenic trauma transmission in the various individual cases. If necessary several expert sessions will be held.

## **Goal**

The goal of the study consists in generating hypotheses from the empirical material about how and in what way, specifically in Germany, the extremely traumatic experiences of the Nazi extermination of the Jews are transmitted by survivors to the following generations.

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## Conceptual Studies

## The Conscious Id

Solms, M. (1997): What is consciousness? *J Am Psychoanal Ass* 45, 681-778.

Solms, M. & Panksepp, J. (2012): The id knows more than the ego admits. *Brain Sci* 2, 147-175.

Solms, M. (2013). Das bewusste Es. *Psyche-Z Psychoanal* 67, 991-1022.

### Summary

Two aspects of the body are represented in the brain, and they are represented differently. The more important difference is that the brain regions for the two aspects of the body are associated with different aspects of consciousness. Very broadly speaking, the brainstem mechanisms derived from the autonomic body are associated with affective consciousness and the cortical mechanisms derived from the sensory motor body are associated with cognitive consciousness. Moreover, the upper brainstem is intrinsically conscious whereas the cortex is not; it derives its consciousness from the brainstem. These facts have substantial implications for psychoanalytic metapsychology because the upper brainstem (and associated limbic structures) performs the functions that Freud attributed to the id, while the cortex (and associated forebrain structures) performs the functions he attributed to the ego. This means that the id is the fount of consciousness, and the ego is unconscious in itself. The basis for these conclusions, and some of their implications, are discussed in several papers in different fashions.

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# Towards a better use of psychoanalytic concepts: A model illustrated using the concept of enactment

Bohleber, W., Fonagy, P., Jiménez, J., Scarfone, D., Varvin, S., & Zysman, S. (2013). Towards a better use of psychoanalytic concepts: A model illustrated using the concept of enactment. *International Journal of Psychoanalysis*, 94, 501-530.

Canestri, J., Bohleber, W., Denis, P., & Fonagy, P. (2006). The map of private (implicit, preconscious) theories in clinical practice. In J. Canestri (Ed.), *Psychoanalysis. From Practice to Theory* (pp. 29-44). Chichester: Whurr Publishers.

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## Summary

It is well known that there is a lack of consensus about how to decide between competing and sometimes mutually contradictory theories, and how to integrate divergent concepts and theories. In view of this situation the IPA Project Committee on Conceptual Integration developed a method that allows comparison between different versions of concepts, their underlying theories and basic assumptions. Only when placed in a frame of reference can similarities and differences be seen in a methodically comprehensible and reproducible way. We used “enactment” to study the problems of comparing concepts systematically. Almost all psychoanalytic schools have developed a conceptualization of it. We made a sort of provisional canon of relevant papers we have chosen from the different schools. The five steps of our method for analyzing the concept of enactment will be presented. The first step is the history of the concept; the second the phenomenology; the third a methodological analysis of the construction of the concept. In order to compare different conceptualizations we must know the main dimensions of the meaning space of the concept, this is the fourth step. Finally, in step five we discuss if and to what extent an integration of the different versions of enactment is possible.

Keywords: Enactment, countertransference, acting-out, Agieren, conceptual research, conceptual integration.

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# Unconscious phantasy and its conceptualizations: An attempt at conceptual integration

Bohleber, W., Fonagy, P., Jiménez, J., Scarfone, D., Varvin, S., & Zysman, S. (2013). Towards a better use of psychoanalytic concepts: A model illustrated using the concept of enactment. *International Journal of Psychoanalysis*, 94, 501-530.

Bohleber, W., Jiménez, J.P., Scarfone, D., Varvin, S., & Zysman, S. (in press). Unconscious phantasy and its conceptualizations: An attempt at conceptual integration. *International Journal of Psychoanalysis*, 96.

## Summary

That there is a lack of consensus as to how to decide between competing, at times even contradictory theories, and about how to integrate divergent concepts and theories is well known. In view of this situation, the IPA Committee on Conceptual Integration (2009–2013) developed a method for comparing the different versions of any given concept, together with the underlying theories and fundamental assumptions on which they are based. Only when situated in the same frame of reference do similarities and differences begin to appear in a methodically comprehensible and reproducible form. After having studied the concept of enactment followed by the publication of a paper in the *International Journal of Psychoanalysis* in 2013, we proceeded to analyze the concept of unconscious phantasy while at the same time continuing to improve our method. Unconscious phantasy counts among the central concepts in psychoanalysis. We identified a wide range of definitions along with their various theoretical backgrounds. Our primary concern in the present paper addresses the dimensional analysis of the semantic space occupied by the various conceptualizations. By way of deconstructing the concepts we endeavoured to establish the extent to which the integration of the different conceptualizations of unconscious phantasy might be achieved.

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# What is conceptual research in psychoanalysis?

Leuzinger-Bohleber, M.; Dreher, A.U.; Canestri, J. (Eds.) (2003): *Pluralism and Unity? Methods of Research in Psychoanalysis*. (The International Psychoanalysis Library). London: International Psychoanalytical Association.

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Leuzinger-Bohleber, M.; Fischmann, T. in cooperation with the Research Subcommittee for Conceptual Research of the IPA (2006): What is conceptual research in psychoanalysis? *International Journal of Psychoanalysis*, 87, 1355-1386

## Summary

The development of psychoanalysis as a science and clinical practice has always relied heavily on various forms of conceptual research. Thus conceptual research has clarified, formulated and reformulated psychoanalytic concepts permitting to better shape the findings emerging in the clinical setting. By enhancing clarity and explicitness in concept usage it has facilitated the integration of existing psychoanalytic thinking as well as the development of new ways of looking at clinical and extra-clinical data. Moreover, it has offered conceptual bridges to neighbouring disciplines particularly interested in psychoanalysis e.g. philosophy, sociology, aesthetics, history of art and literature and more recently cognitive science/ neuroscience.

In the present phase of psychoanalytic pluralism, of worldwide scientific communication amongst psychoanalysts irrespective of language differences and furthermore of an intensifying dialogue with other disciplines the relevance of conceptual research is steadily increasing. Yet, it still often seems not clear enough how conceptual research can be characterized in contrast to clinical and empirical research in psychoanalysis. Therefore the Subcommittee for Conceptual Research of the IPA presented some of its considerations on the similarities and the differences between various forms of clinical and extraclinical research, their specific aims, quality criteria and thus their specific chances as well as their specific limitations in this paper. Examples taken from two volumes of the *International Journal of Psychoanalysis* 2002/2003 served as illustrations for eight different subtypes of conceptual research.

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## Conceptual and clinical research

- Dreher, A. U. (2002). Psychoanalytische Konzeptforschung und psychoanalytische empirische Forschung: das Beispiel "psychisches Trauma". In: Giampieri-Deutsch, P. (Hrsg.) *Psychoanalyse im Dialog der Wissenschaften. Europäische Perspektiven*. Kohlhammer.
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- Dreher, A. U. (2010) Pluralism in theory *and* in research—and what now? A plea for connectionism. In: M. Leuzinger-Bohleber, J. Canestri, and M. Target (Eds.), *Early Development and Its disturbances: Clinical, conceptual and empirical research on ADHD and other psychopathologies and its epistemological reflections* (pp. 239-266). London, Karnac Books.
- Dreher, A. U. (2015) Psychoanalytic research with or without the psyche? Some remarks on the intricacies of clinical research. In: Boag S., Brakel L., Talvitie, V. (eds.) *Philosophy, Science, and Psychoanalysis*. London: Karnac, 219-246

### Summary

Psychoanalysis as a treatment method not only has generated an abundance of empirical evidence, but also - as theoretical edifice - powerful concepts, which played an essential role in the discourses of the human sciences. Concepts do change; they live just like scientific language games in general live. When the 'world' changes, when there are new clinical observations or extra-clinical empirical findings, this can influence the meaning of familiar concepts. Such constant change of meaning in the course of theoretical development, sometimes can lead to substantial differentiations, sometimes to school specific concept usages up to completely different ones.

In our psychoanalytic concepts an essential nucleus of clinical, empirically based knowledge is preserved and psychoanalysis is dependent upon attempts to constantly clarify their meaning. Conceptual research – as an ongoing research program – enables us to take such a decentred perspective on concepts through systematically reconstructing and critically discussing such changes of a concept in their respective conceptual fields and to possibly propose ways to a more homogeneous usage of central psychoanalytic concepts.

Thus, it is of fundamental significance, that whatever kind of empirical data *as also* the use of concepts, their role and function in psychoanalysis, should be subject of psychoanalytic research. Emphasis is on the interrelatedness and interdependency of empirical and conceptual research activities for the development of psychoanalysis as a human science.

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## Criteria for judging results. A study about conceptualization of goals in psychoanalysis

- Westenberger-Breuer, H. (2003). *Kriterien des Erfolgs. Eine Untersuchung zum Konzept des Behandlungsziels in der Psychoanalyse* {Criteria of success. An investigation on the concept of treatment goals in psychoanalysis}. Tübingen: edition diskord.
- Westenberger-Breuer, H., (2007) The goals of psychoanalytic treatment: conceptual considerations and follow-up interview evaluation with a former analysand, *International Journal of Psychoanalysis*, 88, 1-13.

There has been an increasing number of studies of the effects of psychoanalytic treatment over the past 20 years which many psychoanalysts approach rather sceptically. One of the criticisms concerns the criteria by which treatment results are judged. The sought-after changes unique to psychoanalytic treatment are seen as impossible to operationalize, i.e. according to this view, they simply cannot, or not sufficiently, be grasped within the confines of empirical research. Studying this argument reveals that the opinions of psychoanalysts concerning the goals to which psychoanalysis aspires in treating patients vary extensively, even including the position that psychoanalytic treatment ought to be utterly goalless. Without a common understanding of the results that can generally be expected from a psychoanalytic treatment conducted *lege artis*, it is impossible to reflect on and judge our own methods. Even if as a psychoanalyst one believes that the changes resulting from psychoanalytic treatment simply cannot be measured psychometrically, in some way or other these changes ought to be conceived of as treatment effects so that potentially necessary corrections can be developed in our understanding and technique.

There already exist a plethora of goal definitions by psychoanalysts from the various theoretical schools, so many that many authors even lament their confusing and contradictory diversity. The wealth of goal descriptions that can be found in the literature was reduced by differentiating the definitions according to their content and their level of abstraction at which they are formulated. They were grouped in four categories. The proposal for a conceptualization was, that the goal of psychoanalytic treatment encompasses these four components:

Changes in symptoms and complaints

Changes in life adjustment

Changes in personality structure

Realization of procedural goals

### Method/Design

This definition of the goal in psychoanalysis was tested by presenting a transcript of two follow-up interviews with a former analysand to 19 psychoanalysts. The case comes from the follow-up study of the German Psychoanalytic Society (DPV), reported by Leuzinger-Bohleber, M. et al. in 2002. There were audio-taped discussions in the local and in the nationwide research group, in which the statements of the former analysand were evaluated. Additionally two other colleagues commented the interviews. The group included psychoanalysts of various ages, with differing interests and theoretical orientations.

Moreover the transcripts of the follow-up interviews were presented to a philosopher, a behavioural therapist, a sociologist, an educational researcher, a psychiatrist, a Gestalt therapist, a systems therapist and a manager of the Association of Statutory Health Insurance Physicians.

Those formulations which refer to goal criteria have been placed into the categories defined above. The statements have been taken from the protocols verbatim and from authorized protocols of the interviews with the experts. The selection of statements taken from the protocols and their classification in the form given here were reviewed by another person, who agreed in large part with that of the author.

In Westenberger-Breuer (2003) all the protocols can be found, as well as a complete report of the follow-up interviews with the former patient.

## **Results**

The judgments of the analysts who co-operated in this follow-up project can be meaningfully assigned to the defined categories. Psychoanalysts use the criteria defined above implicitly in forming their opinions about treatment outcome. None of the aspects remains unmentioned, no aspect is singled out in its importance and no special weight is accorded to specific theoretical orientations by individual psychoanalysts in their concrete overall appraisal to treatment outcome. Moreover the psychoanalysts not only employed similar criteria in their assessments, but also showed wide agreement in judging the content.

The outside experts came to similar results. There was wide agreement with the criteria used by the psychoanalysts, as well as with judging the content of the treatment outcome.

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# Psychoanalytic considerations on psychopathology and conceptual research

Löffler-Stastka, H., Szerencsics, M., & Blüml, V. (2009). Dissociation, trauma, affect regulation and personality in patients with a borderline personality organization. *Bulletin of the Menninger Clinic*, 73(2), 81-98. DOI: 10.1521/bumc.2009.73.2.81

Parth, K., Hrusto-Lemes, A., Löffler-Stastka, H. (2014). Clinical reasoning processes and authentic clinical care for traumatised patients. *Journal of Traumatic Stress Disorders & Treatment*, 3(4), DOI: 10.13140/2.1.4065.3441

## Brief Summary

While the association between dissociation and trauma has been the subject of intensive research, the relationship between dissociation, childhood trauma, and personality characteristics has not yet been explored in detail. Patients suffering from a personality disorder completed the Dissociative Experiences Scale, the Childhood Trauma Questionnaire, and the personality and affect regulation measurement instruments SWAP and AREQ. Results are critically discussed within a psychoanalytic framework, which should also help clarify the rather vague concept of dissociation. In this diagnostic context the concept of countertransference is a central foundation pillar of psychoanalytic theory and practice. It has become increasingly influential in other forms of therapy and in neuroscience research into resting-states. It is, like many other concepts in psychoanalysis, characterized by its elasticity and covers a wide range of phenomena inside and outside the clinical sector. Attempts to measure countertransference phenomena empirically, on a quantitative or qualitative level have been avoided for a long time due to its complexity. Recently however, various methodologies and approaches to conduct empirical research in this field have become more and more successful in documenting the importance of countertransference for treatment of patients in the medical context and as well as for diagnostic purposes. We report here the findings of an exemplary study that surveyed and analysed the role of countertransference in regards to clinical care for traumatised patients. Making use of the Childhood Trauma Questionnaire and the Harvard Trauma Questionnaire, the study compared two groups of patients. One was comprised by patients who could and the other comprised by patients who could not remember having been traumatised, yet suffered from Borderline Personality Disorder and displayed symptoms characteristic for traumatised patients. The Countertransference Questionnaire measured the relationship between therapist and patient. The results indicate that the measurement of countertransference feelings in the clinician can be utilized as a crucial tool for understanding unconscious dynamics in traumatised patients. The results suggest that only making use of the concept of countertransference enables accessing those traumatic fears, phantasies and memories that cannot be communicated verbally but only in the relationship to the therapist. Furthermore, the paper discusses these results, their clinical implications and contextualizes them with theoretical concepts and a case study.

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# What does Generalized Anxiety Disorder mean for psychoanalysts? An empirical qualitative approach about its conceptualization in the psychoanalytic framework

Gómez Penedo, J.M., Etchebarne, I., Juan, S., & Roussos, A. (2013). Um olhar ao transtorno de ansiedade generalizada desde a psicanálise: uma aproximação empírica sobre sua conceptualização [A View of Generalized Anxiety Disorder from the Psychoanalytic Perspective: an Empirical Approach about its Conceptualization]. *Psicanálise Revista da Sociedade Psicanalítica de Porto Alegre*, 15 (2), 331-356.

Juan, S., Etchebarne, I., Gómez Penedo, J.M., & Roussos, A. (2010). Una perspectiva psicoanalítica sobre el Trastorno de Ansiedad Generalizada: Raíces históricas y tendencias actuales [A Psychoanalytic Perspective on Generalized Anxiety Disorder: Historical Roots and Current Trends]. *Revista de la Sociedad Argentina de Psicoanálisis*, 14, 197-219

Juan, S., Gómez Penedo, J.M., Etchebarne, I., & Roussos, A. J. (2012). El método de investigación cualitativa consensual (Consensual Qualitative Research, CQR): Una herramienta para la investigación cualitativa en psicología clínica [Consensual Qualitative Research (CQR) Method: a Tool for Qualitative Research in Clinical Psychology]. *Anuario de investigaciones de la Facultad de Psicología de la Universidad de Buenos Aires*, 18 (1), 47-56.

## Aims and rationale of the study

This study analyzed how expert psychoanalysts conceptualized Generalized Anxiety Disorder (GAD), as it is described in DSM-IV-TR (2001). Potential GAD's defense mechanisms, predominant anxieties, and etiological factors were explored; as well as psychoanalysts' conceptualization on GAD's diagnostic validity and possible underlying structure.

There are current debates regarding GAD's psychopathological understanding and diagnostic validity that represent a challenge when identifying how different theoretical frameworks, such as psychoanalysis, conceptualize generalized anxiety phenomenon (Juan, Etchebarne, Gómez Penedo, & Roussos, 2010). This study focuses on analyzing the way in which the psychoanalytic tradition, that historically reject descriptive diagnostic manuals such as DSM, approach this condition, given that many patients in psychoanalytic treatments could be potentially diagnosable as a GAD case. Thus, studying the psychoanalytic conceptualization of GAD could help to address the gap between psychiatry and psychoanalysis in the conceptualization and treatment of these patients, as well as enrich the knowledge regarding GAD and anxiety in general terms. Further details about this study are presented in: Gómez Penedo, Etchebarne, Juan, & Roussos, A. (2013).

## Methods

10 Individual semi-structured interviews were conducted with certified expert psychoanalytic psychotherapists from Buenos Aires exploring their conceptualizations about GAD. A Spanish guide (Juan, Gómez Penedo, Etchebarne, & Roussos, 2012) for conducting Consensual Qualitative Research (CQR) (Hill, Thompson y Nutt-Williams, 1997) was used for the data analysis.

## Results and discussion

GAD was generally related to Freudian classical notions of anxiety neurosis (Freud, 1895/2001) and anxiety hysteria (Freud, 1909/2001). Also there was a generally trend to relate GAD with insecure attachment and primitive anxieties. Although participants typically considered that GAD did not present main defense mechanism as other pathologies, they related it to primitive defense mechanisms and even considered that worry, GAD's main feature, could be conceptualized as a non-effective

defense mechanism to avoid traumatic representations. Regarding the underlying structure, most of the psychoanalysts conceptualized generalized anxiety as a trans-structural phenomenon that could be present in both neurotic and borderline structures.

The study performed has triggered some questions and hypotheses about the nature of GAD from a psychoanalytic perspective. Future studies are needed to increase knowledge of the relationships (and potential mutual enrichment) between GAD and fundamental concepts of the psychoanalytic framework for clinical practice and psychotherapy research.

### **Limitations of the study and future directions**

The qualitative and exploratory nature of this research was not orientated to test hypotheses but to generate them. Because of the non-probabilistic sampling, and the fact that we only studied expert psychoanalysts, generalization of these results to the population of psychoanalysts is unknown. Further research may analyze GAD conceptualization from the psychoanalytic perspective in a bigger sample and also study the links between these conceptualizations and the way in which psychoanalysts treat patients with GAD.

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# The Three-Level Model for Observing Patient Transformations (3-LM)

Altmann de Litvan (Ed.), Bernardi, R., Hernandez, S., Ungar, V., Fitzpatrick-Hanly, M., Leuzinger-Bohleber, M., Gullestad, S., Leibovich de Duarte, A., Sebek, M., White, R., Kantrowitz, J., Hurvich, M., de León, B., Fudin de Winograd, L. & Miller, D., White, R. (2014) *Time for change. Tracking transformations in psychoanalysis*. London: Karnac

Bernardi, R. (in press). Clinical Research and Systematic Empirical Research: What Can We Learn about Them from Current Controversies? *International Journal of Psychoanalysis*.

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## Brief Summary

The 3-LM is a guide or heuristic to observe clinical materials from three different levels: 1) Phenomenological description of transformations; 2) Identification of the main diagnostic dimensions of change; and 3) Explanatory hypotheses of change. It proposes a second look to what occurs to a particular patient with a particular analyst in the context of their work, taking as a reference not ideal theoretical models, but what takes place in real practice, seeking to assess transformations in the patient, while observing the analytic process with the analyst.

This model centres on patients as persons in their context, the reason that brought them to analysis, and how and in which ways patients' answers were heard and explored at different moments of their analysis.

This model is used for the group discussion of clinical material and it helps analysts examine the explicit and implicit theories they have applied with patients and consider if other approaches would be better to promote patients' transformations of the aspects that are worked on in analysis, shedding light on blind spots or specific challenges that the particular patient may pose to the analyst. With the three-level model, the group of analysts discussing the clinical material acts as a "consensus of experts" that validates or not the analyst's observations and systematically documents convergences and divergences with clinical observation (method developed in the DPV follow-up study by Leuzinger-Bohleber et al.)

The IPA Clinical Observation Committee has been working on and with the The Three-Level Model for Observing Patient Transformations (3-LM) in different groups formed by analysts in different regions. Up to April 2015 approximately 800 analysts have participated in working groups with the 3-LM.

## Evaluation

Analysts participating in the groups are asked to fill a questionnaire with items regarding their evaluation of the changes in the patient ex ante and ex post the group discussion.

Some members of the Committee are working in a research project to study the degree of agreement among analysts with different theoretical assumptions regarding how they assess transformations in patients during long periods of analysis.

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## Neuropsychanalytical Studies

## Psychoanalytical dream theory and brain mechanisms

- Solms, M. (2001) Dreaming and REM sleep are controlled by different brain mechanisms.' *Behavioral and Brain Sciences*, 83, 843-850.

### Brief Summary

The equation of dreaming and REM sleep has massive implications for the credibility of psychoanalytic dream theory, for the reason that the brain mechanisms of REM sleep are automatic and “motivationally neutral” (Hobson). This equation was established in humans in the 1950s, but the elucidation of its brain mechanisms was performed mainly in rats and cats, where there is no possibility of monitoring the concomitant effects of REM manipulations on dreaming.

This study represents the first systematic attempt to characterise the effects of localised brain lesions on human dreaming (N=361). The results were dramatic: firstly it was found that lesions which obliterate REM sleep do not obliterate dreaming; secondly it was found that lesions which obliterate dreaming do not obliterate REM sleep; and thirdly it was found that lesions which obliterate dreaming are located in forebrain structures responsible for higher cognitive and motivational functions, namely visuospatial perception (parieto-occipital cortex) and reward (mesocortical-mesolimbic dopamine system).

### Follow-up studies

Researchers at the Sigmund Freud Institute (Frankfurt) and University of Cape Town are using the above-identified patients (non-dreamers with focal brain lesions) to establish the biological function of dreaming as opposed to REM sleep. Freud's hypothesis that dreams protect sleep is being tested, along with other competing hypotheses.

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# Serotonin-transporter (SERT) densities in dynamic psychotherapy of depression

Joensuu M, Lehto S, Tolmunen T, Saarinen P, Valkonen-Korhonen M, Vanninen R, Ahola P, Tiihonen J, Kuikka J, Pesonen U, Lehtonen J. 5-HTTLPR polymorphism and serotonin transporter binding in drug-naïve patients with major depression. *Psychiatry and Clinical Neurosciences* 64:387-393, 2010.

Lehtonen J, Tiihonen J, Joensuu M, Lehto SM, Ahola P, Saarinen PI, Valkonen-Korhonen M, Tolmunen T, Kuikka J. Toward molecular psychotherapy of Depression? Pp. 219-232. In: Levy, R., Ablon, S., Kächele, H. (Eds.) *Psychodynamic Psychotherapy Research. Practice-Based Evidence and Evidence-Based Practice* (pp. 219-232). Humana Press, New York, 2012.

Lehtonen J. At the crossroads of psychoanalysis and neuroscience. *Scandinavian Psychoanalytic Review*, 35, 9-20, 2012a.

## Brief summary

We found in two case-reports (Viinamäki et al. 1998, Saarinen et al. 2005) that lowered SERT in patients with major depression was normalised during dynamic psychotherapy, and we also found that SERT densities were elevated in mixed mania (Tolmunen et al. 2004). We then collected a naturalistic sample of patients with major depression and followed their Hamilton scores and SERT densities for psychotherapy of six months. It was found that the relationship between Hamilton score decrease and SERT increase during psychotherapy followed an inverted U-curve, thus suggesting two different types of responses (Laasonen-Balk et al. 2004).

We thereafter collected a sample of drug-naïve first-episode patients with major depression (intention to treat analysis n=33) and randomised them to two groups, one being treated immediately after baseline measurements and the other after waiting six months for dynamic psychotherapy. The baseline findings revealed significant SERT reduction at the level of midbrain (MB) (Joensuu et al. 2007), and moreover an association was discovered between the SERT SS-allele genotype and SERT reduction in medial prefrontal cortex (MPC)(Joensuu et al. 2010).

The patients in both groups received a one-year treatment twice a week with dynamic psychotherapy. The SERT changes did not differ between the groups which were consequently pooled together. It was found that in patients with atypical symptoms SERT densities changed towards normal, but not in patients with Hamilton scores typical for major depression (Lehto et al. 2008a). In the same sample dopamine transporter (DAT) densities showed an association with the length of depression (Lehto et al. 2008b).

When the whole sample, with a significant baseline SERT reduction, was not selected according to the type of symptoms, it was found that after one-year of treatment patients with high severity of symptoms (above median) at the baseline showed significant SERT normalisation during the one-year therapy whereas patients with low severity (under median symptom burden) did not show changes in SERT densities. However, both groups showed equal reduction in Hamilton scores. (Joensuu et al. 2014, submitted).

We conclude that SERT normalisation during dynamic psychotherapy is likely to be related to the reduction of symptom severity and that patients with less symptom burden do not respond to psychotherapy with a change in their lowered SERT levels.

Moreover, our findings on the SERT genotype at baseline is suggestive that different SERT genotypes may have a differential effect on the behaviour of SERT densities in depression.

An overview of our findings until 2012 has been presented in Lehtonen et al. 2012. The conceptual body-mind philosophy problems in connecting psychodynamic understanding with brain state variables has been published in Lehtonen 2012a and 2012b.

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# Gen environment relations in depression: Chilean Millennium Nucleus: “Psychological Intervention and Change in Depression”

Nuevo, R., Leighton, C., Dunn, G., Dowrick, C., Lehtinen, V., Dalgard, O. S., Ayuso-Mateos, J. L. (2010). Impact of severity and type of depression on quality of life in cases identified in the community. *Psychological Medicine*, 40(12), 2069-2077. doi: 10.1017/s0033291710000164

## Background

Gen environment relations in the origin of depression and well being

Genetically our differences are small, so it can be assumed, that the relation with the unique environment that each person suffers since conceived plays an important role in creating our uniqueness. Depression constitutes a recurrent, frequently chronic condition requiring long-term clinical management (Angst, 1997). Both genetic and environmental factors have been implicated in developmental pathways to depression (Saveanu & Nemeroff, 2012; Sullivan, Neale, & Kendler, 2000).

With regard to depression, much research has focused on interactions between environmental factors and polymorphisms, since the leading study of Caspi and colleagues (Caspi et al., 2003) demonstrating that individuals with one or two copies of the short allele of the serotonin transporter gene promoter region exhibited more depressive symptoms, diagnosable depression, and suicidality in relation to stressful life events than individuals homozygous for the long allele. This has led to a renewed focus on stress (Hammen, 2005) and early and later adversity in particular in explaining vulnerability for depression, especially among genetically predisposed individuals (Heim & Nemeroff, 2001; Heim, Newport, Mletzko, Miller, & Nemeroff, 2008; Risch et al., 2009).

Research in this area has mainly focused on studying the moderation of negative environment from a diathesis- stress perspective. In recent years, studies began to include positive variables such as preventive interventions, positive parenting styles, or even no trauma, it was noted that in some cases, the same alleles that were more sensitive to negative events, were also more sensitive to positive events. Hence, the model began to shift from a model of diathesis to stress or vulnerable phenotype to the model of differentiated sensitivity to the environment or social susceptibility (Bakermans-Kranenburg & van Ijzendoorn, 2011; Bakermans-Kranenburg, Van, Pijlman, Mesman, & Juffer, 2008; Belsky & Pluess, 2009; Boyce & Ellis, 2005; Cicchetti & Rogosch, 2012; Ellis & Boyce, 2008; Ellis, Boyce, Belsky, Bakermans-Kranenburg, & Van Ijzendoorn, 2011; Ellis, Essex, & Boyce, 2005; Orelund, Nilsson, Damberg, & Hallman, 2007; Pluess, Belsky, Way, & Taylor, 2010; Roisman et al., 2012; Sheese, Voelker, Rothbart, & Posner, 2007), which contends that more susceptible individuals in a positive environment will show more favourable outcomes but if they experience negative environments will show more negative results. This model argues that certain genes make us more sensitive or reactive to the environment "for better or for worse", leading to the notion of plasticity or malleability genes. The importance of including recent and positive events in the interaction of gene and environment studies is that maybe transforming the environment in a positive one by psychotherapy or promoting social positive policies, could have a positive and effective outcome, especially in more sensitive people. Noticing the importance and power of social context to modify risky vulnerabilities.

## Subprojects

Two systematic reviews are taking place in this field:

(1) DIFFERENTIAL SUSCEPTIBILITY GENES; A SYSTEMATIC REVIEW OF GXE and (2) GENETIC POLYMORPHISMS, OXYTOCIN AND DEPRESSION

## **Research questions**

The aim of these review, therefore is to provide a critical review of research on GxE. Specifically, provide a systematic qualitative review of research on various genes that have been investigated in GxE research and the genetic contribution of oxytonergic system polymorphisms in the pathophysiology of depression with the aim to address gaps in our knowledge and formulate a number of recommendations for future research.

## **Design and method**

For this reviews, empirical studies published in peer-reviewed journals in English, between January 2002 to April 2014, were retrieved using several search engines (PubMed, PsycINFO, and Google Scholar). Finally, references of retrieved papers were hand searched. After two of the authors (AB y CL) screened for these inclusion criteria, 241 studies were recruited for the first review and 11 studies were identified for the oxytonergic review,

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# Changes in brain functions in chronic depressed patients after long-term psychoanalytic compared with cognitive behavioural treatments: Frankfurt fMRI / EEG Depression Study (FRED)

Fischmann T, Russ M.O. and Leuzinger-Bohleber M. (2013): Trauma, dream and psychic change in psychoanalyses: a dialogue between psychoanalysis and the neurosciences. *Frontiers in Human Neuroscience*, 7, 877. doi: 10.3389/fnhum.2013.00877.

Fischmann, T., Leuzinger-Bohleber, M., Kächele, H. (2012): Traumforschung in der Psychoanalyse: Klinische Studien, Traumserien, extraklinische Forschung im Labor. *Psyche*, 66, 833-861.

Leuzinger-Bohleber, M., *Fischmann, T.* (2014): Transgenerationale Weitergabe von Trauma und Depression: Psychoanalytische und epigenetische Überlegungen. In: V. Lux & T. Richter (Hrsg.): *Kulturen der Epigenetik: Vererbt, codiert, übertragen*. Berlin: DeGruyter, S. 69-88.

The FRED started in 2007 and is a still ongoing study conducted at the Sigmund-Freud-Institut in cooperation with the research team of the LAC-depression study, the Brain Imaging Center (BIC) and the Max-Planck-Institute for brain research (MPIH) in Frankfurt, the Hanse Neuro-Psychoanalysis study (HNPS) and the sleep-somnological centre of the hospital Hofheim. The research is funded by the Neuro-Psychoanalysis Society – HOPE and the Research Advisory Board of the IPA.

## Background

Depression from a brain physiological angle may be related to a neurotransmitter disorder, or a frontal lobe dysfunction (Belaker & Agam, 2008; Caspi et al., 2003; Risch et al., 2009). It may also be the result of a disturbed “reward system” (Northoff & Hayes, 2011). But despite these findings no distinct brain physiological marker for depression has been found so far.

## Objective

The FRED study aims at researching whether changes in the course of therapy have brain physiological correlates looking at some of these areas. Assuming that psychotherapy working on memory and recurring dysfunctional behaviors and experiences has precipitations within in the brain like synapse configuration, priming and axonal budding the hypotheses for FRED are (1) psychotherapy is a process of change in encoding conditions of memory, and (2) elements of memory can be depicted in fMRI by a recognition experiment of memories related to an underlying conflict. Another aspect of change relevant for the FRED study is that of clinical change found in dreams in the course of psychotherapy. Hence changes of dreams in the course of therapy are investigated as well and related to the neurophysiological findings.

## Method

Seventeen chronically depressed patients were recruited from the pool of the LAC-depression study and participated in a naturalistic observational design. In a first diagnostic phase an operationalized diagnostics (OPD) interview concentrating on axis II (relational) and a dream interview was conducted. From these two interviews the stimuli for the fMRI scanning were created individually for each patient. For one, one, dream words were taken from a significant dream elicited in the dream interview and for the other confrontational sentences taken from the OPD interview were formulated. Brain activation patterns resulting from these stimuli in the fMRI serve as dependent variables. Measurements are taken at three different time points – each one minimum 8 months apart – revealing changes in activation patterns occurring in the course of therapy.

## Results

First results of the dream experiments revealed that patients confronted with dream words in contrast to so-called neutral words (taken from an all-purpose story) showed differential activation of the precuneus, the ventro-lateral pre-frontal cortex (VLPF), and the anterior cingulate gyrus, among others. These three brain areas are known to be involved in self processing operations (experience of self agency), generation of basic causal explanations, and regulating emotions (see also below), where the ACC is also known for its conflict monitoring feature. In the course of therapy it could be shown that the recognition or rather re-sounding of initially significant dream content at the beginning of therapy activated specifically the precuneus and the left parietal lobe, which did not substantiate after one year of therapy. The disappearance of these areas—which are involved in attention processes but are also significant to emotional processing by the self—at T2 allude to the supposition that possibly the dream content has lost its special importance and is experienced now in the same manner as the neutral story.

As for the OPD part of FRED, it consists of three conditions in the fMRI scanner, which are repeated six times each. In condition 1 four subjectively confrontational (conflict-oriented) statements extracted from the previously conducted OPD interview (relational axis II) are presented consecutively in the fMRI scanner on a screen. In condition 2 subjects see four statements of an all-purpose situation presented in the same manner, and finally condition 3 is composed of four relaxation statements. Analysis of the fMRI brain scans contrasting the different conditions (dysfunctional sentences > traffic + relaxation) revealed specific activation patterns again in the precuneus, and above that of the posterior and anterior cingulate gyrus, medial prefrontal cortex (MFC), occipital cortex and the left hippocampus for condition 1 (dysfunctional sentences). The occipital cortex and precuneus are important brain structures for primary visual processes (occipital c.) and visual-spatial imagery (precuneus). But besides this the precuneus is also known to be an important brain area for episodic memory retrieval and self-processing operations, i.e., for first person perspective taking and experience of agency. The cingulate gyrus being an important part of the limbic system helps regulate emotions and pain and constitutes an important feature of memory just like the hippocampus, which is aligned for memory formation, specifically long-term memory (episodic biographic). The MFC is postulated to serve as an online detector of information processing conflict (Botvinick, Cohen & Carter, 2004) but also has a regulative control function of affective signals (Critchley, 2003; Matsumoto, Suzuki & Tanaka, 2003; Posner & DiGirolamo, 1998; Roelofs, van Turenout & Coles, 2006; Stuphorn & Schall, 2006). In a single case study it could also be shown that MFC activation could no longer be detected after one year of psychotherapy, suggesting that the conflict impact has diminished in the course of therapy

## Evaluation

While it is the first study of its kind, the study has its limitations. The sample size is relatively small, which is due for one to the longitudinal design of the study and for the other to the fact that investigating in an fMRI environment limits possible candidates. The strength of the study is the naturalistic design. The study scientifically follows chronically depressed patients in the course of their long-term psychoanalytical therapy, where changes in brain functions are investigated on 'real' patients undergoing psychotherapies realized in the offices of 'real' psychotherapists associated with a high external validity of the findings. A comparison to a non-depressive control-group is still lacking.

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# Neuroimaging and attachment with “children-at-risk”

Leuzinger-Bohleber, M., Fischmann, T., Neubert, V., Hartmann, L.K., Läzer, K.L., Pfenning-Meerkötter, N., Schreiber, M., Ackermann, P. (2014): Project Eva: Evaluation of two prevention programs with high-risk children in kindergarten. *Journal of the American Psychoanalytic Association*, 62(3), NP29-NP31.

Ekman, M., Derrfuss, J., Tittgemeyer, M., & Fiebach, C. J. (2012). Predicting errors from reconfiguration patterns in human brain networks. *Proceedings of the National Academy of Sciences*, 109, 16714-16719

Fiebach, C. J., Rissman, J., & D’Esposito, M. (2006). Modulation of inferotemporal cortex during verbal working memory maintenance. *Neuron*, 51, 251-261.

The neuroimaging study on attachment with “children-at-risk” will start in 2015 and will be conducted at the Sigmund-Freud-Institute in cooperation with the Institute for Neurocognitive Psychology of the Goethe University (fiebachlab). The Research is funded by the Deutsche Forschungsgemeinschaft (DFG: FI 2065/1-1).

## Brief Summary

The integration of children-at-risk is one of the most pressing societal tasks. Moreover there is a growing risk of social disintegration of at-risk children. Social disintegration, low educational success, violence, psychosomatic and emotional disturbances as well as increased drug consumption especially in adolescents are attributable – among others – to emotional neglect respectively to severe traumatization in early childhood. In recent years a vast amount of studies from the field of empirical attachment research illuminated factors which influence cognitive-affective and social development of children. They investigated among others the development of attachment patterns of children in their first years of life.

In this study this thread will be taken up by investigating children with an insecure-disorganized attachment with respect to neuronal correlates of emotional reaction to attachment-relevant stimuli. Since disorganized attached children in elementary school age show an increasing amount of psychosocial and aggressive problems, a further hypothesis is tested, whether those children will have a more intensive reaction on social ostracism than securely attached children.

This interdisciplinary study investigates disorganized attached children in comparison to securely attached children with respect to structural and functional neurobiological conspicuities by means of structural and functional magnetic resonance imaging (sMRI/fMRI). The research aims at investigating relationships of early childhood experiences, individual attachment patterns and neurobiological correlates.

## Evaluation

A literature review revealed that differences in attachment styles lead to differential modulation of different neuronal systems. Most of these findings stem from investigations on rodents. The few studies on humans on neurophysiological correlates of attachment were mainly conducted with adults and therefore don’t permit a distinct linkage between early childhood experience and neurophysiological correlates. Early childhood experiences are most probably reshaped by a variety of experiences in adolescents and adulthood. Therefore this research appears to be most valid despite the heightened difficulties to recruit children with reliably determined problematic attachment-type for neurocognitive studies.

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# The Hanse-Neuro-Psychoanalysis-Study

Buchheim, A., Cierpka, M., Kächele, H., Taubner, S., Kessler, H., Wiswede, D., Münte, T., Roth, G. (2008). Psychoanalyse und Neurowissenschaften. Neurobiologische Veränderungsprozesse bei psychoanalytischen Behandlungen von depressiven Patienten. *Nervenheilkunde*, 27, 441-445.

Taubner, S., Buchheim, A., Rudyk, R., Kächele, H., Bruns, G. (2012). How does neurobiological research influence psychoanalytic treatments. *The American Journal of Psychoanalysis* 72: 269-286.

In recent years, human neuroscience has become interested in the investigation of brain changes when patients are under psychotherapy. As this is a complex process that cannot be adequately captured with standard experimental paradigms from neuroscience, new approaches and the inclusion of the subjective, individual perspective have to be applied.

Previous studies examining the functional neuroanatomy of psychotherapy in depressed patients have mostly studied interpersonal therapy or cognitive behavioral therapy. The present research from the Hanse-Neuro-Psychoanalysis Study reports on the first fMRI study with recurrently depressed patients treated with long-term psychoanalytic therapy (Buchheim et al. 2008).

## Design

Our study design differed from that of previous studies in the following respects.

1) Neuroimaging studies have examined the effects of short time psychotherapy (e.g. 12-20 weeks), applying cognitive-behavioral or interpersonal therapy in depressed patients. We examined depressed patients during psychoanalytic treatment providing a longer observation window (15 months of therapy).

2) Most studies used more unspecific and non-personal stimuli (e.g. International Affective Picture System or the Ekman faces) to induce certain moods to assess neural changes during therapy. Our research group developed two different fMRI paradigms with an individualized research approach in order to operationalize processes relevant for depression and therapeutic change on different levels:

(a) Adult Attachment Projective Picture System to assess representations of significant attachment experiences (e.g. separation, loss etc) and relationships (Part I),

b) Operationalized Psychodynamic Diagnosis (OPD-2) as a valid tool to investigate the participant's dysfunctional interpersonal relationship patterns (see Part II).

The OPD paradigm is also applied in the Frankfurter-fMRI/EEG-Depressionsstudie (FRED) (PI: PD Dr. T. Fischmann) in the context of a collaborative study.

In an attempt to bridge the gap between science and clinical practice, a clinical research project was initiated together with the participating psychoanalysts. It investigated the influence of the neuroscientific study on the therapeutic process by regular group meetings of the psychoanalysts, case reflections and self-report data from patients (Taubner et al. 2012).

# Neural changes in prefrontal-limbic function in chronically depressed patients after 15 months of psychoanalytic therapy using the Adult Attachment Projective Picture System (AAP) as an individualized paradigm

Buchheim, A., Viviani, R., Kessler, H., Kächele, H., Cierpka, M., Roth, G., George, C., Kernberg, O.F., Bruns, G., Taubner, S. (2012). Changes in prefrontal-limbic function in major depression after 15 months of long-term psychotherapy. *PLoS ONE* 7(3): e33745. doi: 10.1371/journal.pone.0033745

Buchheim, A., & George, C. (2012). Using the AAP in neurobiology research. In: C. George & M. West, M. (Eds.), *The Adult Attachment Projective Picture System* (pp. 253-274). New York: Guilford Press..

Buchheim, A., Labek, K., Taubner, S., Kessler, H., Kächele, H., Cierpka, M., Roth, G., Pogarell, O., Karch, S. (2014). Neural changes in depressed patients during psychodynamic psychotherapy: An fMRI and EEG study using an attachment paradigm. The 15th International Neuropsychoanalysis Congress, New York, 24.-26. July 2014

We investigated recurrently depressed (*DSM-IV*) unmedicated outpatients ( $N=16$ ) and healthy control participants matched for sex, age, and education ( $N=17$ ) before and after 15 months of psychoanalytic therapy. The stimulus materials were attachment-related pictures from the Adult Attachment Projective Picture System (AAP), an interview measure for assessing attachment representations that has been shown to be feasible for using in an fMRI environment (Buchheim & George 2012). These pictures are designed to elicit mental engagement with attachment-related experiences such as separation, illness, danger, and loss. To increase the capacity of the signal to elicit a response related to the emotional processes of each individual, material was here prepared using personalized content derived from AAP interviews with each participant. In the personally relevant condition the AAP attachment scenes were accompanied by individually tailored descriptions containing core sentences from the patient's own narrative previously elicited by each picture. The same series of attachment scenes accompanied by a standard factual, non-emotional description for all participants was used as control condition. Participants were scanned at two time points (at the beginning of therapy and after 15 months). Outcome measure was the interaction of the signal difference between personal and neutral presentations with group and time, and its association with symptom improvement during therapy.

## Results

In the fMRI study signal associated with processing personalized attachment material varied in patients from baseline to endpoint, but not in healthy controls. Patients showed a higher activation in the left anterior hippocampus/amygdala, subgenual cingulate, and medial prefrontal cortex before treatment and a reduction in these areas after 15 months. This reduction was associated with improvement in depressiveness specifically, and in the medial prefrontal cortex with symptom improvement more generally. The pattern of changes in prefrontal areas found in the present study may be associated with mechanisms of emotional appraisal and control, suggesting reduced recourse to styles characterized by suppression and avoidance after long-term therapy. This interpretation outlines a possible mechanism for the understanding of emotional appraisal and regulation in the psychodynamic psychotherapy of depression.

The same sample was also examined in an EEG setting. At the beginning of treatment, patients confronted with the attachment paradigm showed a sustained gamma-band activity and a significant higher late positive potential (LPP) at fronto-central sites compared to the healthy controls. After 15 months of treatment, gamma band responses to personalized stimuli were significantly decreased in patients. This effect was not observed in the control group. In addition, the LPP amplitudes of the patients decreased and equalized to the amplitudes of the healthy controls. A smaller LPP as well as

gamma band response after 15 months of treatment may indicate reduced emotional responses e.g. due to enhanced emotion regulation strategies. (Buchheim et al. 2014).

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# Neural correlates of therapeutic changes in chronically depressed patients in psychoanalytic psychotherapy with the Operationalized Psychodynamic Diagnosis (OPD)

Kessler, H., Taubner, S., Buchheim, A., Münte, T.F., Stasch, M., et al. (2011). Individualized and clinically derived stimuli activate limbic structures in depression: An fMRI Study. *PLoS ONE* 6(1): e15712.

Kessler, H., Stasch, M., & Cierpka, M. (2013). Operationalized psychodynamic diagnosis as an instrument to transfer psychodynamic constructs into neuroscience. *Frontiers in Human Neuroscience* 7:718.

Taubner, S., Kessler, H. & Wiswede, D (2013). Neural activity in relation to empirically derived personality syndroms of depression using a psychodynamic fMRI paradigm. *Frontiers in Human Neuroscience* 7:812. DOI:10.3389/fnhum.2013.00812

Wiswede, D., Taubner, S., Buchheim, A., Münte, T.F., Stasch, M., et al. (2014) Tracking functional brain changes in patients with depression under psychodynamic psychotherapy using individualized stimuli. *PLoS ONE* 9(10): e109037.

Operationalized Psychodynamic Diagnosis (OPD-2) served as a tool to investigate complex intrapsychic processes in a reliable way by constructing core conflict formulations that were presented to the patients in the scanner. Kessler et al. (2013) provides the foundation and rationale of this procedure.

## Design

18 unmedicated patients with recurrent major depressive disorder were confronted with individualized and clinically derived stimuli in a functional MRI experiment before (T1) and after eight months (T2) of psychodynamic therapy. A control group of 17 healthy subjects was also tested twice without intervention. The experimental stimuli were sentences describing each participant's dysfunctional interpersonal relationship patterns derived from clinical interviews based on OPD (Kessler et al., 2011; Wiswede et al., 2014).

## Results

At T1 patients showed enhanced activation compared to controls in several limbic and subcortical regions, including amygdala and basal ganglia, when confronted with OPD sentences. At T2 the differences in brain activity between patients and controls were no longer apparent. Concurrently, patients had improved significantly in depression scores. Using ecologically valid stimuli, this study supports the model of limbic hyperactivity in depression that normalizes after treatment. Additionally, this study provides empirical evidence that the application of individualized stimuli is a powerful method to investigate complex intrapsychic processes as well as deepen our understanding of depression and its neural correlates.

Taubner et al. (2013) studied subgroups within the sample of chronically depressed patients. Using empirically derived personality syndroms with the Shedler-Westen-Assessment-Procedure, two personality factors could be distinguished: depressive or emotional-hostile-externalizing personality respectively. The degree to which patients score on the second correlated with relatively higher activity in three key areas involved in emotion processing, evaluation of reward/ punishment, negative cognitions, and social knowledge.

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# fMRI-Monitoring of an ongoing psychoanalysis

Buchheim A, Labek K, Walter S, Viviani R (2013) A clinical case study of a psychoanalytic psychotherapy monitored with functional neuroimaging. *Frontiers in Human Neuroscience*.

For the first time the Ulm study group explored the feasibility of single case research approach of an ongoing psychoanalysis using repeated fMRI measurements. We pursued the integration of clinical presentation, of operationalized formal instruments to describe the individual psychotherapeutic process (PQS), and of neuroimaging techniques to monitor the psychotherapeutic process on both the clinical and the neural levels. In the fMRI scans, the individualized attachment paradigm was used again (see also Buchheim et al. 2012).

Clinically, this patient presented defense mechanisms that influenced the relationship with the therapist and that was characterized by fluctuations of mood that lasted whole days, following a pattern that remained stable during the year of the study. The two modes of functioning associated with the mood shifts strongly affected the interaction with the therapist, whose quality varied accordingly ('easy' and 'difficult' hours).

In the fMRI data, the modes of functioning visible in the therapy hours were significantly associated with modulation of the signal elicited by personalized attachment-related scenes in the posterior cingulate. This region has been associated in previous studies to self-distancing from negatively valenced interactions presented during the scan.

## Evaluation

This pilot study may provide indications of the possible involvement of this brain area in spontaneously enacted self-distancing defensive strategies, which may be of relevance in resistant patient reactions in the course of a specific phase in psychoanalytic psychotherapy (Buchheim et al. 2013).

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with group and time as well as changes on psychodynamic dimensions, particularly in those related to interpersonal relations (OPD-2, OPD-SF, MIPQS, IIP-D, IMI, FKBS).

## **Discussion**

This study adopts an individualized neuroimaging approach to track neurobiological changes underlying psychodynamic psychotherapy. The strength of the study design resides in the use of an innovative fMRI paradigm along with a large set of psychological and psychodynamic measures. Also, collaboration with other psychotherapeutic institutes enabled the inclusion of different treatment groups (cognitive behavioural psychotherapy and body-centred psychotherapy). Limitations of the study design include methodological challenges of using an individualized neuroimaging approach. Furthermore, variability in the different treatment groups was only controlled to a certain extent.

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Prof. Dr. med. Heinz Böker

# Neural Predictors of Successful Brief Psychodynamic Psychotherapy for Persistent Depression

Roffman, J.L. Witte, J.M., Alexandra S. Tanner, A.S., Ghaznavi, S. Abernethy, R.S., Crain, L.D., Giulino, P.U., Lable, I., Levy, R. A., Dougherty D.D., Evan, K.C., Fava, M.(2014): *Neural Predictors of Successful Brief Psychodynamic Psychotherapy for Persistent Depression*, *Psychother Psychosom* 2014;83:364–370

## Summary

Psychodynamic psychotherapy has been used to treat depression for more than a century. However, not all patients respond equally well, and there are few reliable predictors of treatment outcome.

## Methods

We used resting 18 F-fluorodeoxyglucose positron emission tomography ( 18 FDG-PET) scans immediately before and after a structured, open trial of brief psychodynamic psychotherapy (n = 16) in conjunction with therapy process ratings and clinical outcome measures to identify neural correlates of treatment response.

## Results

Pretreatment glucose metabolism within the right posterior insula correlated with depression severity. Reductions in depression scores correlated with a pre- to posttreatment reduction in right insular metabolism, which in turn correlated with higher objective measures of patient insight obtained from videotaped therapy sessions. Pretreatment metabolism in the right precuneus was significantly higher in patients who completed treatment and correlated with psychological mindedness.

## Conclusions

Resting brain metabolism predicted both clinical course and relevant psychotherapeutic process during short-term psychodynamic psychotherapy for depression.

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4. A metaanalysis on outcome studies on longterm psychoanalytical treatments and psychoanalyses

# Evidence for psychodynamic psychotherapy in specific mental disorders: a systematic review

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*This article reviews the empirical evidence for psychodynamic therapy for specific mental disorders in adults. According to the results presented here, there is evidence from randomized controlled trials (RCTs) that psychodynamic therapy is efficacious in common mental disorders, including depressive disorders, anxiety disorders, somatoform disorders, personality disorders, eating disorders, complicated grief, posttraumatic stress disorder (PTSD), and substance-related disorders. These results clearly contradict assertions repeatedly made by representatives of other psychotherapeutic approaches claiming that psychodynamic psychotherapy is not empirically supported. However, further research is required, both on outcome and processes of psychodynamic psychotherapy. There is a need, for example, for RCTs of psychodynamic psychotherapy of PTSD. Furthermore, research on long-term psychotherapy for specific mental disorders is required.*

*Keywords: psychodynamic psychotherapy; empirically supported treatments; psychotherapy outcome research; evidence-based medicine*

In this article, the available evidence for psychodynamic psychotherapy (PDT) in adults is reviewed. The focus will be on randomized controlled trials (RCTs), which are regarded as the ‘gold standard’ for demonstrating treatment efficacy. Previous reviews have been undertaken, for example, by Fonagy, Roth, and Higgitt (2005), Leichsenring, Klein, and Salzer (in press), Shedler (2010), and Gerber et al. (2011). Shedler (2010) came to the conclusion that effect sizes of PDT are as large as those reported for other forms of psychotherapy that are regarded as ‘empirically supported.’ In addition, he found that effects of PDT were stable or tended to improve after the end of treatment. In a quality-based review of RCTs, Gerber et al. (2011) found PDT to be at least as efficacious as another active treatment in 34 of 39 studies (87%). In comparison with inactive conditions, PDT was superior in 18 of 24 adequate comparisons (75%).

In another quality-based review of RCTs, Thoma et al. (2012) examined the methodological quality of RCTs of cognitive-behavioral therapy (CBT) in depression. Contrary to their expectation, the authors found no significant differences in methodological quality between RCTs of CBT in depression and RCTs of PDT. Taking the frequently put forward criticism of the methodological quality of studies of PDT into account (e.g., Bhar & Beck, 2009), the result reported by Thoma et al. (2012) is of some importance. In another context, we showed that often double standards were applied when studies of PDT were criticized by representatives of other approaches (Leichsenring & Rabung, 2011).

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## Evidence-based medicine and empirically supported treatments

Several proposals have been made to grade the available evidence of both medical and psychotherapeutic treatments (Canadian Task Force on the Periodic Health Examination, 1979; Chambless & Hollon, 1998; Clarke & Oxman, 2003; Cook, Guyatt, Laupacis, Sackett, & Goldberg, 1995; Nathan & Gorman, 2002). Apart from other differences, all available proposals regard RCTs (efficacy studies) as the ‘gold standard’ for the demonstration that a treatment is effective. According to this view, only RCTs can provide level I evidence, which is the highest level of evidence. RCTs are conducted under controlled experimental conditions, allowing one to control for variables systematically influencing the outcome apart from the treatment. The defining feature of an RCT is the random assignment of subjects to the different conditions of treatment (Shadish, Cook, & Campbell, 2002). Randomization is regarded as indispensable in order to ensure that a priori existing differences between subjects are equally distributed. The goal of randomization is to attribute the observed effects exclusively to the applied therapy. Thus, randomization is used to ensure the internal validity of a study (Shadish et al., 2002). Gabbard, Gunderson, and Fonagy (2002) discuss different types of RCTs that provide different levels of evidence. The most stringent test of efficacy is achieved by comparison with rival treatments, thus controlling for specific and unspecific therapeutic factors (Chambless & Hollon, 1998, p. 8). Furthermore, such comparisons provide explicit information regarding the relative benefits of competing treatments. Treatments that are found to be superior to rival treatments are more highly valued.

As RCTs are carried out under controlled experimental conditions, their internal validity is usually high. However, for this very reason, their external validity may be limited, in that their results may not be fully representative of clinical practice. In contrast to RCTs, naturalistic studies (observational or effectiveness studies) are conducted under the conditions of clinical practice. Thus, their results are usually more representative for clinical practice with regard to patients, therapists, and treatments (external validity). RCTs and observational studies address different questions of research, i.e., efficacy under controlled experimental conditions versus effectiveness under the conditions of clinical practice (Leichsenring, 2004). For this reason, RCTs are not ‘bad’ and observational studies are not ‘good’ or vice versa. Their relationship is complementary rather than one of rival (Leichsenring, 2004).

## Methods

### Definition of Psychodynamic Therapy (PDT)

PDT operates on an interpretive-supportive continuum (Gunderson & Gabbard, 1999; Wallerstein, 1989). Interpretive interventions enhance the patient’s insight about repetitive conflicts sustaining his or her problems (Gabbard, 2004; Luborsky, 1984). Supportive interventions aim to strengthen abilities (‘ego-functions’) that are temporarily not accessible to a patient due to acute stress (e.g., traumatic events) or that have not been sufficiently developed (e.g., impulse control in borderline personality disorder; BPD). Thus, supportive interventions maintain or build ego functions (Wallerstein, 1989). Supportive interventions include, for example, fostering a therapeutic alliance, setting goals, or strengthening ego functions such as reality testing or impulse control (Luborsky, 1984). The use of more supportive or more interpretive (insight-enhancing) interventions depends on the patient’s needs. The more severely disturbed a patient is, or the more acute his or her problem is, the more supportive and less interpretive interventions are required and vice versa (Luborsky, 1984; Wallerstein, 1989). Borderline patients, as well as healthy subjects, in an acute crisis or after a traumatic event may need more supportive interventions (e.g., stabilization, providing a safe and supportive environment). Thus, a broad spectrum of psychiatric problems and disorders can be treated with PDT, ranging from milder adjustment disorders or stress reactions to severe personality disorders such as BPD or psychotic conditions.

## Inclusion and exclusion criteria

The following inclusion and exclusion criteria were applied: (1) PDT according to the definition above was applied, (2) RCT, (3) reliable and valid measures for diagnosis and outcome, (4) use of treatment manuals, and (5) study of specific mental disorders. Studies examining the combination of psychodynamic therapy and medication were not included, however, concomitant medication in both treatment arms was allowed.

We collected studies of PDT that were published between 1970 and September 2013 by use of a computerized search of MEDLINE, PsycINFO, and Current Contents. The following search terms were used: (psychodynamic or dynamic or psychoanalytic\*) and (therapy or psychotherapy or treatment) and (study or studies or trial\*) and (outcome or result\* or effect\* or change\*) and (psych\* or mental\*) and (RCT\* or control\* or compare\*). Manual searches in articles and textbooks were performed. In addition, we communicated with authors and experts in the field.

## Efficacy studies of PDT in specific mental disorders

A total of 47 RCTs providing evidence for the efficacy of PDT in specific mental disorders were identified and included in this review. These studies are presented in Table 1.

**Tabelle 1**

Study	Disorder	N (PP)	Comparison Group	Concept of PP	Treatment Duration
<b>Depressive disorders</b>					
Barber et al. (2012)	Major depression	51	Pharmacotherapy: N = 55	Luborsky	20 sessions
			Placebo: N = 50		16 weeks
Barkham et al. (1996)	Major depression	18	CBT: N = 18	Shapiro and Firth	8 versus 16 sessions
Driessen et al. (2013)	Major depression	117	CBT: N = 164	de Jonghe	16 sessions
Gallagher-Thompson and Steffen (1994)	Major, minor or intermittent depression	30	CBT: N = 36	Mann, Rose and DelMaestro	16-20 sessions
Johannson et al. (2012)	Major depression	46	Structured Support: N = 46	Internet-guided self-help; Silverberg	10 weeks
Maina et al. (2005)	Dysthymic disorder	10	Supportive therapy: N = 10	Malan	15-30 sessions
			Waiting list: N = 25		
Salminen et al. (2008)	Major depression	26	Fluoxetine: N = 25	Mann, Malan	16 sessions
Shapiro et al. (1994)	Major depression	58	CBT: N = 59	Shapiro and Firth	8 versus 16 sessions

Thompson et al. (1987)	Major depression	24	BT: <i>N</i> = 25	Horowitz and Kaltreiter	16-20 sessions
			CBT: <i>N</i> = 27		
			Waiting list: <i>N</i> = 19		
<b>Anxiety disorders</b>					
Bögels et al. (2003)	social phobia	22	CBT: <i>N</i> = 27	Malan	36 sessions
Crits-Christoph et al. (2005)	Generalized anxiety disorder	15	Supportive therapy: <i>N</i> = 16	Luborsky; Crits-Christoph et al.	16 sessions
Knijnik (2004)	Social phobia	15	Credible placebo control group: <i>N</i> = 15	Knijnik et al.	12 sessions
Leichsenring et al.: 820099	Generalized anxiety disorder	28	CBT: <i>N</i> = 29	Luborsky; Crits-Christoph et al.	30 sessions
Leichsenring et al. (2013a)	Social phobia	207	Cognitive therapy: <i>N</i> = 2009	Luborsky, Leichsenring, Beutel; Leibing	30 sessions
Milrod et al. (2007)	Panic disorder	26	Waiting list: <i>N</i> = 79 CBT (applied relaxation), <i>N</i> = 23	Milrod et al.	24 sessions
<b>Mixed samples of depressive and anxiety disorders</b>					
Bressi et al. (2010)	Depressive and anxiety disorders	30	TAU: <i>N</i> = 30	Malan	40 sessions
Knet et al. (1989)	Depressive and anxiety disorders	128, 101	Solution-focused therapy: <i>N</i> = 97	Malan; Sifneos; Gabbard	235 sessions; 49.9 sessions; 29.9 sessions
PTSD Brom et al. (1989)	PTSD	29	Desensitization: <i>N</i> = 31	Horowitz	18.8 sessions
			Hypnotherapy: <i>N</i> = 29		
<b>Somatoform disorders</b>					
Creed et al. (2003)	Irritable bowel	59	Paroxetine: <i>N</i> = 43	Hobson; Shapiro and Firth	8 sessions
			TAU: <i>N</i> = 86		
Faramaszi et al. (2013)	Functional dyspepsia	24	Medical treatment: <i>N</i> = 25	Luborsky, Book	16 sessions
Guthrie et al. (1991)	Irritable bowel	50	Supportive listening: <i>N</i> = 46	Hobson; Shapiro and Firth	8 sessions

Hammilton et al. (2000)	Functional dyspepsia	37	Supportive Therapy: N = 36	Spapiro and Firth	7 sessions
Monsen and Monsen (2000)	Somatoform Pain disorder	20	TAU/no therapy: N = 20	Monson and Monson	33 sessions
Sattel et al. (2012)	Multi-somatoform disorder	107	Enhanced medical care: N = 104	Hardy; Barkham et al.	12 sessions
<b>Eating disorders</b>					
Bachar et al. (1999)	Anorexia nervosa, Bulimia nervosa	17	Cognitive Therapy: N = 17	Barth; Goodsitt; Geist	46 sessions
			Nutritional counseling: N = 10		
Dare et al. (2001)	Anorexia nervosa	21	Cognitive-analytic therapy (Ryle): N = 22	Malan; Dare et al.	M = 24.9 sessions
			Family therapy: N = 22		
			Routine treatment: N = 19		
Zipfel et al. (2013)	Anorexia nervosa	80	Enhanced CBT: N = 80	Schauenburg et al.	LTPP: 39.9 sessions
			Enhanced CBT: 44.8 sessions		
			Optimized TAU: 50.8 sessions		
Fairburn et al. (1986)	Bulimia nervosa	11	CBT: N = 11	Rosen; Stunkard; Bruch	19 sessions
Garner et al. (1993)	Bulimia nervosa	25	CBT: N = 25	Luborsky	19 sessions
Gowers et al. (1994)	Anorexia nervosa	20	TAU: N = 20	Crisp	12 sessions
Tasca et al. (2006)	Binge eating disorder	48	Group CBT: N = 47	Tasca et al.	16 sessions
			Waiting list: N = 40		
<b>Substance related disorders</b>					
Crits-Christoph et al. (1999, 2001)	Cocain dependence	124	CBT+ group DC: N = 97	Mark and Luborsky + group DC	Up to 36 individual and group sessions; 4 month
			Individual DC: N = 92		

			Individual DC + group DC: <i>N</i> = 96		
Sandahl et al. (1998)	Alcohol dependence	25	CBT: <i>N</i> = 24	Foulkes	15 sessions ( <i>M</i> = 8.9)
Woody et al. (1993, 1990)	Opiate dependence	31	DC: <i>N</i> = 35	Luborsky + DC	12 sessions
			CBT + DC: <i>N</i> = 34		
Woody et al. 1995)	Opiate dependence	57	DC: <i>N</i> = 27	Luborsky + DC	26 sessions
<b>Borderline personality disorder</b>					
Bateman and Fonagy (1999, 2001)	BPD	19	TAU: <i>N</i> = 19	Bateman and Fonagy	18 month
Bateman and Fonagy (2009)	BPD	71	Structured clinical management: <i>N</i> = 63	Bateman and Fonagy	18 month
Clarkin et al. (2007)	BPD	30	Dialectical behavioral therapy: <i>N</i> = 30	Kernberg; Clarkin et al.	12 month
			Supportive therapy: <i>N</i> = 30		
Doering et al. (2010)	BPD	43	Treatment by experienced community therapist: <i>N</i> = 29	Clarkin et al.	Assessment after 1 year
Giesen-Bloo et al. (2006)	BPD	42	CBT: <i>N</i> = 44	Kernberg; Clarkin et al.	3 years with sessions twice a week
Gregory et al. (2008)	BPD	15	TAU: <i>N</i> = 15	Gregory and Remen	24.9 sessions
Munroe-Blum and Marziali (1995)	BPD	31	Interpersonal Group: <i>N</i> = 25	Kernberg	17 sessions
<b>Cluster C personality disorders</b>					
Muran et al. (2005)	Cluster C personality disorders	22	Brief relational therapy: <i>N</i> = 33	Pollack et al.	30 sessions
			CBT: <i>N</i> = 29		
Svartberg et al. (2004)	Cluster C personality disorders	25	CBT: <i>N</i> = 25	Malan; McCullough Vaillant	40 sessions
<b>Avoidant personality disorder</b>					
Emmelkamp et al. (2006)	Avoidant personality disorder	23	CBT: <i>N</i> = 21	Malan; Luborsky; Luborsky and Mark; Pinsker et al.	20 sessions
			Waiting list: <i>N</i> = 18		

Samples of mixed personality disorders					
Abbas et al. (2008)	Heterogeneous personality disorders	14	Minimal contact: N = 14	Davenloo	27.7 sessions (mean)
Hellerstein et al. (1998)	Primarily Cluster C personality disorders	25	Brief supportive psychotherapy: N = 24	Davenloo	40 sessions

## Models of PDT

In the studies identified, different forms of PDT were applied (Table 1). The models developed by Luborsky (1984), Shapiro and Firth (1985), and Malan (1976) were used most frequently.

## Evidence for the efficacy of PDT in specific mental disorders

The studies of PDT included in this review will be presented for different mental disorders. However, from a psychodynamic perspective, the results of a therapy for a specific psychiatric disorder (e.g., depression, agoraphobia) are influenced by the underlying psychodynamic features (e.g., conflicts, defenses, personality organization), which may vary considerably within one category of psychiatric disorder (Kernberg, 1996). These psychodynamic factors may affect treatment outcome and may have a greater impact on outcome than the phenomenological DSM categories (Piper, McCallum, Joyce, Rosie, & Ogrodniczuk, 2001).

### Depressive disorders

At present, several RCTs are available that provide evidence for the efficacy of PDT compared to CBT in major depressive disorder (Barkham et al., 1996; Driessen et al., 2013; Gallagher-Thompson & Steffen, 1994; Shapiro et al., 1994; Thompson, Gallagher, & Breckenridge, 1987). It is of note that due to the large sample size the RCT by Driessen et al. (2013) was sufficiently powered for an equivalence trial. Different models of PDT were applied (Table 1). Thase (2013) concluded from this RCT: *'On the basis of these findings, there is no reason to believe that psychodynamic psychotherapy is a less effective treatment of major depressive disorder than CBT.'*

In another RCT by Salminen et al. (2008), PDT was found to be equally efficacious as fluoxetine in reducing symptoms of depression and improving functional ability. However, with sample sizes of N1 ¼ 26 and N2 ¼ 25, statistical power may have not been sufficient to detect possible differences between treatments. In a small RCT, Maina, Forner, and Bogetto (2005) examined the efficacy of PDT and brief supportive therapy in the treatment of minor depressive disorders (dysthymic disorder, depressive disorder not otherwise specified, or adjustment disorder with depressed mood). Both treatments were superior to a waiting-list condition at the end of treatment. At six-month follow-up, PDT was superior to brief supportive therapy. In a recent study by Barber, Barrett, Gallop, Rynn, and Rickels (2012), PDT and pharmacotherapy were equally effective in the treatment of depression. However, neither PDT nor pharmacotherapy was superior to placebo.

An earlier meta-analysis (Leichsenring, 2001) found PDT and CBT to be equally effective with regard to depressive symptoms, general psychiatric symptoms, and social functioning. These results are consistent with the findings of more recent meta-analyses by Barth et al. (2013) and Driessen et al. (2010; Abbass & Driessen, 2010). Barth et al. (2013) did not find significant differences in outcome between different forms of psychotherapy of depression. Driessen et al. (2010) found PDT significantly superior to control conditions. If group therapy was included, PDT was less efficacious compared to other treatments at the end of therapy. If only individual therapy was included, there were no significant differences between PDT and other treatments (Abbass & Driessen, 2010). In three-month and nine month follow-ups, no significant differences between treatments were found.

Meanwhile, internet-guided self-help is also available for PDT. In an RCT, Johansson et al. (2012) found internet-guided self-help based on PDT significantly more efficacious than a structured support intervention (psychoeducation and scheduled weekly contacts online) in patients with major depressive disorder. Treatment effects were maintained at 10-month followup.

Psychodynamically oriented self-help was based on the concept by Silverberg (2005). Silverberg's internet-guided self-help based on PDT is a promising approach, especially for patients who do not receive psychotherapy. Further studies should be carried out.

In summary, several RCTs provide evidence for the efficacy of PDT in depressive disorders.

## Pathological grief

In two RCTs by McCallum and Piper (1990) and Piper et al. (2001), the treatment of prolonged or complicated grief by short-term psychodynamic group therapy was studied. In the first study, short-term psychodynamic group therapy was significantly superior to a waiting list (McCallum & Piper, 1990). In the second study, a significant interaction was found. With regard to grief symptoms, patients with high quality of object relations improved more in interpretive therapy, and patients with low quality of object relations improved more in supportive therapy. For general symptoms, clinical significance favored interpretive therapy over supportive therapy (Piper et al., 2001).

## Anxiety disorders

For anxiety disorders, several RCTs are presently available (Table 1). With regard to panic disorder (with or without agoraphobia), Milrod et al. (2007) showed in an RCT that PDT was more successful than applied relaxation. For social phobia, three RCTs of psychodynamic therapy exist. In the first study, short-term psychodynamic group treatment for generalized social phobia was superior to a credible placebo control (Knijnik, Kapczinski, Chachamovich, Margis, & Eizirik, 2004).

In a study by Bögels, Wijts, and Sallerts (2003), PDT proved to be as effective as CBT in the treatment of (generalized) social phobia. However, with sample sizes of  $N = 22$  and  $N = 24$ , statistical power may have not been sufficient to detect possible differences between treatments.

In a large-scale multicenter RCT, the efficacy of PDT and cognitive therapy (CT) in the treatment of social phobia was studied (Leichsenring et al., 2013a). In an outpatient setting, 495 patients with a primary diagnosis of social phobia were randomly assigned to CT, PDT, or the waiting list.

Treatments were carried out according to manuals and treatment fidelity was carefully controlled for. Both treatments were significantly superior to the waiting list. Thus, this trial provides evidence that PDT is effective in the treatment of social phobia according to the criteria proposed by Chambless and Hollon (1998). There were no differences between PDT and CT with regard to response rates for social phobia (52% vs. 60%) and reduction of depression. There were significant differences between CT and PDT in favor of CT, however, with regard to remission rates (36% vs. 26%), self-reported symptoms of social phobia, and reduction of interpersonal problems. Differences in terms of between-group effect sizes, however, were small and below the priori set threshold for clinical significance (Leichsenring, Salzer, & Leibing, in press; Leichsenring et al., 2013a). Taking these results referring to clinically significant differences into account, recommending CBT over PDT in social anxiety disorders is not warranted. As Kraemer (2011, p. 1350) puts it: 'Only if the ES [effect size] is greater than some value  $d^*$  [threshold of clinical significance] is a strong clinical recommendation of one treatment over the other warranted.' For the comparison of PDT with CBT, this was not the case. Furthermore, in the follow-up study 6, 12, and 24 months after end of therapy, neither statistically significant nor clinically significant differences were found between CT and PDT in any outcome measure (Leichsenring et al., 2013b). In general, the differentiation between statistical and clinical significance has not yet been sufficiently taken into account in psychotherapy research. From small,

but statistically significant differences, the conclusion is drawn that one treatment is superior to another (Leichsenring et al., in press).

In a randomized controlled feasibility study of generalized anxiety disorder, PDT was equally effective as a supportive therapy with regard to continuous measures of anxiety, but significantly superior on symptomatic remission rates (Crits-Christoph, Connolly Gibbons, Narducci, Schamberger, & Gallop, 2005). However, the sample sizes of that study were relatively small (N = 15 vs. N = 16), and the study was not sufficiently powered to detect more possible differences between treatments. In another RCT of generalized anxiety disorder, PDT was compared to CBT (Leichsenring et al., 2009). PDT and CBT were equally effective with regard to the primary outcome measure. However, in some secondary outcome measures, CBT was found to be superior, both at the end of therapy and at the six-month follow-up. Other differences may exist that were not detected due to the limited sample size and power (CBT: N = 29; PDT: N = 28). In the one-year follow-up, results proved to be stable (Salzer, Winkelbach, Leweke, Leibing, & Leichsenring, 2011). Contrary to short-term PDT (STPP), a core element in the applied method of CBT consisted of a modification of worrying. This specific difference between the treatments may explain the superiority of CBT in the Penn State Worry Questionnaire (Meyer, Miller, Metzger, & Borkovec, 1990) and, in part, also in the State-Trait Anxiety Inventory (trait measure) (Spielberger, Gorsuch, & Lushene, 1970) – the latter also contains several items related to worrying. The results of that study may suggest that the outcome of STPP in generalized anxiety disorder may be further optimized by employing a stronger focus on the process of worrying. In PDT, worrying can be conceptualized as a mechanism of defense that protects the subject from fantasies or feelings that are even more threatening than the contents of his or her worries (Crits-Christoph, Wolf-Palacio, Ficher, & Rudick, 1995).

According to the available RCTs, PDT is efficacious in anxiety disorders. If differences between PDT and CBT were found, they showed up in secondary outcome measures or corresponded to small differences in effect size. This is consistent with a recent meta-analysis by Baardseth et al. (2013) who did not find significant differences in favor of CBT compared to bona fide treatments.

For CBT, a recent historical review showed that the efficacy of treatments for anxiety disorders has not increased but rather decreased from the 1980s to the present (Öst, 2008). Furthermore, a substantial proportion of patients do not sufficiently benefit from the treatments and the proportion of nonresponders does not appear to have decreased over time (Öst, 2008). For these reasons, there is a need to further improve the treatment of anxiety disorders (Schmidt, 2012). This is true not just for CBT, but also for PDT as well (Leichsenring, Klein, Salzer, 2014). In one of the most promising approaches to address this problem, psychotherapy research is moving from single-disorder-focused manualized approaches toward ‘transdiagnostic’ and modular treatments (e.g., Barlow, Allen, & Choate, 2004; McHugh, Murray, & Barlow, 2009). The rationale for transdiagnostic treatments focuses on similarities among disorders, particularly in a similar class of diagnoses (e.g., anxiety disorders), including high rates of comorbidity and improvements in comorbid conditions when treating a principal disorder (Barlow et al., 2004; McHugh et al., 2009). For these reasons, researchers in the field of CBT have developed transdiagnostic treatment protocols (e.g., Barlow et al., 2004; McHugh et al., 2009; Norton & Phillip, 2008). It is an advantage that PDT is traditionally less tailored to single mental disorders, but focuses on core underlying processes of mental disorders. A recent review has shown that the empirically supported methods of PDT for specific anxiety disorders have core treatment components in common (Leichsenring & Salzer, in press). These components have been distilled and integrated into an evidence-based Unified Psychodynamic Protocol for ANXIety disorders (UPPAnx; Leichsenring & Salzer, in press).

Integrating treatment elements of empirically supported methods of PDT for specific anxiety disorders, the manualized UPP-Anx has the potential to: (1) be more effective than single-disorder psychotherapy, (2) be more effective than routine PDT, (3) improve comorbid symptoms, (4) enhance patients’ quality of life, (5) facilitate translation of research into clinical practice of mental health professionals, (6) facilitate training for practitioners and dissemination of the approach relative to

training in several distinct single-disorder treatments, (7) be more cost efficient (e.g., by additionally improving comorbid symptoms), and (8) have an impact on both the health-care system and public health. As a next step, we are planning to evaluate the UPP-Anx in a RCT.

### Mixed samples of depressive and anxiety disorders

Knekt et al. (2008a, 2008b) compared STPP, long-term psychodynamic psychotherapy (LTPP), and solution-focused therapy (SFT) in patients with depressive or anxiety disorders. STPP was more effective than LTPP during the first year. During the second year of follow-up, no significant differences were found between long-term and short-term treatments. In the three-year follow-up, LTPP was more effective; no significant differences were found between the short-term treatments. With regard to specific mental disorders, it is of note that after three years significantly more patients recovered from anxiety disorders in LTPP (90%) compared to STPP (67%) and SFT (65%). For depressive disorders, no such differences occurred. In an RCT by Bressi, Porcellana, Marinaccio, Nocito, and Magri (2010), PDT was superior to Treatment as Usual (TAU) in a sample of patients with depressive or anxiety disorders.

### Posttraumatic stress disorder

In an RCT by Brom, Kleber, and Defares (1989), the effects of PDT, behavioral therapy, and hypnotherapy in patients with posttraumatic stress disorder (PTSD) were studied. All of the treatments proved to be equally effective. The results reported by Brom et al. (1989) are consistent with that of a more recent metaanalysis by Benish, Imel, and Wampold (2008), which found no significant differences between bona fide treatments of PTSD. In a response to the metaanalysis by Benish et al. (2008), Ehlers et al. (2010) critically reviewed the study by Brom et al. (1989). A comprehensive discussion with a convincing reply to the critique by Ehlers et al. (2010) was given by Wampold et al. (2010). In the present context, we shall only address the critique put forward by Ehlers et al. (2010) against the study by Brom et al. (1989). Ehlers et al. (2010) reviewed the study by Brom et al. (1989) in the following way (p. 273, italics by the authors): ‘In this study, neither hypnotherapy nor psychodynamic therapy was consistently more effective than the waiting-list control condition across the analyses used . . .’ In addition, Brom et al. (1989) pointed out that ‘Patients in psychodynamic therapy showed slower overall change than those in the other two treatment conditions, and did not improve in intrusive symptoms significantly . . .’

Results are different for different outcome measures. For the avoidance scale and the total score of the Impact of Event Scale (Horowitz, Wilner, & Alvarez, 1979), PDT was significantly superior to the waiting-list condition, both after therapy and at follow-up (Brom et al., 1989, p. 610, Table 1). While effect sizes for PDT were somewhat smaller at posttreatment (avoidance: 0.66, total: 1.10), PDT achieved the largest effect sizes at follow-up (avoidance: 0.92, total: 1.56) as compared to CBT (avoidance: 0.73, total: 1.30) and hypnotherapy (avoidance: 0.88, total: 1.54).

For the intrusion scale of the Impact of Event Scale, the primary outcome measure, it is true that PDT was not superior to waiting list both at posttest and at three-month follow-up. Intrusion is one of the core symptoms of PTSD. Pre–post differences of PDT, however, were significant and the pre–post and prefollow-up effect sizes were large (0.95 and 1.55, respectively). In contrast, the pre–post effect size for the waiting list was small (0.34). For the CBT condition (trauma desensitization), the pre–post and pre-follow-up effect sizes were 1.66 and 1.43, respectively. Thus, at follow-up, PDT achieved a larger effect size than CBT. While the effect size of CBT tended to decrease at follow-up, it tended to increase for PDT; as will be shown below, this is true for the avoidance scale and the total score of the Impact of Event Scale. For this reason, it is strange that the difference between PDT and the control condition was reported by Brom et al. (1989) to be not significant at follow-up. For intrusion, PDT achieved the lowest score of all conditions at follow-up. These results, however, were not reported by Ehlers et al. (2010). The figure presented by Ehlers et al. (2010, p. 273, Figure 2) only included the

pre-post effect sizes, but not the pre-follow-up effect sizes, for which PDT achieved larger effect sizes, as shown above. In a critical review, results of all analyses should be presented, not only the results that support one's own perspective. Furthermore, for general symptoms, Brom et al. (1989) wrote that PDT 'seems to withstand the comparison [with waiting list] best' (p. 610). Thus, after all, it seems to take (a little bit, i.e., three months!) longer for PDT to achieve its effects, but these effects are at least as large as those of CBT.

Further studies of PDT in PTSD are required. At present, only one RCT of PDT in PTSD is presently available.

## Somatoform disorders

At present, five RCTs of PDT in somatoform disorders that fulfill the inclusion criteria are available (Table 1). In the RCT by Guthrie, Creed, Dawson, and Tomenson (1991), patients with irritable bowel syndrome, who had not responded to standard medical treatment over the previous six months, were treated with PDT in addition to standard medical treatment. This treatment was compared to standard medical treatment alone. According to the results, PDT was effective in two-thirds of the patients. In another RCT, PDT was significantly more effective than routine care, and as effective as medication (paroxetine) in the treatment of severe irritable bowel syndrome (Creed et al., 2003). During the follow-up period, however, PDT, but not paroxetine, was associated with a significant reduction in health-care costs compared with TAU. In an RCT by Hamilton et al. (2000), PDT was compared to supportive therapy in the treatment of patients with chronic intractable functional dyspepsia, who had failed to respond to conventional pharmacological treatments. At the end of treatment, PDT was significantly superior to the control condition. The effects were stable in the 12-month follow-up.

An RCT by Faramarzi et al. (2013) corroborated these results with PDT combined with medical treatment being superior to medical treatment alone, with regard to gastrointestinal symptoms, defense mechanisms, and alexithymia, both at the end of therapy and at the 1- and 12-month follow-up. Monsen and Monsen (2000) compared PDT of 33 sessions with a control condition (no treatment or TAU) in the treatment of patients with chronic pain. PDT was significantly superior to the control group on measures of pain, psychiatric symptoms, interpersonal problems, and affect consciousness. The results remained stable or even improved in the 12-month follow-up. In a recent study, Sattel et al. (2012) compared PDT with enhanced medical care in patients with multi-somatoform disorders. At follow-up, PDT was superior to enhanced medical care with regard to improvements in patients' physical quality of life.

Abbass, Kisely, and Kroenke (2009) carried out a review and meta-analysis on the effects of PDT in somatoform disorders. They included both RCTs and controlled before and after studies. Meta-analysis was possible for 14 studies. It revealed significant effects on physical symptoms, psychiatric symptoms, and social adjustment, which were maintained in long-term follow-up. Thus, specific forms of PDT can be recommended for the treatment of somatoform disorders.

## Bulimia nervosa

For the treatment of bulimia nervosa, three RCTs of PDT are available (Table 1). Significant and stable improvements in bulimia nervosa after PDT were demonstrated in the RCTs by Fairburn, Kirk, O'Connor, and Cooper (1986), Fairburn et al. (1995), and Garner et al. (1993). In the primary disorder-specific measures (bulimic episodes, self-induced vomiting), PDT was as effective as CBT (Fairburn et al., 1986, 1995; Garner et al., 1993). Again, however, the studies were not sufficiently powered to detect possible differences (see Table 1m for sample sizes). Apart from this, CBT was superior to PDT in some specific measures of psychopathology (Fairburn et al., 1986). However, in a follow-up (Fairburn et al., 1995) of the Fairburn et al. (1986) study using a longer follow-up period, both forms of therapy proved to be equally effective and were partly superior to a behavioral form of therapy. Accordingly, for a valid evaluation of the efficacy of PDT in bulimia nervosa, longer-term

follow-up studies are necessary. In another RCT, PDT was significantly superior to both a nutritional counseling group and CT (Bachar, Latzer, Kreitler, & Berry, 1999). This was true of patients with bulimia nervosa and a mixed sample of patients with bulimia nervosa or anorexia nervosa.

## Anorexia nervosa

For the treatment of anorexia nervosa, however, evidence-based treatments are barely available (Fairburn, 2005). This applies to both PDT and CBT. In an RCT by Gowers, Norton, Halek, and Crisp (1994), PDT combined with four sessions of nutritional advice yielded significant improvements in patients with anorexia nervosa (Table 1). Weight and body mass index (BMI) changes were significantly more improved than in a control condition (TAU). Dare, Eisler, Russell, Treasure, and Dodge (2001) compared PDT with a mean duration of 24.9 sessions to cognitive-analytic therapy, family therapy, and routine treatment in the treatment of anorexia nervosa (Table 1). PDT yielded significant symptomatic improvements and PDT and family therapy were significantly superior to the routine treatment with regard to weight gain. However, the improvements were modest – several patients were undernourished at the followup.

A recent RCT compared manual-guided psychodynamic therapy, enhanced CBT, and optimized TAU in the treatment of anorexia nervosa (Zipfel et al., 2013). After 10 months of treatment, significant improvements were found in all treatments, with differences in the primary outcome measure (BMI). At the 12-month follow-up, however, psychodynamic therapy was significantly superior to optimized TAU, whereas enhanced CBT was not (Zipfel et al., 2013). Recovery rates were 35% versus 19% versus 13% for psychodynamic therapy enhanced CBT and optimized TAU. Thus, the method of psychodynamic therapy specifically tailored to the treatment of anorexia nervosa yielded promising effects.

## Binge eating disorder

In an RCT by Tasca et al. (2006), a psychodynamic group treatment was as efficacious as CBT and superior to a waiting-list condition in binge eating disorder (e.g., days binged, interpersonal problems). For the comparison of PDT with CBT, again the question of statistical power arises ( $N_1 = 48$ ,  $N_2 = 47$ ,  $N_3 = 40$ ).

## Substance-related disorders

Woody et al. (1983; Woody, Luborsky, McLellan, & O'Brien, 1990) studied the effects of PDT and CBT, both of which were given in addition to drug counseling, in the treatment of opiate dependence (Table 1). PDT plus drug counseling yielded significant improvements on measures of drug-related symptoms and general psychiatric symptoms. At seven-month follow-up, PDT and CBT, plus drug counseling, were equally effective, and both conditions were superior to drug counseling alone. In another RCT, PDT of 26 sessions given in addition to drug counseling was also superior to drug counseling alone in the treatment of opiate dependence (Woody, McLellan, Luborsky, & O'Brien, 1995). At six-month follow-up, most of the gains made by the patients who had received psychodynamic therapy remained.

In an RCT conducted by Crits-Christoph et al. (1999, 2001), PDT of up to 36 individual sessions was combined with 24 sessions of group drug counseling in the treatment of cocaine dependence. The combined treatment yielded significant improvements and was as effective as CBT, which was combined with group drug counseling as well. However, CBT and PDT plus group drug counseling were not more effective than group drug counseling alone. Furthermore, individual drug counseling was significantly superior to both forms of therapy concerning measures of drug abuse. With regard to psychological and social outcome variables, all treatments were equally effective (Crits-Christoph et al., 1999, 2001).

In an RCT by Sandahl, Herlitz, Ahlin, and Ronnberg (1998), PDT and CBT were compared concerning their efficacy in the treatment of alcohol abuse. PDT yielded significant improvements on measures of alcohol abuse, which were stable at a 15-month follow-up. PDT was significantly superior to CBT in the number of abstinent days and in the improvement of general psychiatric symptoms.

## Borderline personality disorder

At present, seven RCTs are available for PDT in BPD (Bateman & Fonagy, 1999, 2009; Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Doering et al., 2010; Giesen-Bloo et al., 2006; Gregory et al., 2008; Munroe-Blum & Marziali, 1995). Of these studies, several showed that PDT was superior to TAU (Bateman & Fonagy, 1999; Doering et al., 2010; Gregory et al., 2008). Bateman and Fonagy (1999, 2001) studied psychoanalytically oriented partial hospitalization treatment for patients with BPD. The major difference between the treatment group and the control group was the provision of individual and group psychotherapy in the former. The treatment lasted a maximum of 18 months. PDT was significantly superior to standard psychiatric care, both at the end of therapy and at the 18-month follow-up.

In a recent RCT, Transference-Focused Psychotherapy (TFP) based on Kernberg's model (Clarkin, Yeomans, & Kernberg, 1999) was compared to a treatment carried out by experienced community psychotherapists in borderline outpatients (Doering et al., 2010). TFP was superior with regard to borderline psychopathology, psychosocial functioning, personality organization, inpatient admission, and dropouts.

Another RCT compared PDT ('dynamic deconstructive psychotherapy') with TAU in the treatment of patients with BPD and co-occurring alcohol use disorder (Gregory et al., 2008). In this study, PDT, but not TAU, achieved significant improvements in outcome measures of parasuicide, alcohol misuse, and institutional care (Gregory et al., 2008). Furthermore, PDT was superior with regard to improvements in borderline psychopathology, depression, and social support. No difference was found in dissociation. This was true although TAU participants received higher average treatment intensity.

Another recent RCT found mentalization-based treatment (MBT) to be superior to manual-driven structured clinical management with regard to the primary (suicidal and self-injurious behaviors, hospitalization) and secondary outcome measures (e.g., depression, general symptom distress, interpersonal functioning) (Bateman & Fonagy, 2009).

With regard to the comparison of PDT to specific forms of psychotherapy, one RCT reported PDT as equally effective as an interpersonal group therapy (Munroe-Blum & Marziali, 1995). PDT yielded significant improvements on measures of borderline-related symptoms, general psychiatric symptoms, and depression, and was as effective as an interpersonal group therapy. Power, however, may have been insufficient to detect differences between treatments ( $N_1 = 22$ ,  $N_2 = 26$ ).

Giesen-Bloo et al. (2006) compared PDT (TFP) with schema-focused therapy (SFT), a form of CBT. Treatment duration was three years with two sessions a week. The authors reported statistically and clinically significant improvements for both treatments. However, SFT was found to be superior to TFP in several outcome measures. Furthermore, a significantly higher dropout risk for TFP was reported. This study, however, had serious methodological flaws. The authors used scales for adherence and competence for both treatments, for which they adopted an identical cutoff score of 60 indicating competent application. According to the data published by the authors (Giesen-Bloo et al., 2006, p. 651), the median competence level for applying SFT methods was 85.67. For TFP, a value of 65.6 was reported. While the competence level for SFT clearly exceeded the cutoff, the competence level for TFP just surpassed it. Furthermore, the competence level for SFT is clearly higher than that for TFP. Accordingly, both treatments were not equally applied in terms of therapist competence. Thus, the results of that study are questionable. The difference in competence was not taken into account by the authors, neither with regard to the analysis of resulting data nor in the discussion of the

results. Thus, this study raises serious concerns about an investigator allegiance effect (Luborsky et al., 1999).

Another RCT compared PDT (TFP), dialectical behavior therapy (DBT), and psychodynamic supportive psychotherapy (Clarkin et al., 2007). Patients treated with all three modalities showed general improvement in the study. However, TFP was shown to produce improvements not demonstrated by either DBT or supportive therapy. Those participants who received TFP were more likely to move from an insecure attachment classification to a secure one. They also showed significantly greater changes in mentalizing capacity and narrative coherence compared to the other two groups. TFP was associated with significant improvement in 10 of the 12 variables across the six symptomatic domains, compared to six in supportive therapy and five in DBT. Only TFP made significant changes in impulsivity, irritability, verbal assault, and direct assault. TFP and DBT reduced suicidality to the same extent. Here as well, power may have been insufficient to detect further possible differences (N1 = 23, N2 = 17, N3 = 22).

In summary, there is clear evidence that specific forms of manual-guided PDT are efficacious in BPD (Leichsenring, Leibing, Kruse, New, & Leweke, 2011). For TFP and MBT, two RCTs carried out in independent research settings are available which provide evidence that both MBT and TFP are efficacious and specific treatments of BPD, according to the criteria of empirically supported treatments proposed by Chambless and Hollon (1998). Studies of both psychotherapy and pharmacotherapy in BPD were recently reviewed by Leichsenring, Leibing et al. (2011). For bona fide treatments, including MBT, TFP, DBT, and schema-focused therapy there is no evidence that one form of psychotherapy is superior to another (Leichsenring, Leibing et al., 2011).

### Cluster C personality disorders

There is also evidence for the efficacy of PDT in the treatment of Cluster C personality disorders (i.e., avoidant, compulsive, or dependent personality disorder). In an RCT conducted by Svartberg, Stiles, and Seltzer (2004), PDT of 40 sessions in length was compared to CBT (Table 1). Both PDT and CBT yielded significant improvements in patients with DSM-IV Cluster C personality disorders. The improvements refer to symptoms, interpersonal problems, and core personality pathology. The results were stable at 24-months follow-up. Nonsignificant differences were found between PDT and CBT with regard to efficacy. However, this study was also not sufficiently powered to detect possible differences (N1 = 25, N2 = 25).

Muran, Safran, Samstag, and Winston (2005) compared the efficacy of psychodynamic therapy, brief relational therapy, and CBT in the treatment of Cluster C personality disorders and personality disorders not otherwise specified. Treatments lasted for 30 sessions. With regard to mean changes in outcome measures, no significant differences were found between the treatment conditions, neither at termination nor at follow-up. Furthermore, there were no significant differences between the treatments with regard to the patients achieving clinically significant change in symptoms, interpersonal problems, features of personality disorders, or therapist ratings of target complaints. At termination, CBT and brief relational therapy were superior to PDT in one outcome measure (patient ratings of target complaints). However, this difference did not persist at follow-up. With regard to the percentage of patients showing change, no significant differences were found, either at termination or at the follow-up, except in one comparison: at termination, CBT was superior to PDT on the Inventory of Interpersonal Problems (Horowitz, Alden, Wiggins, & Pincus, 2000). Again, this difference did not persist at follow-up. The conclusion is that only a few significant differences were found between the treatments but these differences did not persist at follow-up.

## Avoidant personality disorder

Avoidant personality disorder (AVPD) is among the above-mentioned Cluster C personality disorders. In a recent RCT, Emmelkamp et al. (2006) compared CBT to PDT and a waiting-list condition in the treatment of AVPD. The authors reported CBT as more effective than waiting-list control and PDT. However, the study suffers from several methodological shortcomings (Leichsenring & Leibing, 2007). In contrast to CBT, for example, no disorder-specific manual was used for PDT. Some outcome measures applied by Emmelkamp et al. (2006) were specifically tailored to effects for CBT (e.g., to beliefs). Furthermore, an arbitrary level of significance ( $p \leq 0.10$ ) was set by the authors so that a usually not significant difference ( $p \leq 0.09$ ) achieved significance in favor of CBT. At follow-up, no differences between CBT and PDT were found in primary outcome measures. In addition, Emmelkamp et al. (2006) reported that PDT was not superior to the waiting-list group. This was true, but may be attributed to the small sample size and low power of the study. Furthermore, CBT was superior to the waiting-list group in only two of six measures (Leichsenring & Leibing, 2007). Thus, design, statistical analyses and reporting of results raise serious concerns about an investigator allegiance effect (Luborsky et al., 1999).

## Heterogeneous samples of patients with personality disorders

Winston et al. (1994) compared PDT with brief adaptive psychotherapy or waiting-list patients in a heterogeneous group of patients with personality disorders. Most of the patients showed a Cluster C personality disorder. Patients with paranoid, schizoid, schizotypal, borderline, and narcissistic personality disorders were excluded. Mean treatment duration was 40 weeks. In both treatment groups, patients showed significantly more improvements than the patients on the waiting list. No differences in outcome were found between the two forms of psychotherapy.

Hellerstein et al. (1998) compared PDT to brief supportive therapy in a heterogeneous sample of patients with personality disorders. Again, most of the patients showed a Cluster C personality disorder. The authors reported similar degrees of improvement both at termination and at six-month follow-up. However, the studies by Winston et al. (1994) and Hellerstein et al. (1998) were not sufficiently powered to detect possible differences (see Table 1 for sample sizes).

Abbass, Sheldon, Gyra, and Kalpin (2008) compared PDT (intensive short term dynamic psychotherapy, ISTDP) with a minimal contact group in a heterogeneous group of patients with personality disorders. The most common Axis II diagnoses were borderline (44%), obsessive compulsive (37%), and AVPD (33%). Average treatment duration was 27.7 sessions. PDT was significantly superior to the control condition in all primary outcome measures. When control patients were treated, they experienced benefits similar to the initial treatment group. In the long-term follow-up, two years after the end of treatment, the whole group maintained their gains and had an 83% reduction of personality disorder diagnoses. In addition, treatment costs were thrice offset by reductions in medication and disability payments. This preliminary study of ISTDP suggests that it is efficacious and cost-effective in the treatment of personality disorders.

At present, two meta-analyses on the effects of PDT in personality disorders are available (Leichsenring & Leibing, 2003; Town, Abbass, & Hardy, 2011). A meta-analysis addressing the effects of PDT and CBT in personality disorders reported that PDT yielded large effects sizes not only for comorbid symptoms, but also for core personality pathology (Leichsenring & Leibing, 2003). This was true especially for BPD. A more recent meta-analysis by Town et al. (2011) included seven RCTs on STPP in personality disorders. The authors drew the preliminary conclusion that PDT may be considered an efficacious empirically supported treatment option for a wide range of personality disorders, producing significant and medium to long-term improvements for a large percentage of patients.

## Discussion

Under the requirements of the criteria proposed by the Task Force modified by Chambless and Hollon (1998), several RCTs are presently available that provide evidence for the efficacy of PDT in specific mental disorders (Leichsenring et al., in press). There is evidence for the efficacy of PDT in depressive disorders, prolonged or complicated grief, anxiety disorders, PTSD, eating disorders, somatoform disorders, substance-related disorders, and personality disorders, including both less severe (Cluster C) and severe personality disorders (BPD). For PTSD, only one RCT exists (Brom et al., 1989). Thus, we urgently need further studies showing that PDT is effective in complex PTSDs, i.e., in patients suffering from childhood abuse. With regard to personality disorders, no RCTs exist for Cluster A personality disorders (e.g., paranoid, schizoid) and for some relevant Cluster B personality disorders (e.g., narcissistic). This is true, however, for CBT as well. In addition, further RCTs of PDT-LTPP, especially in complex mental disorders, are required.

*In the studies reviewed here, PDT was either more effective than placebo therapy, supportive therapy or TAU, or no differences between PDT and CBT, or between PDT and pharmacotherapy, were found.*

In a few studies, PDT was superior to a method of CBT (Milrod et al., 2007); in another study, PDT was superior to CBT in some outcome measures (Clarkin et al., 2007). However, most of the studies that found no differences in efficacy between PDT and another bona fide treatment were not sufficiently powered. As reported above, testing for non-inferiority (i.e., equivalence) requires  $N1 \frac{1}{4} N2 \frac{1}{4} 86$  patients to detect an at least medium differences (effect size  $d \frac{1}{4} 0.5$ ) between two treatments with a sufficient power ( $\alpha \frac{1}{4} 0.05$ , twotailed test,  $1-b \frac{1}{4} 0.90$ ) (Cohen, 1988). At present, only four RCT comparing PDT with a bona fide treatment fulfill this criterion (Crits-Christoph et al., 1999; Driessen et al., 2013; Knekt et al., 2008a; Leichsenring et al., 2013a). The issue of small sample size studies, however, is not specific to studies of PDT, since many studies of CBT are also not sufficiently powered (Leichsenring & Rabung, 2011).

For comparisons of PDT with bona fide therapies, the between-group effect sizes were found to be small (Driessen et al., 2013; Leichsenring, 2001; Leichsenring, Salzer et al., 2011; Leichsenring et al., 2013a). Thus, it is an open question of research whether more highly powered studies would find significant differences. Furthermore, the question has to be addressed whether these (possibly small) differences are clinically relevant or significant (Jacobson & Truax, 1991).

It is important, however, to realize which mental disorders lack any RCTs of PDT. This is true, for example, for dissociative disorders and for some specific forms of personality disorders (e.g., narcissistic). For PTSD, only one RCT is presently available (Brom et al., 1989).

Some studies reported differences, at least in some measures, in favor of CBT. This is true, for example, for the studies on bulimia nervosa by Fairburn et al. (1986) and Garner et al. (1993), and for the studies on generalized anxiety disorder (Leichsenring et al., 2009) and social phobia (Leichsenring et al., 2013a). For the study on generalized anxiety disorder (Leichsenring et al., 2009), we discussed above whether a stronger focus on the process of worrying would possibly improve the results of PDT.

In general, future research should address the question whether the efficacy of PDT can be improved by putting a stronger focus on the specific mechanisms that maintain the psychopathology of the respective disorder. Mentalization-based therapy or TFP may serve as good examples for psychodynamic treatments that focus on the assumed processes or deficits maintaining a disorder.

According to the results of this review, further research of PDT in specific mental disorders is necessary, including studies of both the outcome and the active ingredients of PDT in these disorders. Not only measures of symptoms and DSM criteria of a disorder should be applied, but also measures more specific to PDT. Future studies should also examine if there are specific gains achieved only by PDT, i.e., the question of ‘added value.’ Furthermore, those methods of therapy that have proved to work under experimental conditions of RCTs need to be studied for their effectiveness in the field (effectiveness studies). The perception that PDT lacks empirical support is not consistent with available empirical evidence and may reflect selective dissemination of research findings (Shedler, 2010).

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# 6. Appendix

## Bibliography of Research Reviews and Studies

*This Bibliography of Research Reviews and Studies has been compiled under the direction of Ayelet Barkai and John Porcerelli for the American Psychoanalytic Association.*

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\* Contributors in bold

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