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Psychodynamic Psychotherapy for Cancer Patients

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Psychodynamic psychotherapy is effective as an approach to understanding the psychological conflicts and the psychiatric symptoms of cancer patients as well as to planning useful psychological interventions. The author recommends that the psychotherapist who treats cancer patients be familiar with the following: 1) the natural course and treatment of the illness, 2) a flexible approach in accord with the medical status of the patient, 3) a common sense approach to defenses, 4) a concern with quality-of-life issues, and 5) counter-transference issues as they relate to the treatment of very sick patients. Case reports illustrate the unique problems facing psychotherapists who are treating cancer patients. Further, these cases show the effective use of psychodynamic principles to inform the therapist of successful psychotherapeutic interventions.

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The model of psychodynamic psychotherapy is particularly useful for understanding the emotional reactions of patients with cancer. It provides a point of view for clarifying the onset of psychiatric symptoms in response to the stresses of having a cancer diagnosis. It also offers a perspective on the doctor–patient relationship that is useful for understanding and resolving conflicts. Compliance and noncompliance with treatment recommendations for cancer can be understood in terms of transferences and resistances as in a psychoanalytic psychotherapy.

Current psychoanalytic theoretical models add to an understanding of the emotional symptomatology of the cancer patient as well as provide a point of view for intervention. The ego psychological model offers a look at defenses and coping mechanisms. The object relations model is helpful in terms of understanding the threat of object loss and the relationship between patient and caregiver. The model of self psychology is pertinent to the threat to the integrity of the self and the need for an empathic approach.

This article briefly reviews findings on the effects of psychosocial factors and psychotherapy on medical outcome, recurrence, and length of survival. The article also highlights certain unique issues that I feel are important in any psychotherapy with cancer patients. Phases of the cancer illness and psychological

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problems of each phase, including case reports, are presented. Each case is examined from a psychodynamic point of view in terms of how the patient was understood and how the psychotherapy unfolded.

BACKGROUND

Psychosocial factors, as well as psychosocial interventions, have now become issues for study in relationship to cancer onset, quality of life, and length of survival. It is now documented that emotional expression,[1] social supports,[2] lower levels of emotional distress,[3,4] and a fighting spirit[5–7] tend to be associated with improved survival time in cancer patients. It would therefore be reasonable to expect that psychotherapeutic interventions that address these issues might improve quality of life, decrease level of stress, and improve survival time for cancer patients.[8] Hill et al.[9] in a recent review showed that in 12 of 17 controlled studies, the psychotherapeutic interventions were efficacious in reducing psychological stress; only 2 studies showed no benefit.

Some studies have indicated a direct beneficial effect of social support on survival time. The first and most publicized study of Spiegel et al.[10] showed that at 10-year follow-up there was a statistically significant survival advantage for women with breast cancer who had participated in group therapy treatment. They lived an average of 18 months longer than control subjects. Richardson et al.[11] reported the effects of home visits and educational interventions on leukemia and lymphoma patients. The intervention group lived significantly longer, even when differences in medical treatment were controlled for. The conclusion was that the psychosocial intervention was the significant variable. Finally, Fawzy et al.,[12] working with melanoma patients, documented a survival advantage and lower rates of recurrence for 40 patients randomly assigned to 6 weeks of extensive group psychotherapy. There are as yet no controlled studies of the impact of individual psychotherapy on recurrence or survival time; however, clinical experience is suggestive.

A very brief review of the psychodynamic psychotherapies is helpful before we examine typical psychological problems of patients with cancer who present for consultation. Briefly, the spectrum includes psychoanalysis and the psychoanalytic psychotherapies such as the exploratory, ego supportive, and crisis intervention therapies.[13] The insight-oriented psychotherapies are most closely related to psychoanalysis. The common elements include a focus on core conflicts as they present in the patient's present life situation, in past family history, and in the transference. These conflicts are analyzed and worked through actively, with the therapist in a position of neutrality. The crisis intervention model[14,15] attempts to relieve symptoms and stabilize the crisis by reviewing recent events, allowing a catharsis, and manipulating the environment. Ego supportive therapy includes support, reassurance, and encouragement. The goal is symptom suppression while promoting a positive transference.

APPROACHES TO THE CANCER PATIENT

Anyone contemplating conducting a dynamic psychotherapy with a cancer patient must have some familiarity with the phases of the cancer illness and the challenges presented to the patient and doctor.[16] Patients who present for psychotherapy in any stage of the cancer illness require a very flexible approach. They need to be evaluated initially on the basis of their presenting symptoms as well as their physical health and the stage of the disease. They also need to have a psychiatric and psychodynamic evaluation. The shifting nature of the disease, with diagnosis, therapy, remissions, recurrences, and terminal illness phases, requires that the person conducting psychotherapy be flexible in his or her approach. Psychoanalysis and/or insight-oriented psychotherapy may have to give way to crisis intervention and supportive therapy (temporarily or permanently, depending on the medical condition of the

patient), whereas patients who might first present for crisis intervention or supportive therapy may later require a more intensive psychotherapy. Furthermore, the psychotherapist must be flexible in regard to the need for medication or for a referral for behavior therapy for conditioned nausea.

I also suggest a common sense approach to defenses[17] as they relate to coping with the cancer illness and treatment. Defenses should be evaluated in terms of whether they are adaptive and promote optional coping and compliance, or whether they are maladaptive. Preconceived notions such as "denial is good" or "denial is bad" do not make sense in the clinical situation. Denial will serve the patient well if it wards off anxiety or depression without interfering with compliance or the patient's life goals; the affect associated with the prognosis is frequently denied. Others, however, might use denial of their state of health to avoid necessary medical appointments. In such instances, denial must be confronted to allow for maximum quality of life. Similarly, regression must be evaluated in terms of its clinical consequences. Regression in terminally ill patients is clinically helpful and can be encouraged, whereas regression in patients in remission needs to be confronted and challenged. These principles are well illustrated in the clinical examples that follow.

Psychotherapists also need to keep quality-of-life issues in focus.[18] The expected life span, the patient's relationship to the oncologist, and issues related to the patient's symptoms should never be far from the psychotherapist's attention. One must be an advocate for the patient in this regard and not remain passive. I would also recommend a focus on continuity of care, so that patients whose psychotherapy terminates are encouraged to return should their disease progress.

Finally, special attention is required in dealing with one's countertransference (N. Straker, unpublished). A failure in this regard will lead to self-protective mechanisms that keep the therapist from engaging with the patient in an empathic, helpful manner. In fact, it might result in premature therapeutic termination or in abandonment of the patient. Other reactions include hopelessness, depression, anxiety, and low self-esteem. I have been impressed each year with the emotional reactions of each new group of psycho-oncology fellows who feel overwhelmed and wonder if psychotherapy has much to offer these people who face pain, terror, death, and despair. They have yet to recognize the power of an empathic relationship and the transference, especially in terminally ill patients. Supervision and support groups with case discussions are very helpful in preventing these reactions and forestalling burnout.[19]

PHASES OF CANCER

First Phase: Diagnosis

The first phase is the diagnostic and initial treatment phase. This phase is usually handled surprisingly well by most patients.[20] Shock, disbelief, anxiety, some depression, guilt, and bitterness usually are buttressed by the hope that the initial treatment will be successful. A positive transference to the healing physician is very important and most common. However, some patients require psychotherapeutic intervention at this stage. For some patients who have devoted themselves to trying to avoid illness through diet, exercise, and a healthy lifestyle, a cancer diagnosis can be a major affront. Many patients feel they have caused their cancer by not handling their life stresses well enough and thus producing a failure of their immune system. Others who might also seek psychotherapy are overwhelmed by the fear of death; the fear of dependency; the threat of loss of power, attractiveness, and income; or existential anxiety about the meaning of life. Some patients, referred by oncologists, cannot comply with treatment recommendations because of denial, obsessive paralysis, or depression.

In general, the psychotherapeutic efforts during this period are primarily directed toward adapting to the crisis and choosing the

appropriate treatment. The ego supportive and crisis intervention models are usually effective on a short-term basis with most patients. Symptom suppression can usually be accomplished by both methods. Occasionally, the addition of psychopharmacological intervention will assist in this process. For others who have long-standing character disorders, the stress of illness may require an insight-oriented psychotherapy to enable them to deal with potential compliance issues and arrive at some acceptance of this new reality.

Clinical Examples

1. A middle-aged woman with breast cancer and a knowledge of the effects of stress on the immune system was referred for brief psychotherapy. She was depressed, pessimistic about her prognosis, and filled with guilt, feeling that she had caused her disease. She was sure her marital infidelities were responsible for causing her cancer—a fitting punishment, she thought. The early phase of psychotherapy allowed her to deal with the fact of being a cancer patient. She was also helped to relate her guilt feelings to her marital infidelities. Her own theory of causality, with cancer as a punishment, was contrasted with scientific knowledge.

This patient was depressed in response to the narcissistic injury of losing her good health. Her character was highly narcissistic with obsessive features. She had always prided herself on being in control and being fit. To become ill was a devastating blow. She reestablished some sense of control by blaming herself for the cancer and feeling guilty.

The psychotherapy evolved into several phases. A positive transference was encouraged while the patient was helped to mourn the loss of her good health. She was also encouraged to take control of understanding her disease and the reasons for her marital infidelities. She worked to improve her marriage, as well as to understand why she was unfaithful. She also became committed to fighting her cancer and became an advocate for more research funding for cancer. She was discharged from psychotherapy after a year and a half of twice-a-week psychotherapy feeling more in control and optimistic. Long-term follow-up of 5 years showed her to be well and still involved in fundraising for cancer research.

2. The next case did not go as well. Despite a dynamic understanding of the case, the resident therapist in supervision experienced the same hostile and aggressive feelings as the referring oncologist. A middle-aged woman with ovarian cancer who had difficulty keeping her scheduled chemotherapy appointments was referred for psychotherapy because of noncompliance. She had a history of long-standing authority problems and marital conflict. Within a few psychotherapy interviews, she developed a negative transference, repeating the problems she had with the oncologist. The psychiatric resident pointed out her core conflicts as they reappeared in the psychotherapeutic relationship. The psychotherapy was stormy, with many arguments that repeated the problems the patient had had with her husband and her father. The patient eventually quit her therapy and was lost to follow-up.

3. In a more successful intervention, a psychiatric resident in supervision was able to intervene and preserve the cancer therapy through interpretive dynamic psychotherapy. A young woman with a history of childhood sexual abuse was referred to psychiatry because of difficulty cooperating in vaginal exams and a refusal of vaginal implants, the treatment required for her advanced cervical cancer. The patient's difficulty in complying with the treatment was understood to be the result of a resonance with earlier childhood traumatic experiences. Insight-oriented psychotherapy was recommended. As the female resident continued working with her, the patient recognized her feelings of being invaded by the psychotherapist, and she expressed the desire to discontinue her psychotherapy. Skillful interpretive work by her psychiatrist allowed for a working through of her core conflict of experiencing the repetition of sexual abuse in the psychotherapy, the vaginal exams, and the radiation implants. The therapy allowed for compliance and a good outcome. This intervention was brief, one time per week, until the cancer therapy was complete.

Second Phase: Follow-Up

The follow-up phase after the first cancer treatment (surgery, chemotherapy, and/or

radiotherapy) is usually greeted with mixed emotions. The patient is pleased to be done with the rigors of treatment and side effects, but now has to face the future with less certainty of good health. This new vulnerability may be denied by some or become overwhelming to others. The threat of recurrence or of an early death may lead some patients who have achieved a somewhat fragile adaptation to regress and become dysfunctional. Others, who had previously never faced their own mortality, will have to come to terms with unaccomplished life goals and the pressing need to immediately address them.

Patients referred for consultation during this phase of their illness tend for the most part to be in remission and physically well. This is the phase in which referrals for dissatisfaction with relationships and/or careers will be most prevalent, the result of character pathology. I recommend that assessment of these patients for psychotherapy be based primarily on their psychological needs and psychiatric diagnosis. In this group, there will be some who require insight-oriented psychotherapy or psychoanalysis. Such patients will be those who have strong motivation, psychological mindedness, tolerance for anxiety, and enough intelligence to engage in a process that could offer significant psychological change.

Clinical Examples

1. A middle-aged man with lymphoma was described as the ideal patient during his arduous chemotherapy treatment. When the treatment was over, the oncologist expressed surprise that with an excellent result and a good prognosis the patient was depressed and panicky. The patient, an overachiever, had always taken control of his life, beginning at age 8 when he first began delivering newspapers. He never received financial help of any kind from his family. His hard work and take-charge attitude resulted in great success in the corporate world and the belief that he alone could totally control his destiny. He emotionally confronted the reality of his cancer only after he had finished his chemotherapy. He felt totally vulnerable, panicky, and unable to depend on anyone. Dependency was to be avoided at all costs, as it had only led to rejection and disappointment during his childhood.

The early phase of psychotherapy focused on the importance of establishing a relationship with the therapist. His childhood and the coping mechanisms he used were reviewed and discussed in relationship to his reluctance to count on anyone. At the same time, he was encouraged to accept his need to depend on his wife and children, as well as his therapist. He was also helped to experience the feelings he had dissociated and suppressed during his chemotherapy. His need for control was redirected to healthier pursuits. He began to learn about his cancer and to focus on how he might cope with it. He became interested in the importance of diet and exercise, as well as modifying his lifestyle in an effort to "control his destiny." He became partners with his therapist in his exploration of how to have a healthier lifestyle. He felt more optimistic and less vulnerable 6 months after his remission, and he claimed he looked and felt younger and stronger than before he became ill. An understanding of the character and defenses of the patient allowed for this psychodynamic intervention, which addressed the suppression of affects and the need for dependency and redirected the patient to once again take control of his life by encouraging him to adopt a healthier lifestyle.

2. Two female patients in their twenties presented severely regressive symptomatology after arduous treatments for cancer. One patient had extensive chemotherapy for bone cancer; the other patient had two bone marrow transplants for lymphoma. They both achieved a marginal adult adjustment after a stormy adolescence and difficulty separating from home to go to college. The mothers of both patients were reported to have very disturbed personalities. The fathers were both highly successful and had the closest attachment to their daughters with cancer. During the cancer treatments the patients returned to their parents' homes and became enmeshed in old family dynamics. The marriages of the parents in both situations underwent serious strain. At the end of the cancer treatments, both patients were totally dysfunctional and regressed, unable to separate from their parents (especially their fathers) and resume independent living. As a transition to independence, both patients required an

intensive supportive psychotherapy three to four times per week. In both cases, the treatments were successful in dealing with the cancer experience and working through conflicts from the past. This allowed the patients to resume their independent lives: a legal career in one case, postgraduate school in the other. One of the patients had psychoanalysis for 5 years and, at follow-up, was well and married with two children.

3. In several cases, workaholic males with very successful careers have presented for psychotherapy following remission of cancer. They are narcissistic characters with shallow relationships whose main interest in life is becoming very wealthy. The confrontation with their own mortality has left them with a life-crisis unparalleled. When they present for psychiatric consultation, their lives feel meaningless and without a legacy. These patients have generally been best suited to an intensive psychotherapy or psychoanalysis. Improved relationships as well as active involvement in charitable organizations have led to a more satisfactory adjustment.

In the above cases from the treatment and remission stages, the patients have all done very well both psychologically and in terms of avoiding a recurrence. The female patient with the negative transference who quit was the one exception. It is tempting to postulate a causal relationship, but clearly without controlled studies such a conclusion would be fallacious.

Third Phase: Recurrence

The recurrence and re-treatment phase tends to repeat the diagnostic and first-treatment phase, with the following major differences. The meaning of recurrence makes the patient less hopeful for cure. Patients may blame themselves or their doctors for what is usually considered a failure. Anger, depression, anxiety, and distrust will be more prominent. Alternative treatments are more likely to be sought out. Compliance with medical recommendations may be lower than before. Problems erupt in the doctor–patient relationship, especially hostility toward the doctor.

Psychotherapeutic issues more closely resemble those in the diagnostic and initial treatment phase. Crisis intervention and ego supportive therapy, with or without medication, will often be sufficient to reestablish medical compliance. However, patients with character problems will be in need of a more intensive insight-oriented psychotherapy that will highlight the problem of compliance as it reappears in the psychotherapeutic relationship in the form of resistance. Others, whose compliance problems are related to maladaptive defenses such as denial, require confrontation so that they can have an opportunity to mourn their hopes for continual remission and begin to accept the need to choose a new therapy.

Patients referred following recurrence of cancer have often suffered the consequences of relying too heavily on the psychological defense of denial in relationship to their illness, prognosis, or state of health. Following are several examples, with psychotherapeutic strategies appropriate to the psychiatric diagnoses and medical conditions of the patients.

Clinical Examples

1. A 70-year-old man with no history of manic-depressive disease was referred for consultation when he became manic on learning of his recurrence. He had all the symptoms of mania and was unable to comply with recommendations to discuss the need for more cancer or psychiatric treatment. History revealed a successful businessman with a life dedicated to physical fitness and weightlifting even at age 70. He was sure he had beat the cancer. It was quite difficult to enlist the cooperation of the patient in treating the manic episode. The psychiatric resident invoked family pressure after the patient engaged in wild spending sprees. Finally, the patient accepted lithium. The task in the psychotherapy was to confront the patient's denial with the utmost sensitivity and tact so that he would not flee the treatment. He did become depressed, as was expected, and was continued in a supportive psychotherapy with antidepressants and lithium. The intervention allowed for more chemotherapy and a successful remission.

2. A young man in his thirties who prided himself on his independence could not accept his deteriorating health from a recurrent lymphoma. In fact, his denial was so great that he applied for a work position that was in a distant city and required physical vigor. His oncologist, recognizing his flight from reality, referred the patient for psychotherapy. This psychotherapeutic treatment required sensitivity, but, after a supportive relationship had been established, it also required direct confrontation of his denial. After several sessions, the resident therapist, with encouragement from his supervisor, did confront the patient. The resident pointed out the patient's need—because of his fear of being dependent—to try to flee his weakness and failing health by pretending he had the vigor of a man without cancer. This interpretation, repeated several times, allowed the patient to begin to talk about his fears of being feminine and weak when growing up. The patient became very emotional and temporarily very dependent on the resident therapist for frequent psychotherapeutic sessions. The resident therapist felt quite guilty about disturbing the patient's psychological defenses, and worried about whether the patient's upset mental state might lead to his becoming less able to fight his cancer. The supervisor supported the resident, reminding him of the need to confront the patient's maladaptive denial and fears of dependency and accept the patient's temporary upset and need for dependency. The patient continued in a long-term supportive therapy while complying with the chemotherapeutic regimen.

Fourth Phase: Terminal Stage

The terminal palliative phase is the most difficult, especially for physicians. Only recently have medical students and physicians been better taught to deal with the terminal phase of illness. Palliative techniques can reduce pain, anxiety, depression, insomnia, and other discomforts to tolerable levels if physicians have been taught well and can face the death of their patients. Psychiatric consultation in the hospital during this phase is quite common. Aside from the management of delirium, anxiety, or depressive symptoms, some patients and their families request psychiatric intervention to discuss when to terminate active treatment and how to live knowing your time is limited. More recently, some patients have wanted to discuss assisted suicide. Occasionally patients are more realistic than their physicians regarding their prognosis and need assistance in asserting their desire to end heroic treatments. Others need affirmation about the life they have led and may need to address unfinished business in relation to family members or friends. Still others need comfort and empathic supportive relationships because they fear abandonment. Treatment based on an understanding of Kohut's idealized and omnipotent transferences[21] and an encouragement of regression in the terminal phase is of great comfort to some patients. Norton[22] recommends helping the patient to defend against object loss by facilitating a regressive relationship. Deutsch[23] writes about the importance of settling differences. Eissler[24] recommends that the psychiatrist share the patient's belief in immortality and indestructibility, as well as sharing the patient's defenses and developing an admiration for the patient's inner strength. Finally, Cassem[25] emphasizes a common sense approach and regards listening to the patient tell his or her own story in a supportive relationship as most therapeutic. Tact and support are essential.

Clinical Examples

The following case examples illustrate the value of a psychodynamic approach to the terminally ill patient who is undergoing palliative care. The first case illustrates the importance of recognizing that some cases of depression in patients who have led active, controlling lives are due to feelings that they have lost all control and power as they get physically weaker. The psychotherapeutic intervention that allows the person to take some control and exercise his or her power even while bedridden can relieve the sense of passivity and hopelessness. The second case focuses on the importance of providing affirmation and selfobject relatedness to a patient

who was experiencing excessive isolation and feelings of abandonment. The third case, with similar dynamics to the second, required the addition of heavy doses of anxiolytic medications to permit sufficient regression to enable the patient to experience the staff as idealized, omnipotent parent images so that her panic feelings of helplessness would be dissolved.

1. A 68-year-old man in the terminal phase of his disease refused to make a will or help his family make plans to manage his large and successful business. All his life the patient had been a very active man who took great pleasure in being "in charge." His failing health had resulted in an uncharacteristic passivity and severe depression. Discussion with the patient centered on reviewing his former life pursuits, his pleasure in having taken care of his family over the years, and his need to feel that he was still in control. He was helped to become aware that he still had the power to affect the future of his family and business. The patient was again able to assume an in-charge position. He subsequently made out a will and began teaching members of his family how to run the business. His new sense of purpose resulted in significant alleviation of depression, even in the final weeks of life.

2. A 71-year-old married father of two, terminally ill with colon cancer, felt the need to talk about his life and resolve some family matters. This was his first request for psychotherapy. He had led a very active, successful professional life and was accomplished in the community and socially. He had not been able to successfully communicate intimately with his family. He had some guilt in this regard. The therapy focused on mirroring his life accomplishments, providing the intimacy he felt he had lacked, and encouraging him to broach the subjects he felt he had neglected with his family. The psychotherapy continued until the patient died. The treating resident felt the satisfaction of helping this patient improve his final days by encouraging him to communicate more intimately with his family while affirming his life accomplishments.

3. A 52-year-old divorced mother of two children became progressively panicky as her breast carcinoma showed symptoms of spreading to the brain. She lost a quadrant of her visual fields, and this was followed by weakness in her legs and arms. This nightmare promoted a severe helpless panic. The patient, whose level of consciousness varied, was quite panicky when conscious. Her psychiatrist's use of a combination of benzodiazepines and major tranquilizers and his twice-daily visits, however brief, were an attempt to tranquilize her without undue sedation and regress her to the state in which he and other staff members functioned as omnipotent selfobjects. The family was grateful for the extra time the patient could be conscious, as a result of minimal sedation without panic, until she slipped into a coma.

COMMENT

The cases reported in this article demonstrate several of the important principles that are unique to the psychotherapeutic work with cancer patients. These principles include a focus on the medical illness, an adaptive, common sense approach to defenses such as denial, a focus on quality-of-life issues, and a special sensitivity to countertransference issues as they relate to patients with cancer. The fear of disrupting patients' defenses can often result in therapeutic passivity. Also, common countertransference issues such as hopelessness or depression, especially when a therapist is confronting very sick or terminally ill patients, often lead to premature withdrawal from patients. Psychiatric residents often feel nihilistic about what they can offer patients, particularly in the terminal or palliative phase of treatment. Supervision and case conferences should emphasize the value of the transferential relationship along with practical therapeutic approaches that can enhance the quality of life for patients in the final phases of life. This emphasis in training will counter the "what can I do?" attitude of those with little experience treating terminally ill cancer patients.

Dynamic psychotherapy with cancer patients is emotionally challenging, intellectually stimulating, and highly rewarding. Time pressures will often enhance the motivation for

psychological change and allow the patient and therapist to work productively and rapidly toward resolving long-standing conflicts. Work of this kind requires therapists to believe in the value of dynamic psychotherapy in the face of pain, suffering, and death, and to be able to cope with intimacy and separation without undue disruption to themselves.

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REFERENCES

1. Jensen AB: Psychological factors in breast cancer and their possible impact upon prognosis. Cancer Treat Rev 1991; 18:191–210
2. Maunsell E, Jacques B, Duschene L: Social support and survival among women with breast cancer. Presented at the Annual Psycho-Oncology Meeting, Memorial Sloan-Kettering Cancer Center, New York, NY, October 1993
3. Dean C, Surtees PG: Do psychological factors predict survival in breast cancer? Journal of Psychosocial Research 1989; 33:561–569
4. Forsen A: Psychosocial stress as a risk for breast cancer. Psychother Psychosom 1991; 55:176–185
5. Derogatis LR, Abeloff MD, Melisartos N: Psychological coping mechanism and survival time in metastatic breast cancer. JAMA 1979; 242:1504–1508
6. Greer S, Morris J, Pettingage KW: Psychological response to breast cancer: effect on outcome. Lancet 1979; 2:785–787
7. Greer S: Psychological response to cancer and survival. Psychol Med 1991; 21:43–49
8. Spiegel D, Kato P: Psychosocial influences on cancer incidence and progression. Harvard Review of Psychiatry 1996; May/June, pp 10–26
9. Hill D, Kelleher K, Shamaker SA: Psychosocial interventions in adult patients with coronary heart disease and cancer: a literature review. Gen Hosp Psychiatry 1992; 14(6, suppl):285–425
10. Spiegel D, Bloom JR, Kraemer HC, et al: Effect of psychosocial treatment on survival of patients with metastatic breast cancer. Lancet 1989; 2:888–901
11. Richardson JL, Shelton DR, Kasilo M, et al: The effect of compliance with treatment on survival among patients with hematological malignancies. J Clin Oncol 1990; 8:356–364
12. Fawzy FI, Fawzy NW, Hyun CS, et al: Malignant melanoma: effects of an early structured psychiatric intervention, coping, and effective state on recurrence and survival, 6 years later. Arch Gen Psychiatry 1993; 50:681–689
13. Straker M: A review of short-term psychotherapy. Diseases of the Nervous System 1977; 38:813–816
14. Caplan G: Principles of Preventative Psychiatry. New York, Basic Books, 1964
15. Lindemann E: Symptomatology and management of acute grief. Am J Psychiatry 1944; 101:141–148
16. Schmale A: Principles of psychosocial oncology, in Clinical Oncology For Medical Students and Physicians: A Multidisciplinary Approach, 4th edition. Rochester, NY, University of Rochester School of Medicine and Dentistry/American Cancer Society, 1974, pp 109–118
17. Straker N, Wyszynski A: Denial in the cancer patient: a common sense approach. Internal Medicine for the Specialist 1986; 7(3):150–155
18. Leshan L, Leshan E: Psychotherapy and the patient with a limited lifespan. Psychiatry 1961; 24:318–323
19. Wise TN, Berlin RM: Burnout: stresses in consultation. Psychosomatics 1981; 22:744–751
20. Holland J: Psychological management of cancer patients and their families. Practical Psychology 1977; October, pp 14–20
21. Kohut H: The Analysis of the Self. New York, International Universities Press, 1971
22. Norton J: Treatment of a dying patient. Psychoanal Study Child 1963; 18:541–560
23. Deutsch F: Euthanasia: a clinical study. Psychoanal Q 1933; 347–368
24. Eissler K: The Psychiatrist and the Dying Patient. New York, International Universities Press, 1955
25. Cassem NH: The dying patient, in Massachusetts General Hospital Handbook of General Hospital Psychiatry, edited by Hackett T, Cassem N. St Louis, MO, CV Mosby, 1978, pp 579–606

Structuring Training Goals for Psychodynamic Psychotherapy

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A multiaxial model that structures educational goals for psychodynamic psychotherapy has been developed. It specifies core aspects of psychodynamic psychotherapy, clusters them in categories that further define and link related areas, and presents a sequence that enables educators and students to focus on training goals in a consistent progression. This model has been used by the Director of Education as a basis for developing the curriculum, by students as a way of focusing learning and giving perspective to current work, and by supervisors to link individual teaching to the goals of the training program. This method has enhanced consistency, clarity, and efficiency in the psychotherapy program.

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Education in psychodynamic psychotherapy is steeped in a rich tradition. An extensive literature has evolved describing the supervisory relationship[1–6] and teaching trainees how to think, in preference to a technique-oriented approach.[7–10] The focus on process in education is of central importance and reflects the nature of psychotherapeutic work. There has been a more recent trend toward elaborating the specifics of teaching. This endeavor has included writing about supervisory styles,[11,12] developmental models,[13–15] lists of objectives,[16] innovative seminars,[17,18] and questioning students and supervisors about their work together.[19–21]

A number of textbooks[22–34] provide comprehensive presentations of technique and theory. Although they are indispensable to psychotherapy education, they do not provide a concise framework from which to organize a training program. A model curriculum for teaching psychodynamic psychotherapy in psychiatric residency programs was developed by members of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry.[35] It contains a consensus about core goals, an educational philosophy, and a recommendation for sequencing training over the course of the entire residency.

Further development of a curriculum approach to psychotherapy training will produce

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more consistent and effective methods of education. Overtly defined goals and objectives that are organized and sequenced can enable educators to approach the questions of what, when, how, and in what context to teach. Students and teachers can work more collaboratively when they share a defined set of educational tasks. A concise description of the areas and skills relevant to psychodynamic psychotherapy can be used to augment education that takes place in individual supervision and case-based seminars. There is always a need for balance between an objective curriculum approach and the individually focused orientation of traditional psychotherapy education.

A number of authors have directly addressed the question of educational goals and their possible sequence. Fleming and her coworkers[7,36,37] developed an educational model that moved from listening and gathering information to organizing and processing the data into meaningful units, integrating what has been learned, and responding to the patient. Fleming stressed the importance of beginning within a phenomenological context. She also advocated a planned learning approach in which both teacher and student actively work to meet overtly defined teaching objectives. Ornstein[38] shares the view that early training should focus on observable data. The teacher's role is to facilitate the student's discovery of ways of observing and forming intuitions from the clinical situation without the early encumbrance of theory. Ornstein specifically elaborates the basic skills of observation, evocative listening, empathy, intuition, and introspection for beginning training in psychotherapy. Ralph[13] describes a series of four developmental steps: 1) observation and listening, 2) a patient-centered approach within the theoretical framework of the training institution, 3) a relationship-centered approach that focuses on process, and 4) a self-perspective. Levenson[39] favors a style of supervision that begins with boundaries of therapy, moves to a developmental history, and finally focuses on the analysis of transference. This method is for supervision of analytic candidates, but it is noteworthy that even here, emphasis on theory is saved for later in training. Melchiode[40] describes a developmental supervisory model for psychiatric residents in six stages: 1) elaborating the history, 2) observing affect, 3) developing empathy, 4) recognizing unconscious processes, 5) using the therapist's fantasies, and 6) understanding theory. Rodenhauser[15] provides a comprehensive summary of developmental training approaches and offers an interactional developmental schema involving the supervisor, the supervisee, and the patient.

In all of these phased-learning approaches to education, there is remarkable consistency in moving from a descriptive position to various ways of organizing clinical data. An early focus on clinical phenomenology is also reflected in the results of research on residents' preferences in supervision.[19] These models have the attributes of clarity and a sense of movement over time. They present organizing principles in stages, but they do not delineate the multiple areas of psychotherapeutic work. A more fully articulated developmental model describing core skills and concepts is a natural progression from these earlier conceptualizations.

The model presented here is an amalgamation of a developmental approach with a more inclusive list of discrete learning tasks such as those found in many psychotherapy texts and described by Buckley and co-workers.[16,41] This model provides a framework from which to develop a sequence of seminars. It also provides a framework for periodic review by residents and supervisors to focus learning and evaluate progress. It is not intended to impose a static structure on psychotherapy education. Rather, it adds a counterpoint to the richness and diversity contained in individualized, process-oriented, student/patient-focused teaching.

THE MODEL

The fundamental assumptions used in constructing this model are that 1) the educational process can be facilitated if the training goals

for dynamic psychotherapy are explicitly defined and structured; 2) there exist a variety of goals that can be organized into clusters (here called "developmental categories"); 3) relatively discrete "phases of learning" can be postulated that outline a progression in education; and 4) there is a complex interplay and individual variation among the various kinds of skills, knowledge, and behaviors across developmental categories and phases of learning.

The model as illustrated in Table 1 describes a traditional analytic approach. It does not include the most recent advances in psychodynamic psychotherapy or make specific connections to cognitive, interpersonal, and other approaches. The model structure can include such additions as they become relevant to a specific emphasis or are indicated by an evolving consensus in the field. The details presented here represent a classical or baseline approach so that the model can be presented most clearly. In actual practice, newer ideas are included, as well as links to other psychotherapeutic disciplines. Advances in technique, especially brief treatment models,[33,34] integrate various approaches, and integration is increasingly a central focus in education. This is particularly true after basic skills are acquired and the emphasis of each approach is understood. This model is helpful in articulating the analytic perspective, presenting aspects common to all psychotherapies (particularly in Phase I), and providing points of connection to other techniques. The ultimate purpose of the model is to facilitate education for practice in the evolving mental health environment. Brief psychotherapy, focused interventions, and integration with psychopharmacologic treatments all benefit from a psychodynamically informed perspective.

The model consists of two coordinates: the "phases of learning" along the horizontal axis and the "developmental categories" along the vertical axis. The concept of "phases of learning" is an attempt to delineate broad sequential steps in the educational process. Each phase describes the primary learning perspective for the educational objectives within it. The "developmental categories" are groupings of closely related learning tasks that evolve toward increasing complexity and sophistication. The phases and developmental categories are described in detail in the next section.

The sequence of learning moves through each successive phase; the student achieves basic competence in areas within one phase before learning in substantive areas within the next. There are times when it is necessary or reasonable to focus on more advanced areas prior to the completion of a phase. This usually occurs when supervision of a treatment requires interventions that are in advance of a resident's clinical experience. The handling of early disruptive transference reactions, for example, is an area that frequently needs attention before the student has gained a true understanding of the phenomena. Supervision also depends on the proclivities of individual residents and the preferences of some supervisors. Students are exposed to the entire training agenda from the outset so that they can place their current areas of learning in context. They will have an intellectual notion of transference and resistance, for example, long before they are ready to do sustained, integrated work in these areas. They are also able to benefit from supervision in specific aspects of technique in advance of their readiness to learn about them in depth.

PHASES OF LEARNING

This model posits a sequence of learning that moves from what is directly observable to areas that are more difficult to understand and integrate. The specific developmental phases are based on the notion of beginning with clinical phenomena, organizing them into clusters that are informed by a psychodynamic perspective, and, finally, demonstrating important clinical interrelationships. Not all learning goals fit neatly into each phase. The trend is consistent enough, however, to make such categorization useful. The phases also roughly follow the progression in treatment, from data gathering, to the identification of consistent

patterns and processes, through to a detailed and integrated understanding.

Phase I, Observation and Description, focuses on the student's ability to observe, collect clinical data, and describe what is seen, heard, and experienced. There is little attempt to organize observations around theoretical knowledge. The student learns how to describe the patient and his or her behaviors in detail, enable the patient to talk freely, listen openly and carefully, and pay attention to the interactive nature of the clinical encounter. An important aspect of this work includes consensual validation by teachers and peers. Students are also asked to pay attention to themselves as participants. Most of these skills, although difficult to work on, require no leap of faith. Working from the manifest data is in the biomedical tradition, so residents do not need to see psychotherapy as an unfamiliar departure from their work up until that point. Phase I includes many skills that are basic to all forms of psychotherapy.

Phase II, Conceptualization, centers on placing manifest communications, behaviors, and interactions within frameworks that help to explain psychotherapy process and aid in the choice of interventions. Students begin paying attention to repetitive themes and behaviors, patterns of interactions, latent communications, and the ebb and flow of the therapeutic working relationship. At this point, a variety of clinically useful theoretical concepts are learned and integrated directly with clinical data. An overview of the analytic theory of technique as well as a psychodynamic view of behavior are needed. The Conceptualization phase therefore represents a major shift from manifest phenomena to more covert data and abstract levels of understanding.

Phase III, Synthesis, involves a fuller integration of the skills, knowledge, and behaviors learned up until this point. The most important abilities needed here are a fluidity of thinking that can integrate multiple areas of knowledge about the patient and the therapy process, the ability to understand complex interrelationships, and the freedom to see the same phenomenon from different perspectives. Although new knowledge is continually being introduced, the major emphasis is on the integration of already existing knowledge and its increasingly skillful applications during clinical work.

During Phase III, the resident develops the ability to place recurrent behaviors and thematic material within the context of the therapeutic relationship, the evolving psychodynamic formulations, and the patient's life history. The interplay between resistance, transference, and thematic interpretation, together with the content, depth, and timing of interventions, becomes increasingly important. Brief psychotherapy, for example, requires the ability to rapidly assess process within the session and direct efforts at focused and effective interventions. This requires the integration of knowledge and skills drawn from multiple areas and coupled with new techniques. Phase III is a time for the expansion and integration of theoretical and clinical knowledge from interpersonal, cognitive, existential, and other perspectives.

DEVELOPMENTAL CATEGORIES

Discrete areas of learning are grouped together into "developmental categories." Different numbers of categories and other organizing principles could be used, but the educational goals included here represent widely agreed-upon fundamentals in the field. Placing discrete learning tasks into larger groups is not only an organizational aid but also helps to demonstrate the interrelationships among the tasks. The developmental categories are understood to have a dynamic character: each category is composed of a variety of goals that are closely interrelated, and each depends upon learning within the other categories for optimal progression.

The five developmental categories are 1) Goals, Roles, and Boundaries; 2) Participants; 3) Verbal Flow; 4) Technique; and 5) Theory. Each group of learning goals will be briefly described over the course of its

TABLE 1. Educational goals: traditional psychodynamic psychotherapy

Developmental Categories	Phases of Learning I Observation and Description	II Conceptualization	III Synthesis
1. **Boundaries, roles, and goals**	Boundaries: • Time, space, and money • Outside relationships • Professional relationship • Privacy and confidentiality Therapist's roles: • Analytic attitude (neutrality, abstinence, safety/freedom) • Interventions • Education of patient (overt and covert) Patient's roles: • Active participant • Free association • Curiosity Goals: • Symptom relief, behavioral change, and relationship to self-exploration • Realistic vs. idealized outcomes	Recognition of breaches in boundaries and roles as they occur within the context of treatment. Ability to correct obvious problems. Goals: • Interplay of symptoms and behaviors with process in treatment and intrapsychic life • Ability to assess patients and establish specific and realistic goals • Time (brief and longer term goals)	Ability to consider breaches in the context of dynamic understanding and the overall process of the therapy. Ability to interpret and correct during hour. Goals: • Ability to match patient to levels of intervention and focused treatment goals • Integration with other forms of intervention (somatic and psychotherapeutic)
2. **Participants**	Therapist: • Attention to one's own overt thoughts, feelings, and fantasies Patient: • Description of patient (affects, character, nonverbal behavior) • Life history: development, themes, repetitions, meaning (narration) • Handling patient's level of anxiety and avoidance	Therapist: • Development of introspection and self-reflection • Recognition of prominent countertransference reactions Patient: • Ability to recognize and describe transference • Dynamic formulation • Ability to recognize and describe resistance	Therapist: • Application of knowledge gained from introspection for interpretation • Use of countertransference for interpretation Patient: • Management and interpretation of transference • Ability to interpret resistance • Use of dynamics to make interventions

	Dyad: • Rapport • Effects on each other	Dyad: • Working alliance • Repetitive interactions (overt and covert)	Dyad: • Ability to repair working alliance • Integration of repetitive interactions, transference/countertransference, and use in interpretations
3. Verbal Flow	• Listening with openness and concentration • Ability to summarize manifest themes • Maintaining verbal flow • Tolerance for ambiguity	• Active listening/empathic listening • Identifying major latent theme(s) • Appropriate focusing and unfocusing	• Matching latent theme to dynamics • Integrating latent themes with transference, resistance, treatment focus, and stage of treatment
4. Technique	Theory: • Repetition of outside behaviors and relationship in the treatment • Overview of phases of treatment Skills: • Open-ended and focused questions • Listening/responding/listening • Supportive/expressive techniques • Confrontation and clarification	Theory: • Transference/countertransference • Resistance • Functions of interpretation Skills: • Interpretation • Use of self with patient • Pacing of interventions	Theory: • Integration of theory, resistance, transference, and interpretations • Working through • Termination • Therapeutic action and its comparison with other modalities Skills: • Subtleties of interpretation (i.e., depth, timing, content, style) • Different approach to patients • Integration with other approaches (e.g., cognitive, interpersonal, systems)
5. Theory	• The unconscious • Importance of early development • Repetition of past in present • Historical and narrative truths	• Conflicts and defense • Symptom formation • Developmental theory • Object relations perspective • Fantasy and dreams	• Specific models: structural, ego psychology, object relations, self psychology • Comparison with other frameworks: interpersonal, behavioral, family, cognitive, systems, other

progression through the three phases of learning. This is not a comprehensive review, but rather a demonstration of the ways in which this form of organizing educational goals can be useful.

Category 1: Boundaries, Roles, and Goals

The establishment of the roles, boundaries, and goals specific to the practice of dynamic psychotherapy is a fundamental aspect of training. These dimensions define the frame in which therapy takes place, together with the expectations for participation and the purpose of the work. The educational tasks include 1) the practical aspects of structuring the relationship between patient and therapist, 2) a clear definition of the necessary attitudes and responsibilities of both participants, and 3) an understanding of the realistic goals of this method of treatment. Of particular importance are 1) the accent on a safe and stable environment against which behaviors can be observed, 2) an understanding of the characteristics of the analytic attitude, and 3) the development of open and active participation by the patient.

In Phase I, Observation and Description, the need for a stable environment, neutrality, and the nondirective stance, and the purpose of helping patients to talk freely, all require a basic conceptual framework. Residents need to understand the purpose of their activities and the requests of their patients. It is helpful for them to realize that the frame of the therapy dramatically influences the kinds of data available, the processes that unfold, and the kinds of outcomes that are attainable.

In Phase II, Conceptualization, the student begins to appreciate more conceptually the patterns of behaviors that are important to both therapist and patient. Now some of the "rules" of therapy begin to make more sense. At this time, the focus will be on observing the ways in which boundaries and roles are breached. Some understanding of the reasons why this takes place will also be possible, as will moves to restore a stable working environment. Residents can begin to understand the concept of intrapsychic change as a goal and its relationship to symptom relief and change in behaviors. This phase is also a time to educate residents further about specifying treatment goals and maintaining a focus.

During Phase III, the Synthetic phase, a deeper understanding of the importance of boundaries and therapeutic posture takes place. The resident is now able to make use of breaches in these areas as a means for deeper understanding and effective interventions. There is also a greater flexibility in setting goals in response to the needs, capabilities, and requests of particular patients. Therapists are now more comfortable with their unique styles of doing therapy while still being able to maintain a consistent treatment approach. There is also more tolerance for changes in goals over time, together with an ability to use dynamic psychotherapy in an integrated way in other approaches.

Category 2: Participants

This category contains some of the most important facets of training: the life history; in-depth description of behavior; dynamic formulations; introspection; the working alliance; and the ability to work with transference, countertransference, and resistance. Seeing psychodynamic psychotherapy as an experience occurring between and within two people is one of the most central aspects of this treatment.

The beginning therapist must learn to become a participant-observer. During Phase I, the focus is on manifest feelings and thoughts. The influences of the patient and therapist on each other and the context in which these influences are felt is a subject for observation, description, and discussion. In these ways, the resident develops the ability to observe carefully, along with vocabulary and perspectives through which to portray the richness of human behavior.

During Phase II, the student begins to link recurrent patterns to conceptual frameworks.

A richer appreciation of psychoanalytically informed clinical phenomena (transference, countertransference, defense, and resistance) is fostered. Now the student can understand what is occurring in therapy in ways that can provide other levels of information about the patient and can aid in the selection of areas to intervene. By this time, for example, the student is able to understand a particular form of resistance in a patient who seems to know more than he or she professes, comes late to sessions that follow a "good" hour, and has stimulated annoyance and boredom in the therapist. The student can then go beyond a manifest affect or behavior to explore with the patient the presence of resistance and begin to understand its functions and meanings. Phase II abilities provide the developing therapist with a greater sense of control of the process and allow for interventions that deepen the work.

In Phase III, the Synthetic phase, the student confronts a matrix of intersecting educational tasks involving the interplay of transference, countertransference, resistance, the status of the working alliance, the deepening understanding of the patient's dynamics, and an ability to select and maintain a treatment focus. It is desirable for all residents to have an overview of the work at this level, even if they do not develop into competent dynamic psychotherapists. The application of analytic understanding to general clinical psychiatry is of great importance to the field,[42,43] and an appreciation of interrelationships at this level is relevant to that goal.

Category 3: Verbal Flow

The patient's communication through language and the therapist's ability to recognize emerging themes are fundamental to psychotherapeutic work. Phase I involves training the resident to pay attention to the details and flow of what is being said without premature closure and to be able to summarize what has been heard. Some residents will be able to begin to quickly "hear" latent levels of meaning, but the student must first be able to absorb what the patient is saying before paying closer attention to underlying themes. The technical skills of interviewing are closely connected to this process.

Phase II learning centers upon active, flexible listening for preconscious themes. There is a shift from content to process and manifest to latent. The starting point always remains, however, with the data obtained from the patient and from the therapist's reflections. While the way in which thematic material is organized, understood, and applied will be strongly influenced by psychodynamic perspectives, the validity of this method must be repetitively demonstrated by direct links with what is observable.

Phase III, Synthesis, involves connecting the predominant themes or focal conflicts to the emerging understanding of the patient and therapy process. This connection of theme, patient, and process requires the integration of knowledge about the patient's life history, current life stressors, recurrent behaviors, character style, and manner of self-expression with the evolving dynamic formulation. This understanding must, in turn, be informed by an appreciation of the degree of transference and resistance present. In this way, the student will be able to select the most useful treatment interventions.

Category 4: Technique

Technique can be conceptualized as existing across a continuum, ranging from interviewing to the subtleties of interpretive work. These abilities must be placed within a theoretical context that defines the major areas in therapy that require intervention. This developmental line is therefore divided into 1) the acquisition of knowledge about the theory of therapy and 2) the technical skills of questioning, responding, and interpreting.

The psychoanalytic theory of therapy rests primarily on the concepts of transference, countertransference, resistance, and working through with the use of interpretation. Attaining this theoretical perspective is a necessary

precondition to conceptualizing clinical phenomena and working with a traditional psychodynamic method. For example, in order for a student to make use of an important transference reaction during treatment, there must be a working definition of 1) what transference represents, 2) the way it can be used to work through unresolved conflicts, 3) its relationship to resistance, and 4) how the interpretation of this phenomenon relates to the patient's problems and the goals of treatment. This knowledge must be combined with a sense of when and how transference is to be addressed. An awareness of the degree of rapport and empathy, the status of the working alliance,[25] and where the patient is on the supportive/expressive continuum[34] are also necessary preconditions for the understanding of transference interpretation. Although there is considerable variation in the translation of these analytic principles to the practice of dynamic psychotherapy, an integrated overview of this aspect of therapy is essential.

In the model, the theory of technique has been divided to correspond to the phases of learning so that each area anticipates the focus of each phase. Thus, Phase I stresses the importance of a developmental history, the fact that outside relationships are paralleled in treatment, and the need to set the stage for the interpretive work that is to follow. Phase II requires some explication of transference, countertransference, resistance, and working through so that the student will be able to recognize these phenomena in clinical work. Over time, these categories are placed within an integrated model of the process of therapy, and this leads to the synthetic work of Phase III.

The technical skills needed to practice dynamic psychotherapy have only more recently received the attention they deserve. Training has shifted toward technique because of the recent emphasis on treatment specificity, variations in technique, focused goals, and outcome research. Well-defined interventions and manualized dynamic treatments[33,34,44] are much more explicit about how to do the work. The considerable variety in emphases and styles of intervention continues to grow as newer approaches are validated. The basics of traditional technique are presented here, but more recent technical advances can also be added.

Phase I skills enable the listening and data-gathering process and introduce the ability to move treatment toward interpretation. They therefore begin with interviewing skills and the nondirective stance. The student learns to pay attention to the interactive process, including listening, making an intervention, and then listening again for the consequences of the intervention. The type and timing of interventions and the interplay of support and pushing the work further (as in the supportive/expressive dimension[34]) are introduced here.

During Phase II, there is increasing emphasis on interpretive work. Once the student understands the presence of a resistance, for example, the technique of pointing this out to the patient and beginning interpretive work can be addressed. The major educational goals of this phase allow for the fuller development of a working alliance and early interpretive work on focal dynamic content, transference, and resistance. This level of technique is attainable by many psychiatric residents and is necessary for the practice of brief dynamic psychotherapy.

Phase III requires a more in-depth development and integration of interpretive abilities. The student is now able to learn how to rationally choose which areas within an hour to address and interpret. There is more sophisticated work on the choice, timing, depth, and content of interventions.

Category 5: Analytic Theory

Of all the areas in psychodynamic psychotherapy education, the timing and depth of exposure to theory is most open to question. This is a reversal from the earlier history of education in this discipline and reflects widespread debate about the validity of analytic theory, as well as its relevance to clinical work. Yet most

educators agree that basic theory is essential. The questions are what it should consist of, how much diversity of viewpoints is desirable, and when to teach it.

This model deemphasizes theory early in training. At Phase I, what is necessary is an introduction to the notion of the dynamic unconscious and its link to development. The centrality of human relationships, attachment, psychic trauma, repetitions, and historical versus narrative truth are concepts that are readily grasped and applicable to early clinical work.

Phase II learning includes knowledge of developmental theory; the concepts of symptom formation, conflict, and defense; object relations; and a richer understanding of the repetition of patterns of behavior. Subjective reality and fantasy are also addressed. Without an awareness of these ideas, it is not possible to understand the utility of dynamic formulations and the interpretation of resistance and transference. Aspects of psychosexual stages, structural theory, object relations theory, and ego and self psychology can be introduced, but there is no attempt at a systematic presentation of these models. What is necessary is a basic conceptual framework that links development, intrapsychic life, repetitive patterns, and unconscious themes seeking expression.

Phase III education can include discussion of the classic analytic literature to promote understanding of the central tenets of each model. Recent contributions and trends are also important here. The ways in which the orientations interrelate and inform clinical work are of particular importance. Links to and comparison with cognitive, behavioral, and systems models are more understandable at this time. It is important to introduce students to the evaluation and current directions of theory. However, the study of theory in depth goes beyond the purview of residency.

DISCUSSION

Attempts to objectify and systematize training in psychodynamic psychotherapy have met both intellectual and emotional resistance. Many educators feel that the field is so complexly interwoven and the learning process is such a personal undertaking that moves toward standardization are undesirable. The supervisory/apprenticeship model has been the primary mode of training, and in that model the individual supervisor's approach to education, together with the student's proclivities and the treatment of specific patients, determine what is taught. There is no question that psychotherapy training must be approached with a flexible attitude that encourages individual variation. The needs of both patients and students must be attended to, and these needs do not follow a uniform sequence. There also has to be room for supervisors to teach what they value and have particular strengths in. Awareness of issues of process in supervision, attention to teaching and learning styles, support for the resident's emotional needs, and personal growth are all necessary. However, there is a need for a content/process, didactic/experiential dialectic in psychotherapy education. Teaching with definite, realistic educational objectives will facilitate education—whether the immediate accent is on an experiential approach, discussion of content, or a specific technique.

This model is an attempt at delineating those aspects of training that can be described objectively and placed within a structure that demonstrates interrelationships and a progression in learning. A major constraint has been the desirability of constructing a model that not only accurately reflects the practice of therapy and helps to inform educational efforts, but is also concise enough to be of use in ongoing training and for evaluation purposes. Three separate steps have been taken in the construction of this model: specifying training goals, organizing them into categories, and placing the categories within learning phases. Each step offers advantages and imposes limitations, and each can be evaluated on its own merits, but it is the combination of the three that gives the model depth and provides educators and students with guidelines for training.

The discrete goals have been chosen as being most representative of the practice of traditional dynamic psychotherapy. Some goals are more specific than others. Although the list is comprehensive, it does not include the nonspecific aspects of therapy, such as warmth, sensitivity, compassion, and a sense of humor. Recent contributions have not been included here. Training programs interested in teaching dynamic psychotherapy will vary considerably with respect to how traditional their approach will be. Some will lean more toward a focus on the elucidation of meaning and observable interpersonal process, while others will prefer an accent on dynamics and transference/resistance interpretation. Although there are important differences among them, all dynamic approaches derive from a perspective that includes influences from development, the unconscious, subjective meaning, process between patient and therapist, and insight.

Placing the educational goals into the categories of development aids training by creating manageable gestalts that serve to highlight important interrelationships and trends. Some of the arbitrariness of this kind of categorization is balanced by an awareness of the dynamic interconnections across boundaries and the constant flow between larger perspectives and minute details. This is an aspect of education that can only be hinted at in an organizational map.

Placing the categories within the sequential learning phases provides an overall dimension to training at different points in the process and helps to further define the progression of specific areas of knowledge. This approach is of help in addressing the difficult questions of what to teach when. The model does not presume a naturally occurring sequence, but rather that such a structure helps to prioritize areas of training. The phases are intended to be used flexibly to orient rather than to strictly define or limit teaching practices. There is always a mixture of observing, conceptualizing, and synthesizing.

The model makes no attempt to suggest how far an individual resident should be expected to progress in training. It is helpful for the resident with no interest in practicing this form of treatment to know how certain clinical skills relate to the dynamic treatment method. Establishing boundaries and rapport, enabling the patient to speak openly, listening, and experiencing oneself as part of the treatment process are examples of core clinical skills that all psychiatrists should possess. Understanding the purview of psychodynamic psychotherapy can enable clinicians to recognize problems and look for help or refer a patient when that is needed. Those residents who wish to become competent dynamic psychotherapists can use the phases to measure progress and help guide ongoing education far beyond residency.

The sequential training model was developed 15 years ago with the primary purpose of constructing a progressive series of seminars that followed a consistent set of overtly defined expectations. With the timing and specifics of the training goals established, there was greater freedom to develop various teaching strategies. A mixture of readings and didactic discussions, process notes and audiotaped case material, roleplaying, and use of the teacher's clinical work all became organized around a progressive set of educational objectives.

Once this model was used to develop and teach a series of seminars, other advantages followed. The Director of Education was able to more consistently assess the progress of individual residents as well as begin to set goals and standards for the program. All residents and teachers had a better sense of what was expected from their work together. The evaluations of supervision, completed by both resident and supervisor, began to reflect a more consistent focus on learning expectations related to timing in training.

Psychiatric residents begin doing psychotherapy in advance of much knowledge of the process. The lack of an organized framework within which to anticipate their work with patients causes more anxiety and confusion than necessary and can interfere with early learning. This model provides an overview of therapy

in a concrete format that can be supportive. It provides a context and rationale for educational goals. The specification of skills and knowledge gives residents a tangible place to start. They can actively pursue agreed-upon objectives rather than believing that they have to learn everything at once and therefore feeling incompetent or paralyzed. As residents progress, they can continue to use the model for orienting current learning and for assessing growth. Since the model encompasses advanced areas of learning, it can continue to be valuable long after formal training has ended.

The supervisor must focus on the resident's educational and emotional needs, the patient, the progress of the therapy, and a diverse variety of related issues. Each supervisor develops a way of using different kinds of information to teach, but some consistent organizing principles can be of great benefit. Without a structure, it becomes easier to become stuck on one area and to miss the possibility that movement in this area is premature or first requires education in other related aspects of therapy. A structure can also help to prevent idiosyncratic choices or education solely based on the needs of the patient presented in supervision. The use of this model encourages the supervisor to be more selective and cautions against moving ahead to complex tasks before basic areas are understood. The overt delineation of current training objectives with the resident enhances the working relationship and improves learning. Impasses between supervisor and supervisee can often be resolved with a refocusing on the most relevant phase-appropriate learning objectives. A rigid adherence to any group of educational goals, however, leads to a stale supervisory experience.

Structuring educational goals offers a number of advantages for ongoing psychotherapy training. More important than any given model, however, is the process that this form of inquiry sets in motion. It causes all involved to think more systematically about what they are doing and to endeavor to improve on current practice. The field of psychotherapy education is hampered by the lack of consensual standards, objective measurement, and research. This model is also an attempt to establish a baseline from which to research more effective educational strategies.

CONCLUSION

An organized and integrated approach to education in psychodynamic psychotherapy is possible and desirable. In order for this to occur, the essential knowledge and abilities that define this method must be clearly articulated. The clustering and sequencing of these goals further enables educators to develop an effective method of training. In this way, questions about the timing and methods of teaching specific aspects of psychotherapy can be more rationally addressed. Evaluation of progress, the establishment of minimal and optimal levels of competence, and comparison with other psychotherapy models can also be facilitated.

REFERENCES

1. Meerlo JAM: Some psychological processes in supervision of therapists. Am J Psychother 1952; 6:467–470
2. Searles HF: The value of the supervisor's emotional experience. Psychiatry 1955; 18:135–146
3. Hora T: Contribution to the phenomenology of the supervisory process. Am J Psychother 1957; 11:769–773
4. Hogan RA: Issues and approaches in supervision. Psychotherapy: Theory, Research and Practice 1964; 1:139–141
5. Gaoni B, Neumann M: Supervision from the point of view of the supervisee. Am J Psychother 1974; 23:108–114
6. Doehrman MJ: Parallel process in supervision and psychotherapy. Bull Menninger Clin 1976; 40:3–104
7. Fleming J, Benedek T: Psychoanalytic Supervision. New York, Grune and Stratton, 1966
8. Bibring GL: Can psychiatry be taught? In The Teaching of Dynamic Psychiatry: A Reappraisal of the Goals and Techniques in the Teaching of Psychoanalytic Psychiatry, edited by Bibring GL. New York, International Clinic Press, 1968, pp 5–20
9. Lowenstein RM: Psychoanalytic theory and the teaching of dynamic psychiatry, in The Teaching of Dynamic Psychiatry: A Reappraisal of the Goals and

Techniques in the Teaching of Psychoanalytic Psychiatry, edited by Bibring GL. New York, International Clinic Press, 1968, pp 104–114
10. Ekstein R, Wallerstein RS: The Teaching and Learning of Psychotherapy (revised edition). New York, Basic Books, 1972
11. Friedman L: A philosophy of psychotherapy supervision. Psychoanal Q 1981; 53:100–105
12. Shanfield SM, Gil D: Styles of psychotherapy supervision. Journal of Psychiatric Education 1985; 9:225–232
13. Ralph NB: Learning psychotherapy: a developmental perspective. Psychiatry 1980; 43:243–250
14. Alonzo A: The Quiet Profession: Supervisors of Psychotherapy. New York, Macmillan, 1985
15. Rodenhauser P: Toward a multidimensional model for psychotherapy supervision based on developmental stages. J Psychother Pract Res 1994; 3:1–15
16. Buckley P, Conte HR, Plutchik R, et al: Psychotherapy skill profiles of psychiatric residents. J Nerv Ment Dis 1981; 169:733–737
17. Corradi RB, Wasman M, Gold FS: Teaching about transference: a videotape introduction. Am J Psychother 1980; 34:564–571
18. Rodenhauser P, Leetz K: Complementing the education of psychiatry residents: a study of novels, plays and films. Journal of Psychiatric Education 1987; 11:243–248
19. Klein FM, Goin MK: You can be a better supervisor. Journal of Psychiatric Education 1977; 1:174–179
20. Balsam A, Garber N: Characteristics of psychotherapy supervision. Journal of Medical Education 1970; 45:789–797
21. Shanfield SB, Mohl PC, Matthews KL, et al: Quantitative assessment of the behavior of psychotherapy supervisors. Am J Psychiatry 1992; 149:352–357
22. Wolberg L: The Technique of Psychotherapy. New York, Grune and Stratton, 1954
23. Menninger K: Theory of Psychoanalytic Technique. New York, Basic Books, 1958
24. Tarachow S: An Introduction to Psychotherapy. New York, International Universities Press, 1963
25. Greenson R: The Technique and Practice of Psychoanalysis, vol 1. Madison, CT, International Universities Press, 1967
26. Dewald PA: Psychotherapy: A Dynamic Approach, 2nd edition. Oxford, Blackwell Scientific, 1969
27. Bruch H: Learning Psychotherapy. Cambridge, MA, Harvard University Press, 1974
28. Wallerstein RS: Psychotherapy and Psychoanalysis: Theory, Practice, Research. New York, International Universities Press, 1975
29. Basch MF: Doing Psychotherapy. New York, Basic Books, 1980
30. Langs R: Psychotherapy: A Basic Text. New York, Jason Aronson, 1982
31. Ursano R, Sonnenberg R, Lazar SG: Course Guide to Psychodynamic Psychotherapy. Washington, DC, and London, American Psychiatric Press, 1991
32. Malan DH: Individual Psychotherapy and the Science of Psychodynamics, 2nd edition. Oxford, Butterworth Heinemann, 1995
33. Strupp HH, Bender JL: Psychotherapy in a New Key: A Guide to Time Limited Dynamic Psychotherapy. New York, Basic Books, 1984
34. Luborsky L: Principles of Psychoanalytic Psychotherapy: A Manual for Supportive/Expressive Treatment. New York, Basic Books, 1984
35. Mohl PC, Lomax J, Tasman A, et al: Psychotherapy training for the psychiatrist of the future. Am J Psychiatry 1990; 147:7–13
36. Fleming J, Hamburg DA: An analysis of methods for teaching psychotherapy with description of a new approach. Arch Neurol Psychiatry 1958; 79:179–200
37. Fleming J: Teaching the basic skills of psychotherapy. Arch Gen Psychiatry 1967; 16:416–426
38. Ornstein P: The sorcerer's apprentice: the initial phase of training and education in psychiatry. Compr Psychiatry 1968; 9:293–315
39. Levenson EA: Follow the fox: an inquiry into the vicissitudes of psychoanalytic supervision. Contemporary Psychoanalysis 1982; 18:1–12
40. Melchiode G: On teaching today's residents psychoanalytic concepts. J Am Acad Psychoanal 1991; 19:648–659
41. Buckley P, Conte HR, Plutchik R, et al: Learning dynamic psychotherapy: a longitudinal study. Am J Psychiatry 1982; 139:1607–1610
42. Schwartz H, Bleiberg E, Weissman S: Psychodynamic Concepts in General Psychiatry. Washington, DC, and London, American Psychiatric Press, 1995
43. Gabbard GO: Psychodynamic Psychiatry in Clinical Practice: The DSM-IV Edition. Washington, DC, and London, American Psychiatric Press, 1994
44. Klerman GL, Weissman MM, Rounsaville BJ, et al: Interpersonal Psychotherapy of Depression. New York, Basic Books, 1984

Symptoms and Character Traits in Patients Selected for Long-term Psychodynamic Psychotherapy

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In this naturalistic study of 55 outpatients selected for long-term psychodynamic psychotherapy, two Swedish assessment instruments are presented (the Karolinska Psychodynamic Profile and the Karolinska Scales of Personality), and the significance of psychodynamic criteria for the selection of patients is discussed. Thirty patients (55%) fulfilled criteria for a DSM-III-R diagnosis. The most prominent psychodynamically defined character pathology was found in the areas of coping with aggressive affects; dependency and separation; frustration tolerance; and impulse control. Some psychodynamically defined character traits, particularly poor frustration tolerance, were related to symptomatic suffering.

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In current psychotherapy research, investigators tend to use experimental or quasi-experimental designs to control factors of interest, resulting in a relative lack of naturalistic studies. Controlled studies, however, do not allow us to investigate how patients are selected for psychotherapy in clinical practice in general and for psychodynamic psychotherapy in particular.

In addition to psychological suffering, the traditional selection criteria for psychoanalysis and psychodynamic psychotherapy have been a high general level of functioning, good ego strength, good reality testing, good capacity to regress in the service of the ego, good object relations in the outer world, and stable object constancy in the inner world. Moreover, suitable patients should be curious about their inner life, be able to tolerate a high degree of frustration, and show "psychological mindedness."[1] Although these criteria have been revised and expanded by several authors, e.g.,

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Kernberg,[2] in Sweden and probably in many other Western countries, they still remain generally accepted guidelines in clinical practice for the diagnosis and selection of patients suitable for both short-term and long-term psychodynamic psychotherapy.

Instruments have been developed to study several aspects of these dynamic diagnostic criteria, including defense mechanisms,[3] ego strength,[4] object relations,[5] and overall psychological health.[6] Nevertheless, phenomenological diagnosis, today most often the DSM-IV,[7] is the most commonly used for pretreatment diagnosis in psychotherapy research. Undoubtedly, the DSM system is a very valuable instrument for defining diagnostic subgroups. However, because it is not based on any specific theory, there is also a need for assessment tools based on theories underlying specific psychotherapies.[8,9]

Diagnostic instruments based on psychodynamic theory often assess aspects of human behavior, such as object relations, defense patterns, and various modes of mental functioning, that could also be described as character traits. In psychoanalytical theory, *character* is conceived of as the individual's attempt to bring the tasks presented by internal demands and by the external world into harmony, resulting in a typical constellation of traits by which we recognize the particular person.[10,11] When the individual's habitual character does not permit successful handling of these tasks, symptoms may evolve.[12,13] The relationship between symptoms and character has always been an important subject of investigation within a psychoanalytical frame of reference. Several typical relationships between character and clinical syndromes have been described,[14] such as the classical associations described by Freud between the hysterical character and conversion[15] and between the anal character and obsessive-compulsive neurosis.[16] There are, however, psychoanalysts who advocate the opposite view, that no such determined associations between character and symptom exist.[17,18]

The aim of the present naturalistic study was twofold. The first goal was to describe a sample of patients selected for long-term dynamic psychotherapy from a psychiatric and a psychodynamic point of view. In addition to the DSM, we introduce an interview-based psychodynamic instrument and a personality inventory commonly used in Scandinavia but not often discussed in the North American literature. The second goal was to study the relationship between DSM-defined symptoms and psychodynamic aspects of character.

METHODS

Subjects

The study was conducted at the Institute of Psychotherapy in Stockholm, which provides long- and short-term psychodynamic psychotherapy. Patients applied by telephone, and a brief interview was conducted during the call. About one-third of the patients who applied were offered one to three exploratory interviews. One-third of these patients (11% of the patients who phoned) were considered suitable for long-term dynamic psychotherapy and were put on a waiting list for treatment at the Institute. Patients with severe psychopathology were referred to other psychiatric clinics, and patients lacking "psychological mindedness" were referred elsewhere for supportive treatment. Thus, the patients were selected in three steps: self-selection (the patients themselves decide to apply for psychotherapy), telephone interview, and exploratory interviews.

By telephone and mail, the first author (A.W.) asked 58 consecutive patients from the waiting list to participate. Fifty-five patients (95%) decided to take part in the study. Patient characteristics are presented in Table 1.

A sample of 65 patients with ulcerative colitis was used as the control group.[19] There were two reasons for using this control group: first, contrary to what is commonly believed, a recent review of 138 studies examining the relation between ulcerative colitis and psychiatric factors concluded that ulcerative colitis

patients had the same prevalence of psychopathology as normal control subjects.[20] Second, data that had been obtained with the same instruments as those used in the present study were available for the ulcerative colitis sample.

Assessments

Psychodynamic Character Assessment: The Karolinska Psychodynamic Profile (KAPP) was used for psychodynamic character assessment.[21,22] The KAPP is a rating instrument based on psychoanalytical theory that assesses relatively stable modes of mental functioning and character traits as they appear in self-perception and in interpersonal relationships. The instrument consists of 18 subscales. Seventeen of the subscales are on a low level of abstraction and could be considered to represent character traits; the last subscale refers to character as organization. Each subscale is provided with a definition and three defined levels. Two additional intermediate levels may be used, resulting in a five-point scale, (1, 1.5, 2, 2.5, and 3). On all subscales, level 1 represents most normal and level 3 least normal. The definitions of the KAPP subscales are presented in Table 2.

Factor analysis of the KAPP in the control group has yielded five factors, which suggests

TABLE 1. Patient characteristics

Characteristic	*n*	%	Mean	Median	Range
Age (years) and gender					
Total	55	100	34	32	21–54
Women	44	80	33	32	21–54
Men	11	20	37	36	27–53
Marital status					
Single	24	44			
Married (de facto married)	21	38			
Divorced	10	18			
Profession (including students in the field)					
Health care	27	49			
Cultural work	15	27			
Other professions	13	24			
Education					
High school or less	18	33			
College or graduate school	37	67			
DSM-III-R Axis I					
None	26	47			
Mood disorders	17[a]	31			
Anxiety disorders	6	11			
Somatoform disorder	2	4			
Sleeping disorder	1	2			
Eating disorder	1	2			
Sexual disorder	1	2			
Sexual dysfunction	1	2			
DSM-III-R Axis II					
Personality disorder NOS	4	7			
Borderline personality disorder	1	2			
Narcissistic personality disorder	1	2			
GAF			70 (SD = 8.0)		50–85

Note: NOS = not otherwise specified; GAF = Global Assessment of Functioning.
[a]12 major depression.

TABLE 2. The Karolinska Psychodynamic Profile (KAPP) subscales

QUALITY OF INTERPERSONAL RELATIONS

1. **Intimacy and Reciprocity**
   Describes different ways of relating to others—from relations characterized by intimacy, reciprocity, and consideration, to unilateral relations based on selfish needs.
2. **Dependency and Separation**
   Describes different types of dependency—from relative independence, as a more adult form of dependency, to infantile dependency.
3. **Controlling Personality Traits**
   Describes different ways in which the need for power and control may be expressed—ranging from mature and flexible attitudes, via covert and indirect bids for power or control, to less mature and more compulsively rigid forms made manifest in relations to both people and things.

SPECIFIC ASPECTS OF PERSONALITY FUNCTIONING

4. **Frustration Tolerance**
   Describes the capacity to endure the tension and displeasure arising from conflict between wishes felt to be essential and the internal or external limitations involved. The subscale describes different ways of responding to frustration—ranging from tolerance and coming to terms with it, via "reactive" modes of functioning, e.g., ego-restrictions, to manifest difficulty in enduring the disagreeable feelings it engenders.
5. **Impulse Control**
   Describes different ways of containing urgent affects, wishes, and needs of different kinds, and the way these are expressed in action—ranging from a mature balance between wishes and reality, via undue emphasis upon the dictates of reality at the cost of wishes, to manifest difficulty in taking reality into consideration in the pursuit of gratification.
6. **Regression in the Service of the Ego**
   Describes the capacity to regress in the service of the ego—ranging from a satisfactory capacity to relinquish the reality principle temporarily, playfully, voluntarily, and under control, to manifest difficulty in doing so.
7. **Coping With Aggressive Affects**
   The subscale ranges from adaptive and goal-directed attitudes, via nonadaptive inhibition of aggression, to impulsive and destructive expression.

AFFECT DIFFERENTIATION, BOTH WITH REGARD TO EXPERIENCE AND EXPRESSION

8. **Alexithymic Traits**
   The subscale ranges from good ability to identify, experience, and articulate variation in feelings and emotional states in a subtle and differentiated manner, to great difficulty in distinguishing between different feelings and sensations and in verbalizing them.
9. **Normopathic Traits**
   The subscale ranges from good ability to give active expression to personal and individualized needs and wishes, to an incapacity for such personal fantasies and instead a clinging to social conventions or mores.

THE IMPORTANCE ATTACHED TO THE BODY AS A FACTOR OF SELF-ESTEEM

10. **Conceptions of Bodily Appearance and Their Significance for Self-Esteem**
    Assesses the individual's more enduring conscious and unconscious conceptions of the appearance of the body and its significance for self-esteem.
11. **Conceptions of Bodily Function and Their Significance for Self-Esteem**
    Assesses the individual's more enduring conscious and unconscious conceptions of the function of the body and its significance for self-esteem.
12. **Current Body Image**
    Assesses the individual's current conceptions, conscious and unconscious, of his or her physical appearance and function, and their effect on self-esteem.

SEXUALITY

13. **Sexual Functioning**
    Assesses the functional sexual capacity of the individual, with regard to sexual activity with a partner.
14. **Sexual Satisfaction**
    Assesses sexual interest, desire, and satisfaction in relation to a partner. The subscale is graded from an active attitude to sex toward greater inhibition and passivity.

THE INDIVIDUAL'S SENSE OF HIS OR HER OWN SOCIAL SIGNIFICANCE

15. **Sense of Belonging**
16. **Feeling of Being Needed**
17. **Access to Advice and Help**
    These three subscales assess the individual's capacity to relate socially, although it is his or her own experience of this and not "objective" fact that is assessed.

CHARACTER AS ORGANIZATION

18. **Personality Organization**
    Assesses the degree of differentiation and integration of internalized object relations, and habitual defense strategies. The subscale is graded from neurotic to psychotic personality organization.

that the KAPP assesses more than one dimension of psychological health or psychiatric severity.[23]

The validity of the KAPP has also been examined by correlating independent KAPP ratings based on material obtained through projective testing with ratings obtained by interview. This analysis yielded significant results.[23] Furthermore, the KAPP has been found to discriminate between patients with and without a DSM diagnosis.[19] Stability over time has been examined by comparing KAPP scores before a major life event (abdominal surgery) and at an average of 22 months later. Scores on 14 of the 18 subscales were similar before and after surgery.[24] Predictive validity has been evaluated by examining the ability of the KAPP to predict long-term outcome after surgery. Results suggested that preoperative character traits could predict the patients' postoperative quality of life beyond what could be predicted by surgical outcome alone. Poor frustration tolerance and the absence of alexithymic traits were found to predict poor postoperative quality of life, indicating that alexithymic traits might actually be adaptive.[25,26]

In the present study, the reliability of the KAPP was tested in three different ways: 1) The first author (A.W.) independently rated 12 audiotaped KAPP interviews made by the second author (R.M.W., one of the developers of the instrument) for another study.[27] The mean intraclass correlation was 0.69 (median 0.69, range 0.33–0.89). 2) A psychologist independently rated 15 audiotaped KAPP interviews made by the first author for the present study. The mean intraclass correlation was 0.53 (median 0.57, range 0.23–0.76). 3) To investigate the stability of the first author's ratings, he rerated 14 of his own audiotaped KAPP interviews from the present study 1.5–2.5 years after his first ratings. On this rerating, the mean intraclass correlation was 0.70 (median 0.78, range –0.02 to 1.00). The lowest correlation was on the subscale Coping With Aggressive Affects, which had a very restricted range of KAPP scores (Table 3). The second

TABLE 3. Descriptive statistics and frequency distribution of scores on the Karolinska Psychodynamic Profile (KAPP)

KAPP Subscale	1	1.5	2	2.5	3	Mean ± SD
Intimacy and Reciprocity	31	18	6	0	0	1.27 ± 0.34
Dependency and Separation	13	18	23	1	0	1.61 ± 0.42
Controlling Personality Traits	34	17	4	0	0	1.23 ± 0.32
Frustration Tolerance	13	28	13	1	0	1.52 ± 0.37
Impulse Control	13	25	17	0	0	1.54 ± 0.37
Regression in the Service of the Ego	28	13	14	0	0	1.37 ± 0.42
Coping With Aggressive Affects	7	20	28	0	0	1.69 ± 0.35
Alexithymia	48	6	1	0	0	1.07 ± 0.20
Normopathy	51	4	0	0	0	1.04 ± 0.13
Bodily Appearance	28	13	12	2	0	1.39 ± 0.46
Bodily Functioning	44	8	3	0	0	1.13 ± 0.28
Current Body Image	42	9	4	0	0	1.16 ± 0.30
Sexual Functioning	42	5	6	0	1	1.19 ± 0.42
Sexual Satisfaction	35	11	6	2	0	1.27 ± 0.42
Sense of Belonging	36	8	7	4	0	1.31 ± 0.49
Feeling of Being Needed	49	4	2	0	0	1.07 ± 0.22
Access to Advice and Help	44	7	3	1	0	1.14 ± 0.33
Personality Organization	39	13	3	0	0	1.17 ± 0.29

Note: Bodily Appearance = Conceptions of Bodily Appearance and Their Significance for Self-Esteem; Bodily Functioning = Conceptions of Bodily Function and Their Significance for Self-Esteem.

lowest intraclass correlation was on the subscale Impulse Control (0.40).

Personality Traits Assessment: The Karolinska Scales of Personality[28] (KSP) is a 135-item personality inventory designed to measure dimensions of temperament, especially those believed to be markers for vulnerability to psychopathology.[29–31] The KSP has been constructed within a biologically oriented frame of reference and has been widely used in a large number of studies in Scandinavia and other countries on various clinical groups and healthy volunteers. The 15 mutually exclusive KSP scales have been classified into three categories: anxiety-proneness scales (Somatic Anxiety, Psychic Anxiety, Muscular Tension, Psychasthenia, and Lack of Assertiveness), extraversion-related scales (Impulsiveness, Monotony Avoidance, Detachment, Socialization, and Social Desirability) and aggression–hostility scales (Indirect Aggression, Verbal Aggression, Irritability, Suspicion, and Guilt). The KSP measures longitudinally stable personality traits[24,32] and has been validated in healthy subjects against other commonly used questionnaires.[28,33] It has also been applied for predicting outcome in clinical studies and for differentiating between various patient samples.[25,34–37] The KSP scales are presented in af Klinteberg et al.[38]

Diagnosis and KAPP Interview Procedures: The DSM-III-R was used to diagnose clinical syndromes (Axis I), personality disorders (Axis II), and global assessment of function (GAF Axis V).[39]

One rater (A.W., a specialist in psychiatry and a trained psychoanalyst) conducted all of the KAPP interviews. Each interview took approximately 2 hours and was audiotaped. Information was also collected for DSM-III-R diagnoses. The KAPP was scored immediately after the interview without listening to the tape. The personality inventory was filled out by the patient the same day.

RESULTS

Description of the Psychotherapy Patients

Personality Traits as Assessed by Personality Inventory, the KSP: The KSP scales were used to compare traits in the psychotherapy patients with those of a normal sample. Raw scores have been standardized to T-scores by using normative data obtained from approximately 200 women and 200 men (ages 20 to 65 years) randomly sampled from the Swedish population (mean = 50, SD = 1.0).

For the psychotherapy patients, the T-scores deviated substantially (defined as more than 0.5 SD; Rosenthal,[40] p. 138) from normative data on 9 of the 15 KSP scales. The patients in the present study had higher T-scores on 4 of the 5 anxiety-proneness scales (Somatic Anxiety, Psychic Anxiety, Muscular Tension, and Psychasthenia). Lower T-scores were found on the Socialization (signifying resentment over childhood experiences and present life situation) and Social Desirability (social conformity versus rebelliousness) scales, and higher on the Monotony Avoidance (excitement seeking) scale. The psychotherapy patients also had higher T-scores on the Irritability and Suspicion scales.

The same differences were found when comparing the psychotherapy patients and the control group, with two exceptions: no difference was found on the Monotony Avoidance scale, and the psychotherapy patients scored higher than the control subjects on the Guilt scale (Figure 1).

Character Traits as Assessed by a Psychodynamic Interview–Based Instrument, the KAPP: There were very few KAPP ratings above level 2 on any subscale. The mean KAPP scores of the psychotherapy patients were above 1.5 only on 4 of the 18 subscales (Figure 2): Coping With Aggressive Affects (expressed as inhibition of aggression), Dependency and Separation (difficulties in forming mature dependent

relationships and in separating), Frustration Tolerance (often expressed by restriction of the ego in order to avoid frustration), and Impulse Control (mostly expressed as an exaggerated inhibition of impulses). A minimal level of pathology was found on the Alexithymia and the Normopathy subscales.

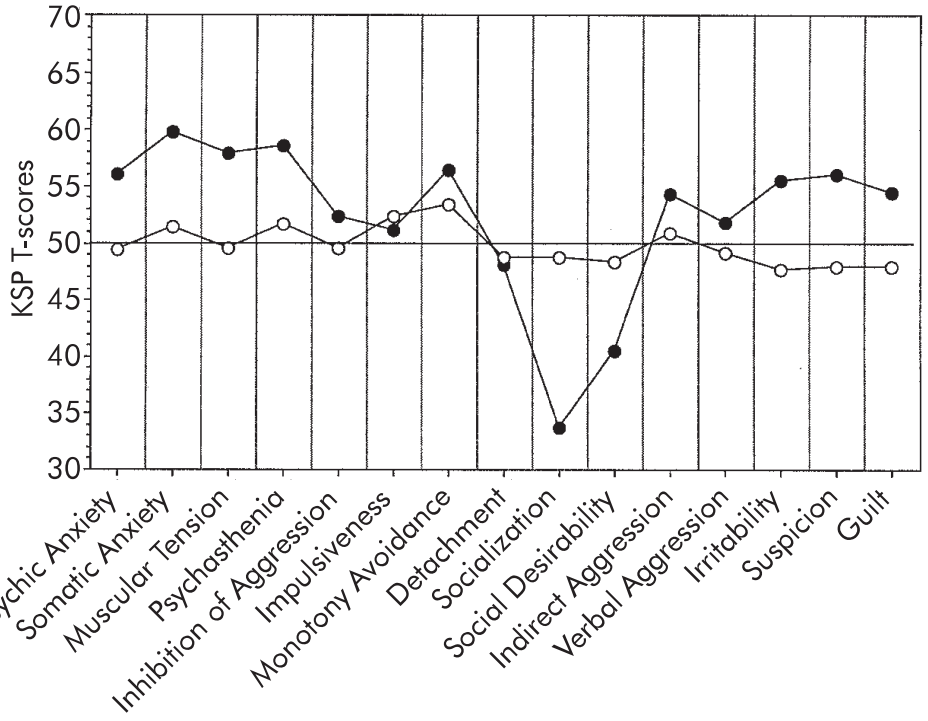
To ascertain how character traits in the psychotherapy patients compared with a nonpsychiatric sample, we used Weinryb and colleagues' published KAPP data of the aforementioned sample of ulcerative colitis patients.[19] Only on the subscale Frustration Tolerance did the psychotherapy patients show more pathology than the ulcerative colitis patients ($t = 3.34$, $P < 0.001$). On 6 KAPP subscales, the psychotherapy patients were less disturbed (i.e., had significantly lower mean scores) than the ulcerative colitis patients (Figure 2). These 6 subscales were Controlling Personality Traits, Regression in the Service of the Ego, Alexithymia, Normopathy, Current Body Image, and Sexual Satisfaction.

Age and Gender Differences in KAPP Scores: Men had significantly higher ("less normal") mean KAPP scores than women on the subscales Alexithymia ($t = 2.06$; $P < 0.05$) and Conceptions of Bodily Function and Their Significance for Self-Esteem ($t = 2.71$; $P < 0.01$). Women had higher mean KAPP scores on the subscale Sexual Satisfaction ($t = -2.03$; $P < 0.05$). With the exception of the subscale Sense of Belonging ($r = 0.36$; $P < 0.001$), no significant association was found between age and the KAPP subscales.

Character Traits and DSM-III-R Psychopathology

To examine the relationship between symptoms and character—that is, between

FIGURE 1. Karolinska Scales of Personality (KSP) T-scores for patients in the current study ($n = 55$, filled circles) and patients with ulcerative colitis ($n = 64$, unfilled cicles).



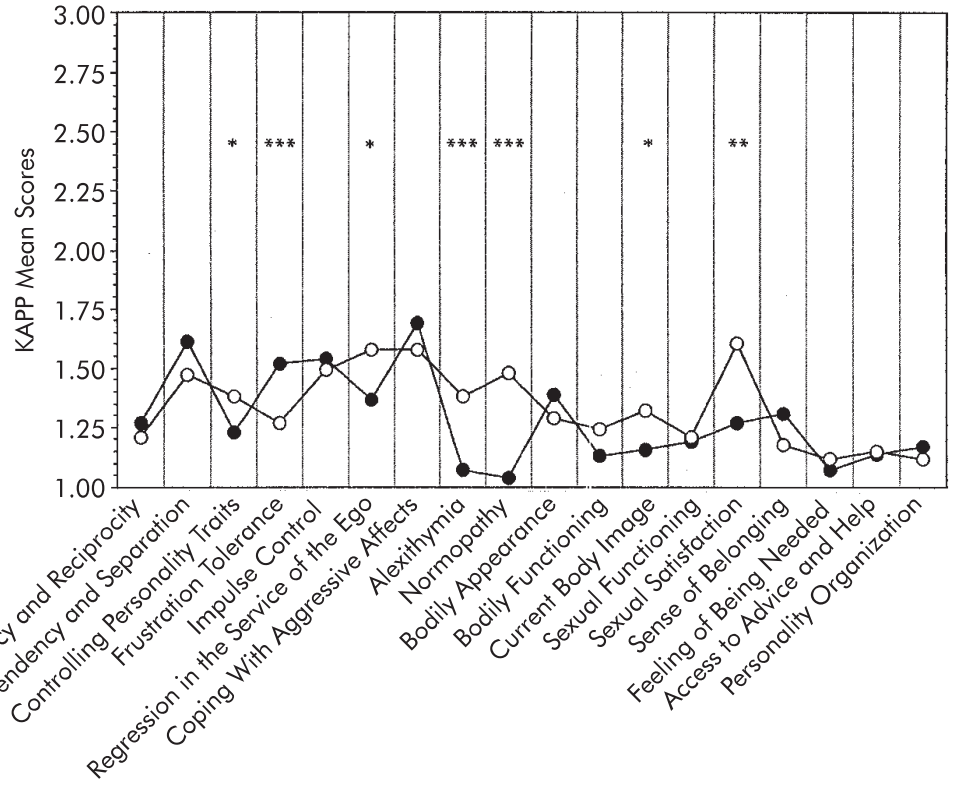
psychiatric syndromes and psychodynamically defined character traits—we compared the KAPP scores of patients who had a DSM-III-R diagnosis and those of patients without such a diagnosis.

The decision to use the presence of any DSM-III-R diagnosis as a comprehensive expression of "symptoms" was made after performing separate *t*-tests comparing patients with and without mood disorders, and also comparing patients with and without Axis II disorders. These separate *t*-tests yielded similar differences in KAPP scores. (Only one of the patients with an Axis II diagnosis did not have a concomitant Axis I diagnosis.)

Thus, we found that patients with a DSM-III-R Axis I or II diagnosis ($n = 30$) had significantly higher (less normal) mean KAPP scores than those without Axis I or II pathology ($n = 25$) on the subscales Intimacy and Reciprocity, Frustration Tolerance, and Personality Organization (Table 4).

Finally, the relationship between KAPP scores and general level of functioning was analyzed. The Global Assessment of Functioning (GAF) scores were significantly and negatively correlated with 7 KAPP subscales. These were Intimacy and Reciprocity, Dependency and Separation, Frustration Tolerance, Conceptions of Bodily Appearance and Their Significance for Self-Esteem, Current Body Image, and Personality Organization (Table 4).

FIGURE 2. Mean Karolinska Psychodynamic Profile (KAPP) scores for patients in current study ($n = 55$, filled circles) compared with mean KAPP scores in ulcerative colitis patients ($n = 65$, open circles). Bodily Appearance = Conceptions of Bodily Appearance and Their Significance for Self-Esteem; Bodily Functioning = Conceptions of Bodily Function and Their Significance for Self-Esteem. *$P < 0.05$; **$P < 0.01$; ***$P < 0.001$.



DISCUSSION

In this naturalistic study of 55 outpatients who were selected in a "traditional" psychodynamic manner for long-term psychodynamic psychotherapy, we found 30 patients (55%) who fulfilled criteria for a DSM-III-R diagnosis, the majority of whom suffered from a mood disorder. From a psychodynamic point of view, there was a low general level of character pathology. The most prominent pathology was found on the KAPP subscales Coping With Aggressive Affects (inhibition), Dependency and Separation, Frustration Tolerance (restrictions of the ego), and Impulse Control (inhibition). Some KAPP-defined character problems were found to be related to symptoms as defined by the DSM-III-R: specifically, poor Frustration Tolerance, problems with Intimacy and Reciprocity, and a more disturbed Personality Organization were related to DSM-III-R diagnosis and a lower general level of function (GAF scores). In addition, problems with Dependency and Separation, Conceptions of Bodily Appearance and Their Significance for Self-Esteem, and Current Body Image were related to lower GAF scores.

Some similarities were found between the present sample and those of other naturalistic studies.[41–43] For example, the sociodemographic characteristics of the patients in the Penn Psychotherapy Project were similar to those of the patients in our sample, with the exception that the patients in the present study were a few years older. The most prevalent diagnosis in the Penn Psychotherapy Project was dysthymia; in our study it was mood disorders. The general level of function appears to be lower in the Penn Psychotherapy Project patients than in our sample (59.5 as measured

TABLE 4. Comparisons of mean KAPP scores (unpaired *t*-test) between patients with and without a DSM-III-R diagnosis: correlations between the KAPP scales and the GAF

	DSM-III-R Diagnosis			
	With ($n = 30$)	Without ($n = 25$)		GAF
KAPP Subscale	Mean ± SD	Mean ± SD	*t*	*r*
Intimacy and Reciprocity	1.38 ± 0.36	1.14 ± 0.27	–2.76**	–0.29*
Dependency and Separation	1.70 ± 0.41	1.50 ± 0.41	–1.81	–0.33*
Controlling Personality Traits	1.22 ± 0.31	1.24 ± 0.33	0.27	–0.10
Frustration Tolerance	1.63 ± 0.37	1.38 ± 0.33	–2.65**	–0.42***
Impulse Control	1.58 ± 0.37	1.48 ± 0.37	–1.03	–0.10
Regression in the Service of the Ego	1.38 ± 0.43	1.36 ± 0.42	–0.20	–0.17
Coping With Aggressive Affects	1.72 ± 0.34	1.66 ± 0.37	–0.59	–0.16
Alexithymia	1.10 ± 0.24	1.04 ± 0.14	–1.15	–0.15
Normopathy	1.02 ± 0.09	1.06 ± 0.17	1.17	–0.18
Bodily Appearance	1.42 ± 0.48	1.36 ± 0.45	–0.45	–0.44***
Bodily Functioning	1.17 ± 0.33	1.08 ± 0.19	–1.22	–0.18
Current Body Image	1.17 ± 0.33	1.14 ± 0.27	–0.32	–0.35**
Sexual Functioning	1.25 ± 0.49	1.13 ± 0.30	–1.15	–0.20
Sexual Satisfaction	1.33 ± 0.46	1.19 ± 0.35	–1.27	–0.22
Sense of Belonging	1.35 ± 0.51	1.26 ± 0.46	–0.68	–0.23
Feeling of Being Needed	1.07 ± 0.17	1.08 ± 0.28	0.22	–0.09
Access to Advice and Help	1.13 ± 0.26	1.16 ± 0.40	0.30	–0.09
Personality Organization	1.25 ± 0.34	1.08 ± 0.19	–2.34*	–0.40*

Note: KAPP = Karolinska Psychodynamic Profile; GAF = Global Assessment of Functioning; Bodily Appearance = Conceptions of Bodily Appearance and Their Significance for Self-Esteem; Bodily Functioning = Conceptions of Bodily Function and Their Significance for Self-Esteem.
*$P < 0.05$; **$P < 0.01$; ***$P < 0.001$.

by the Health–Sickness Rating Scale and 70 by the GAF scale, respectively).

The "traditional" selection of the present sample seems to have favored the inclusion of patients with stable personality organization, good capacity for regression in the service of the ego, and hardly any alexithymic or normopathic traits. That is, these were patients with character traits traditionally considered favorable for psychodynamic psychotherapy.[1]

There was a discrepancy between the low prevalence of severe KAPP-defined character pathology and the relatively higher prevalence of symptomatic psychopathology as defined by the DSM-III-R. We do not know whether this discrepancy is due to the selection process. Our findings do, however, raise the question of whether patients with character pathology, in contrast to patients with symptoms, are excluded in the "traditional" selection process.

It is noteworthy that the self-report KSP revealed significant elevation on 9 of the 15 scales compared with the control group, whereas the interviewer's KAPP ratings were significantly higher than the control on only one scale. This discrepancy may reflect differences relevant to the background and aims of the two instruments or to the different methods of collecting the data. The theory underlying the KSP is biological; that underlying the KAPP is psychodynamic. With the KAPP, an assessment is made of the patient's function in a specific area, using manifest as well as inferred material from the patient's behavior during the interview, while the KSP score reflects the patient's responses to very specific questions, a format that also is more in line with the DSM system. Thus, DSM diagnoses and the KSP self-ratings might reflect the kinds of issues that are reported by patients directly and of which the patients are consciously aware, whereas the KAPP ratings are not only related to the patient's complaints but also to what clinicians infer from the patient. Since the KAPP does not aim at assessing the patient's distress per se, but rather how he or she handles such distress, it is possible that one selection criterion for suitability for psychotherapy might have been how well the patients could contain larger amounts of distress.

Problems with frustration tolerance were prevalent in our sample. Poor frustration tolerance was related to the presence of a DSM-III-R diagnosis and to a lower general level of functioning, which is consistent with earlier findings of Weinryb et al.[22] The most common character problems found on the KAPP frustration tolerance subscale were ego restrictions, implying the patients were using active defensive operations in order to avoid potentially frustrating situations and challenges. The presence of psychiatric suffering indicated that the patients' attempts to avoid problematic and painful situations were unsuccessful. Constructs similar to frustration tolerance have also been considered important by other authors. Thus, Clark et al.[44] have advanced the notion of a general distress factor (implying negative emotionality or neuroticism; that is, a temperamental sensitivity to negative stimuli) similar to the KAPP frustration tolerance scale. A general distress factor was found to be a vulnerability factor for the development of anxiety and depression.[44] Poor frustration tolerance might also be an aspect of the general neurotic syndrome described by Andrews et al.[45] Moreover, poor frustration tolerance preoperatively has been found to predict quality of life after pelvic pouch surgery.[25,26]

Problems with intimacy and reciprocity, and a more disturbed overall personality organization, were found to be related both to DSM-III-R diagnosis and to lower general functioning (GAF scores). The level of pathology on these two subscales was very low in our sample, and reliable conclusions can hardly be drawn. However, the character pathology found on the KAPP intimacy subscale concerned part-object relations expressed by problems in having mutual and close relationships with others and by an impaired capacity to experience conflict and ambivalence. This finding may suggest that even minor disturbances in object relations may contribute to psychopathology. Further investigation of this question is needed.

The KAPP subscales Dependency and Separation, Conceptions of Bodily Appearance and Their Significance for Self-Esteem, and Current Body Image were associated with lower GAF scores. It is not surprising that patients who expressed strong separation anxiety and struggled with dependency showed a lower general level of functioning; however, the association between two of the subscales for assessing the body's importance for self-esteem and low GAF scores is more intriguing. Those subscales assess fantasies of bodily perfection and the individual's narcissistic striving to reach this perfection. Freud[46] believed that depression could be the result of a consciously or unconsciously experienced loss of an object. Narcissistic patients, however, can suffer as a result of an experienced loss of perfection. In these patients, an experienced loss of beauty may result in a depressive reaction or an impaired level of general functioning.[47,48]

In the present study we found that some psychodynamically defined character traits, particularly poor frustration tolerance, were related to symptomatic suffering. The relationship between poor frustration tolerance and psychopathology has recently been reported by several researchers. Whether frustration tolerance is important for the outcome of psychodynamic psychotherapy remains to be demonstrated in future research.

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REFERENCES

1. Crits-Christoph P, Connolly MB: Patients' pretreatment predictors of outcome, in Psychodynamic Treatment Research, edited by Miller NE, Luborsky L, Barber JP, et al. New York, Basic Books, 1993, pp 177–190
2. Kernberg O: Severe Personality Disorders: Psychotherapeutic Strategies. New Haven, CT, Yale University Press, 1984
3. Perry JC: Defense Mechanisms Rating Scales, 5th edition. Cambridge, MA, The Cambridge Hospital and the Harvard Medical School, 1990
4. Bellak L, Goldsmith LA (ed): The Broad Scope of Ego Function Assessment. New York, Wiley, 1984
5. Piper WE, Azim HFA, Joyce AS, et al: Quality of object relations versus interpersonal functioning as predictors of therapeutic alliance and psychotherapy outcome. J Nerv Ment Dis 1991; 179:432–438
6. Luborsky L: Clinicians' judgment of mental health: a proposed scale. Arch Gen Psychiatry 1962; 7:407–417
7. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th edition. Washington, DC, American Psychiatric Association, 1994
8. Kazdin AE: Methodology, design, and evaluation in psychotherapy research, in Handbook of Psychotherapy and Behavior Change, edited by Bergin AE, Garfield SL. New York, Wiley, 1994, pp 19–71
9. Barber J: Efficacy of short-term dynamic psychotherapy: past, present, and future. J Psychother Pract Res 1994; 3:108–121
10. Baudry F: Character, character type, and character organization. J Am Psychoanal Assoc 1989; 37:655–686
11. Fenichel O: The Psychoanalytic Theory of Neurosis (1946). St Edmunds, UK, St Edmundsbury Press, 1982
12. Greenson RR: The Technique and Practice of Psychoanalysis, 6th edition, vol 1. London, Hogarth Press, 1967
13. Freud S: Inhibitions, symptoms and anxiety (1925), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, vol 20, translated and edited by Strachey J. London, Hogarth Press, 1959, pp 77–174
14. Kets de Vries MFR, Persow S (ed): Handbook of Character Studies: Psychoanalytic Explorations. Madison, CT, International Universities Press, 1991
15. Freud S: Fragments of an analysis of a case of hysteria (1905), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, vol 7, translated and edited by Strachey J. London, Hogarth Press, 1953, pp 3–122
16. Freud S: Character and anal erotism (1908), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, vol 9, translated and edited by Strachey J. London, Hogarth Press, 1959, pp 167–175
17. Zetzel E: The so-called good hysteric. Int J Psychoanal 1968; 49:250–260
18. Kernberg O: Borderline Conditions and Pathological Narcissism. New York, Jason Aronson, 1975

19. Weinryb RM, Gustavsson JP, Åsberg M, et al: The concept of alexithymia: an empirical study using psychodynamic ratings and self reports. Acta Psychiatr Scand 1992; 85:153–162
20. North CS, Clouse RE, Spitznagel EL, et al: The relation of ulcerative colitis to psychiatric factors: a review of findings and methods. Am J Psychiatry 1990; 147:974–981
21. Weinryb RM, Rössel RJ: Karolinska Psychodynamic Profile–KAPP. Acta Psychiatr Scand 1991; 83(suppl 363):1–23
22. Weinryb RM, Rössel RJ, Åsberg M, et al: The Karolinska Psychodynamic Profile (KAPP): studies of character and well-being. Psychoanalytic Psychology (in press)
23. Weinryb RM, Rössel RJ, Åsberg M: The Karolinska Psychodynamic Profile, I: validity and dimensionality. Acta Psychiatr Scand 1991; 83:64–72
24. Weinryb RM, Gustavsson JP, Åsberg M, et al: Stability over time of character assessment using a psychodynamic instrument and personality inventories. Acta Psychiatr Scand 1992; 86:179–184
25. Weinryb RM, Gustavsson JP, Liljeqvist L, et al: A prospective study of personality as a predictor of quality of life after pelvic pouch surgery. Am J Surg 1997; 173:83–87
26. Weinryb RM, Gustavsson JP, Barber JP: Personality predictors of dimensions of psychosocial adjustment after surgery. Psychosom Med (in press)
27. Weinryb RM, Rössel RJ, Åsberg M: The Karolinska Psychodynamic Profile, II: interdisciplinary and cross-cultural reliability. Acta Psychiatr Scand 1991; 83:73–76
28. Schalling D, Åsberg M, Edman G, et al: Markers for vulnerability to psychopathology: temperament traits associated with platelet MAO activity. Acta Psychiatr Scand 1987; 76:172–182
29. Eysenck HJ: The Biological Basis of Personality. Springfield, IL, Charles C Thomas, 1967
30. Schalling D: Psychopathy-related personality variables and the psychophysiology of socialization, in Psychopathic Behaviour: Approaches to Research, edited by Hare RD, Schalling D. Chichester, UK, 1978, pp 85–106
31. Sjöbring H: Personality structure and development: a model and its application. Acta Psychiatr Scand Suppl 1973; 43(suppl 244):13–195
32. Brown SL, Svrakic DM, Przybeck TR, et al: The relationship of personality to mood and anxiety states: a dimensional approach. J Psychiatr Res 1992; 26:197–211
33. Curtin F, Walker JP, Badan M, et al: The relations between scores on analogous scales from four personality questionnaires in 50 normal men. Personality and Individual Differences 1995; 19:705–711
34. af Klinteberg B, Humble K, Schalling D: Personality and psychopathy of males with a history of early criminal behavior. European Journal of Personality 1992; 6:245–266
35. Ekselius L, Hetta J, von Knorring L: Relationship between personality traits as determined by means of the Karolinska Scales of Personality (KSP) and personality disorders according to DSM-III-R. Personality and Individual Differences 1994; 16:589–595
36. Nordström P, Schalling D, Åsberg M: Temperamental vulnerability in attempted suicide. Acta Psychiatr Scand 1995; 92:155–160
37. Uvnäs-Moberg K, Arn I, Theorell T, et al: Personality traits in a group of individuals with functional disorders of the gastrointestinal tract and their correlation with gastrin, somatostatin and oxytocin levels. J Psychosom Res 1991; 35:515–523
38. af Klinteberg B, Schalling D, Magnusson D: Childhood behavior and adult personality in male and female subjects. European Journal of Personality 1990; 4:57–71
39. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, revised. Washington, DC, American Psychiatric Association, 1987
40. Rosenthal R: Progress in clinical psychology: is there any? Clinical Psychology 1995; 2:133–150 (p 138)
41. Luborsky L, Crits-Christoph P, Mintz J, et al: Who Will Benefit from Psychotherapy? New York, Basic Books, 1988
42. Olfson M, Pincus HA: Outpatient Psychotherapy in the United States, I: volume, costs, and user characteristics. Am J Psychiatry 1994; 151:1281–1288
43. Vessey JT, Howard KI: Who seeks psychotherapy? Psychotherapy 1993; 30:546–553
44. Clark LA, Watson D, Mineka S: Temperament, personality, and the mood and anxiety disorders. J Abnorm Psychol 1994; 103:103–116
45. Andrews G, Stewart G, Morris-Yates A, et al: Evidence for a general neurotic syndrome. Br J Psychiatry 1990; 157:6–12
46. Freud S: Mourning and melancholia (1917), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, vol 14, translated and edited by Strachey J. London, Hogarth Press, 1957, pp 237–258
47. Rothstein A: An exploration of the diagnostic term narcissistic personality disorder, in Handbook of Character Studies: Psychoanalytic Explorations, edited by Kets de Vries MFR, Perzow S. Madison, CT, International Universities Press, 1991, pp 303–318
48. Grunberger B: Narcissism: Psychoanalytic Essays. New York, International Universities Press, 1979, pp 219–240

Psychodynamic Assessment and Treatment of Traumatized Patients

JUDITH CHERTOFF, M.D.

This article describes how psychodynamic assessment and treatment of traumatized patients can improve clinical acuity. The author describes an ego psychological, psychodynamic approach that involves 1) assessing the impact of trauma on the patient's ego defensive functioning and 2) elucidating the dynamic meaning of both the patient's presenting symptoms and the traumatic events that precipitated them. Clinical descriptions illustrate the ways in which psychodynamic psychotherapy may be particularly useful with patients whose acute symptoms develop following specific events. The author points out the advantages of an ego psychological, psychodynamic approach for her patients and the limitations of more symptom-based diagnostic assessments and treatments.

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Since 1980, there has been a resurgence of psychiatric interest in the impact of trauma on children and adults. This literature has recently been comprehensively reviewed by van der Kolk and colleagues in their book *Traumatic Stress*.[1] The DSM-IV diagnosis of posttraumatic stress disorder (PTSD), derived from evolving research, requires exposure to an event involving "actual or threatened death or serious injury, or a threat to the physical integrity of self or others," and a response involving "intense fear, helplessness, or horror" (pp. 427, 428). DSM-IV lists a series of symptoms as necessary evidence that the event continues to be reexperienced (and/or avoided) and that it continues to evoke symptoms of increased physiologic arousal.[2]

Yehuda and McFarlane[3] have shown that psychological trauma does not necessarily lead to PTSD but may precipitate other symptoms and syndromes. They propose that factors not yet well understood determine the variability of individual responses to trauma. Numerous DSM-IV diagnoses in addition to PTSD have been identified in traumatized patients. These include major and minor depressive syndromes, panic and generalized anxiety, dissociative disorders, borderline personality, and substance abuse.[4–10] van der Kolk et al.[11] have demonstrated that PTSD rarely occurs alone, and they suggest that a range of trauma-related psychological problems, not fully captured in the DSM-IV framework of PTSD, occur to-

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gether, requiring a more comprehensive approach.

Psychoanalytic ego psychology can provide such a comprehensive approach to trauma. Using the ego psychological framework described below, a variety of pathological states caused by a given traumatic event (or events) may be understood. This framework assists the clinician who is attempting to select and implement effective treatment in two ways. First, it provides parameters for evaluating the impact of potentially traumatic events on the patient's ego functioning (the intrapsychic capacity to synthesize and master the emotional impact of both external events and internal stimuli).[12] Second, it orients the clinician toward investigating in depth the dynamic meaning of both the patient's presenting symptoms and the traumatic events that precipitated them.

In this article I will focus on patients who come to treatment with acute symptoms following specific recent experiences and who have functioned at a relatively high level prior to the onset of these symptoms. Although the ego psychological approach to treating patients who complain of severe, chronic symptoms is beyond the scope of this article, the same approach can be clinically useful in understanding such patients.

Currently, the symptom-oriented organization of the *Diagnostic and Statistical Manual*[13] and the increasing availability of medications and behavioral approaches to treat symptoms directly may deflect clinicians from exploring the meaning of recent precipitating events and the complex relationship of such events to their patients' symptoms. Pharmacologic treatments, while often very helpful, are limited by side effects, incomplete results, and lack of acceptance by those patients who prefer to solve problems more definitively in psychotherapy.[14] Cognitive-behavioral therapies, although reported to be efficacious in Vietnam veterans and rape victims,[15] consist of discrete treatments for specific symptoms and do not easily lend themselves to application in more complex clinical situations. In addition, there has been little systematic investigation of what works best in whom.[16] As with pharmacotherapy, some patients refuse to participate, and others may find such treatments ineffective or insufficient. At the other end of the spectrum, inexperienced clinicians armed with the PTSD diagnosis may overzealously explore traumas psychodynamically without adequate attention to the vulnerable state of the patient's ego functioning,[17] thus overwhelming the patient's capacity to cope.

Despite difficulties studying psychodynamic treatments, a controlled study demonstrated that psychodynamic psychotherapy was as effective as hypnotherapy and trauma desensitization for PTSD when treated patients were compared with wait-listed control subjects.[18] Patients treated with psychodynamic psychotherapy showed symptomatic improvement somewhat later than other treated patients, but they showed unexpected, and comparably greater, beneficial changes in personality traits.

Recent reports document that posttraumatic reactions may be long lasting if not treated effectively. Rose,[19] surveying the literature, found that brief supportive psychotherapy for adult survivors of sexual assault had frequently been inadequate to deal with persistent symptoms, even in patients with no preexisting psychopathology. Nader et al.[20] described the considerable degree to which children remained symptomatic 14 months following an acute disaster. Terr[21] prospectively studied children exposed to a day-long schoolbus kidnapping that involved no physical harm. The children showed symptoms of posttraumatic stress 4 years later, despite brief psychotherapy. Kessler et al.[22] found that although treated patients fared better than others initially, one-third of all people with an index episode of PTSD failed to recover even after many years. These data suggest a pressing need for further research into the efficacy and methodology of psychodynamic psychotherapy with traumatized patients.

EGO PSYCHOLOGICAL APPROACH

Freud has been accused by current trauma theorist Judith Herman of denying women's reality when he abandoned his hypothesis that his patients' symptoms were invariably caused by seduction during childhood.[23] Subsequently, he developed a structural theory that gave rise to the concepts of the three functional divisions of the mind: the ego, id, and superego.[24] Simon[25] has reviewed the history of this change in theory and the problems that have evolved in its wake despite the tremendous advantages of the new theory for understanding clinical data. The structural theory marked the beginning of ego psychology and was necessary to account for the multiple factors, including trauma, intrapsychic conflicts, and other vulnerabilities, that contribute to the development of psychopathology. Without this theory, it is more difficult to understand the meaning that patients attribute to traumatic events, the effect that these events have on patients' functioning, and the array of symptoms that traumatized patients develop. However, Freud's abandonment of the seduction hypothesis is often misunderstood to signify that Freud, and subsequently his followers, deny the reality, importance, and impact of external trauma.[26]

It is beyond the scope of this article to review the history of ego psychology since Freud, except to say that Freud's later theory has been continually revised in the light of new analytic and neurobiologic evidence.[27–31] The 1967 volume *Psychic Trauma*[32] contains several landmark papers in the evolution of the ego psychological view of trauma, including Anna Freud's "Comments on Trauma," discussed below. Inderbitzin and Levy,[33] in a paper exemplifying ongoing recent revisions, question the common conceptualization that reliving a trauma is an attempt at mastery by "repetition compulsion." They illustrate the degree to which episodes of reliving contain elements of defense against aggression mobilized by trauma.

Currently, the concept of the "ego" refers to a complex dynamic system of internal, and often unconscious, defenses and functions that mediate between the physiological and emotional needs of the self, such as for food, nurturing, or erotic gratification, and the demands of the external world. Perception, motor capacity, intelligence, thinking, language, and memory are among the many, relatively mature, functions of the ego.[12]

Psychoanalysts with an ego psychological orientation continue to define trauma as an external event, or series of events, that specifically overwhelms ego defenses, causing the traumatized person to regress to earlier modes of functioning.[34,35] For example, following a traumatic event, a child who has been successfully toilet trained and has been sleeping alone for many years may be unable to maintain bowel or bladder control or to fall asleep without mother present. Similarly, following a rape, a previously independent and highly functioning adult who characteristically used humor to cope with adversity may have difficulty concentrating at work and may revert to uncharacteristically primitive defenses, such as projection, to cope with anger.

Anna Freud suggested reserving the term *trauma* for situations in which there is concrete evidence that the ego has been overwhelmed and is unable to perform its usual functions, using its usual defenses.[36] Her view is consistent with DSM-IV, if we consider the intrusive, avoidant, and hypervigilant symptoms (listed under subheadings B, C, and D of the PTSD diagnosis) as concrete evidence of an overwhelmed ego.[2] Anna Freud, unlike DSM-IV, includes cases of cumulative[37] and strain[38] trauma (where lesser events have an additive effect) when there is symptomatic evidence that the ego, at a certain point, has become massively overwhelmed by the accumulated impact of events. Partial trauma, in which some defenses have been mobilized, often combines with other influences to confuse the clinical picture. Where childhood trauma and/or genetic factors have interfered with ego development, patients often present with a particularly

extensive and perplexing array of symptoms and pathologic character traits.[36,39–41]

Most analysts do not expect to fully know whether, and how, an event has been traumatic until treatment has clarified the meaning of the trauma and the patient's associated response. Therefore, unlike treatments where a definitive diagnosis is required at the start, psychodynamic treatment will not preclude cases in which an event's impact is not yet clear or conscious, or in which the effects of trauma have become obscured by other symptoms and experiences.

Initial psychodynamic assessment usually takes place during approximately three 1-hour sessions. While exploring the patient's current problems, past treatment, early development, and social relationships, the interviewer also assesses mental status both indirectly and, when necessary, by asking direct questions. Although keeping in mind areas to cover, the interviewer is not limited in advance to prestructured questions and leaves time for problems and reactions to emerge spontaneously. In addition to focusing on specific symptoms or behaviors such as those listed in DSM-IV, the interviewer attends to patterns of symptom occurrence and recurrence. Using this information, as well as concurrent observations of the patient's behavior and affects, the interviewer evaluates the patient's past and current ego functioning. When the symptom picture suggests acute regression from a relatively high level of functioning but the relationship of symptoms to recent events remains obscure, an extended evaluation, combined with a trial of psychodynamic therapy, may be necessary for more definitive diagnosis and treatment.

Psychodynamic assessment and treatment can be uniquely helpful in clarifying the meaning and influence of traumatic events, as well as the relationship of these events to presenting symptoms. For those patients who have become symptomatic following recent events, who have functioned at a much higher level prior to these events, and whose trauma is no longer ongoing, psychodynamic psychotherapy is often extremely effective and may be relatively short term. Confidentiality is a critical condition for full disclosure from patients (and one that may be compromised by current demands for information from insurance companies).

Factors Affecting Outcome of Trauma

Anna Freud delineated five factors that influence the outcome of trauma. These, when updated with current findings from research, can provide a framework within which to understand the impact of traumatic events on ego functioning, as well as the meaning these events can acquire for the patient. After reviewing Anna Freud's five factors, and a sixth added by van der Kolk more specifically for the assessment of adults,[42] I will illustrate how I used this framework to understand and treat two patients seen in my private office.

The Nature and Intensity of the Event (Factor 1): Certain experiences, such as living in a concentration camp, are so overwhelming that they seem to cause symptoms in most people.[30] Chronic childhood abuse is similarly detrimental.[43,44] However, other potentially intense and devastating experiences have a more variable effect.[45] The effect often depends on the meaning of specific details of the experience.[46]

Sensitization due to Prior Trauma (Factor 2): Sensitization can create a situation where a secondary event, not so obviously unusual as to meet DSM-IV criteria, precipitates a delayed onset of symptoms. Although such symptoms are accounted for in DSM-IV (Specifiers: With Delayed Onset), the clinician may miss the diagnosis when the patient is not consciously aware of prior trauma or when the patient is reluctant to reveal upsetting experiences to the interviewer. (See the case of Ms. B., described below.)

Hereditary and Congenital Factors that Affect the Level of Defensive Functioning (Factor 3): Inherited

and/or congenital vulnerabilities may provide substrates on which external stimuli and intrapsychic conflict act. For example, the recently identified cognitive deficits that underlie vulnerability to schizophrenia[47] may make the schizophrenic patient less able than others to cope with external stress and internal conflict, leading to more extreme decompensation. Rats can be bred to become increasingly susceptible to learned helplessness.[48] Genetic factors increase the vulnerability of individuals to the depression-inducing effect of stressful life events.[49] In bipolar, depressed, and anxiety-prone individuals, we still know relatively little about exactly what traits are inherited or how they predispose to future illness. Nor can we fully explain protective factors such as those found by Maziade et al.,[50] who studied children ages 3 to 8 with "extremely adverse" temperaments (low adaptability, withdrawal in the face of new stimuli, intense emotional reactions, negative mood, and low distractibility). These children had a much higher incidence of behavioral difficulties and clinical disorders in adolescence than did children with other temperaments, but no children with such adverse temperaments developed difficulties if they were living in the most highly functioning families.[50]

Chronological Age and Developmental Stage at the Time of the Trauma (Factor 4): The individual's age and stage of development influence the effect that trauma will have on ego development. As Anna Freud notes, "The young child's task of building up . . . a defensive organization is made immeasurably more difficult if traumatic experiences have to be endured during the critical period of maturation and development, just as the supporting walls of a house are more open to damage during building operations than after completion"[36] (p. 225). See Tyson and Tyson[51] for a recent, thorough description of the specific phases of ego development.

The child often attributes meaning to a traumatic event that is consistent with the child's stage of development and age-appropriate fantasies. For example, potentially traumatic events during the oedipal period (ages 3–6) frequently become linked with sexual conflicts: Glenn described 3 patients who developed severe masochistic symptoms in response to experiencing their painful and frightening surgeries as punishment for sexual fantasies and wishes.[52]

Recent research by van der Kolk et al.[11] confirms prior findings of a relationship between the age at the time of trauma, the nature of the experience, and the clinical outcome.

Environment at the Time of Trauma (Factor 5): Environment can influence the impact of adverse experiences on both children and adults. A supportive parent can provide considerable protection to the vulnerable ego of a child exposed to trauma. In contrast, children living in chronically dangerous and/or abusive environments may cope by means of distorted ego development (including numbing and dissociative states).[41] Traumatized adults are also affected by the extent to which support is available from family members and society.[53]

Preexisting Personality (Factor 6): Character traits, more fully consolidated by adulthood, further affect the outcome of adult trauma, leaving some individuals more susceptible to protracted PTSD reactions than others.[45] Character traits formed in the process of resolving childhood conflicts may be reactivated by adult trauma, influencing the symptomatic picture.

Clinical Cases

Case 1. Ms. A., a married photographer with two young children, came to me with panic attacks. She suffered from palpitations, feelings of impending doom, difficulty sleeping, and nausea, all of which led her to fear she was going crazy. She was tearful, hopeless, and convinced that she had brain damage as a result of a hallucinogen she had ingested 4 years before.

Ms. A. had been treated by two different psychiatrists over a period of 4 years. Her difficulties began when she was given the hallucinogen

at a party, without her knowledge. She experienced depersonalization and became convinced that she was dying. A psychiatrist hospitalized her briefly, treating her with anti-anxiety medication (oxazepam and diazepam). He then maintained her on small doses of medication and weekly supportive therapy for a period of 2 years. She recovered from the physiological effects of the drug but continued to feel intermittently anxious, worrying that the drug had damaged her brain. During the second year, therapy was interrupted when Ms. A. and her children were forced to move because their safety was jeopardized through risks that developed in her husband's work as a criminal lawyer. When this work was over and he joined them, Ms. A. was surprised to find that her symptoms continued and that she began to feel even more depressed.

I saw Ms. A. the following year, after she had been treated by a second psychiatrist for several months. He had given her small doses of anti-anxiety and antidepressive medication (clonazepam 2 mg bid, fluoxetine 20 mg qd) and weekly therapy sessions focused on explaining the physiologic basis for her panic attacks. Ms. A.'s anxiety initially decreased, but she subsequently stopped both medications, claiming that medicines doctors insisted on giving her were making her worse.

Although Ms A. fulfilled DSM-IV criteria for panic attacks, generalized anxiety, and dysthymia, the significance of her symptoms was not initially clear. Nor could I rule out an organic component to her symptoms. But she had experienced obvious stress, and neither of the prior psychiatrists had addressed the impact of her potentially traumatic experiences directly.

Ms. A. had grown up in a relatively stable family. Although childhood conflicts resulted from her interactions with a strict father and a somewhat self-centered mother, there was no clear evidence for severe ego vulnerabilities that were due to genetic factors, prior trauma, or major early environmental deficits. However, she was relatively unaware of many of her feelings and impulses, and there was a brittle quality to her defenses. Her relationship with her children appeared basically sound, despite her symptoms, but some discontent with her husband (experienced, at the time, as mild) had predated the events of the past several years.

I saw Ms. A. in an extended evaluation twice a week over a period of 1 month before I could correctly diagnose her posttraumatic stress reaction. We clarified how she had misinterpreted mild antidepressant side effects, mild benzodiazepine withdrawal symptoms, and the physiologic accompaniments to panic attacks as signs of brain damage. While Ms. A. attempted to engage me in treating her "brain damage," she simultaneously worried that I might further harm her. Although I considered restarting Ms. A.'s antidepressant, it became increasingly evident that medically oriented treatment, rather than alleviating her symptoms, had reinforced her conviction that she was suffering from brain damage. This idea might have been overcome with interpretation, but medication proved unnecessary: she responded with decreased anxiety once we began to understand the meaning of her symptoms and experiences. By observing her reactions over time, we noticed how her symptoms intensified whenever she was confronted with experiences that revived memories and thoughts about the events of the past 4 years: her conviction that doctors were giving her drugs that made her sick was fueled by unexpressed anger at her husband, who had taken her to the party where she ingested the hallucinogen, and the first doctor, who had further plied her with medications without helping her with her experiences. Feeling herself mistreated by insensitive psychiatrists and locked in a crazy spiral of interactions from which she could not extricate herself, she recalled similar feelings that had accompanied threats to her husband and the family in connection with her husband's legal case.

Ms. A. recovered over a period of 5 months. In addition to regaining her pretraumatic equilibrium, she was able to confront her husband about his tendency to misjudge the character of his friends (such as the one who had given the party where she had received a hallucinogen) and to deny the riskiness of his cases. Inhibition had prevented her from doing this earlier, although she felt his trait had contributed to their recent difficulties. The couple planned to begin marital therapy in the near future.

Ego regression, induced by her recent traumatic experiences, seemed the most important determinant of Ms. A.'s symptoms. At the time of her hallucinogen ingestion, although she no doubt experienced physiologic

effects of the drug, Ms. A. had also been faced with a glimpse into her unconscious life for which she was emotionally unprepared. (For example, it seemed likely that her conviction that she was dying derived from unacknowledged anger at her husband for exposing her to risks that both he and she had ignored.) Subsequent dependence on her first psychiatrist, and on medication, further weakened her coping capacity while still keeping her unaware of her anger. The additional risks that developed in connection with her husband's job exerted further stress on an already compromised ego. Ms. A.'s second psychiatrist, using a symptom-oriented approach, compounded her problems by ignoring her trauma, failing to recognize the dynamic significance of her interactions with him, and inadvertently confirming her fears of brain damage.

Childhood conflicts pertaining to her relationship with a domineering father probably contributed to Ms. A.'s marital choice, her brittle defenses against her anger, and her inhibitions in assertiveness. More intensive dynamic work to familiarize her further with her unconscious life and the childhood antecedents of her current conflicts might have been useful. However, she was not interested in such exploration at the time—possibly because she retained some anxiety about her inner life, but also because her gains in treatment had been substantial and marital work took precedence.

Case 2. Ms. B., a married decorator, came to me complaining of several months of increasing tearfulness, suicidal ideation, difficulty sleeping, hopelessness, phobic anxiety about leaving her house, and fear for the safety of her 6-month-old baby. She met DSM-IV criteria for a major depressive episode, and additional components of the clinical picture did not emerge until we proceeded with an extended evaluation and began psychodynamic psychotherapy. She could date her distress from the time of her long, painful labor and delivery. After the birth of a healthy baby, she could not rid herself of the feeling that she had been mistreated and ruined by those who had cared for her. She blamed her husband, who had selected the small suburban hospital through contacts in his medical supply business. Although she had received some supportive therapy following childbirth, she never fully recovered and believed her symptoms were becoming worse again. The intensity of her reaction to the childbirth and her evasiveness about a hospitalization following an adolescent suicide attempt suggested possible trauma. (The childbirth experience alone was not severe enough to meet DSM-IV criteria.)

When Ms. B. was an infant, her mother had developed an unspecified emotional illness. Her father, who was often absent at work, had provided most of her nurturing. Ms. B. reported that during grade school she had been bullied by children in the neighborhood and never felt comfortable. Although she had abused alcohol during adolescence and had subsequently become involved in several self-destructive relationships, she had established emotional stability during the 5 years preceding the birth of her child. She had become competent in her career and had married a nonabusive husband. She was particularly upset with herself because of her feelings toward her formerly loved husband and because tearfulness, anger, and distress left her feeling unable to care for her baby.

In addition to Ms. B.'s obviously overwhelmed ego functioning, her family history of mental illness and stormy past personal history suggested that she might have underlying ego vulnerabilities. She experienced intense anxiety in response to some of my exploratory questions. This response, and the extent of her vegetative symptoms and difficulty coping at home, suggested that she was too distressed to engage in psychotherapy without medication. These factors also suggested she was at risk for further regression at a time when her availability to her baby was crucial. However, her responsiveness to my questions connecting her current symptoms with the feelings, memories, and fantasies stirred up while she was giving birth, and her subsequent revelation of further pertinent information, indicated her receptiveness to psychodynamic treatment and some capacity for insight.

I saw this patient long before the era of media interest in sexual abuse. However, once she was convinced that I would listen to her, rather than accusing her of being irrational or insisting on treating her with medication alone, she revealed that, while in labor, she had remembered a long-forgotten incident of sexual abuse. (Her

father, who had intervened to end the abuse, had been unable to talk to about it to his then 5-year-old daughter.) Ms. B. also told me of a later sexual assault. This she had always remembered, but because she knew she had made herself vulnerable and was convinced that she would be blamed, she never told anyone. Several weeks of careful attention to her evasiveness about her adolescent suicide attempt passed before she told me the details. Despondent because a boyfriend had rejected her, she had joined a group of unsavory boys for a picnic. They had taken her to a deserted park and gang raped her. The complicated childbirth, in which a number of doctors and nurses gathered around her, watching her pain, vividly revived her sensations during the gang rape as well as her memories of the childhood abuse.

Ms. B. responded well to a combination of psychotherapy and antidepressant medication (doxepin 150 mg, decreased to 75 mg after 3 months). Medication alleviated her symptoms sufficiently for her to talk to me about the rapes and childhood abuse without feeling completely overwhelmed. Understanding the relationship of her symptoms to guilt about her early abuse, subsequent rapes, and more recent death wishes toward her baby proved crucial for her eventual recovery. We were able to determine that the death wishes toward her baby derived primarily from her anger at her own mother's inability to nurture her. Ms. B. remained in treatment for approximately 10 months and was able to taper and discontinue medication several months before terminating therapy. Although she described some minor conflicts with her husband, her affectionate feelings toward him returned, and she no longer felt fearful about, or unable to care for, her baby. Remembering her nurturing father and turning to his religion contributed to her recovery. On follow-up several years later, I learned that she went on to have a second baby without recurrent symptoms.

Remarkably, despite severe symptoms throughout her life, Ms. B. had achieved many years of stability before her child was born. Under the stress of pregnancy and a childbirth that elicited sensations similar to the ones she experienced during rape and abuse, she recalled her earliest experience. Had Ms. B. come to treatment at another time, when engaged in self-destructive behavior but without memories of the abuse or motivation to understand her relationship with her mother, she would probably have required more lengthy and intensive treatment.

Ms. B.'s sexual abuse at age 5 had been an isolated incident, rather than ongoing trauma inflicted by a close relative or caretaker. Mother's unavailability had made her vulnerable to an abusive neighbor. The abuse, in the context of her ambivalent relationship with mother, greatly intensified Ms. B.'s conflicts about autonomy and sexuality, making it difficult for her to resolve these conflicts through the usual positive identifications with mother. Father's failure to talk with her about the abuse further increased her vulnerability. She dealt with subsequent difficulties, such as bullying in grade school and rejection by a boyfriend in high school, by becoming a victim.

Her experience illustrates the reverberations trauma may have at several stages of life, and the complexity of its reenactments. For example, when Ms. B. went with the unsavory group of boys who subsequently gang raped her, she had been abandoned by a boyfriend, as she had felt abandoned by her parents in childhood. Again, as in the childhood abuse experience, she felt vulnerable to anyone who showed an interest in her. In allowing herself to accompany the boys she knew to be unsavory, she repeated aspects of the repressed abuse but also punished herself for anger at the abandoning boyfriend (representing both mother and father) and for the then-unconscious sexual feelings that had been aroused by the childhood abuse.

It is not surprising that Ms. B.'s symptoms arose again during childbirth, when unresolved conflicts with mother tend to be revived. Pathological identification with her emotionally unavailable mother left Ms. B. feeling inadequate and withdrawn, and this required our attention before she could feel confident in her own mothering. Fortunately, she was able to make use of her identification with her nurturing and supportive father in recovering her capacity as a parent.

Ms. B. might have been genetically vulnerable to depression (since her mother may have suffered from it), and medication alone may have benefited her symptomatically. However, medication would also have left her vulnerable to further traumatic reenactments, continued difficulties in mothering, and recurrent postpartum depression. Since she had already withheld important information from several mental health professionals, it seems unlikely that Ms. B. would have been able to reveal her traumatic experiences in a more symptom-oriented treatment where her defenses and underlying guilt were not specifically addressed. However, she did need the support of medication in order to tolerate the feelings aroused by exploring her experiences.

DISCUSSION

Those traumatized patients who suffer the acute onset of symptoms following specific events or experiences may become aware of the full impact and meaning of these events only during the course of dynamically oriented treatment. Ms. A. and Ms. B. were both seen during periods of acute decompensation. Two consecutive traumatic events (a hallucinogen given to her without her knowledge and subsequent risks to the physical safety of her family) had overwhelmed Ms. A.'s formerly adequate ego defenses. She became increasingly symptomatic as she attempted to cope with the stress of protecting herself and her children and, simultaneously, with her unconscious anger at her husband. Complications during the birth of Ms. B.'s first baby revived memories of childhood trauma (an isolated instance of child abuse in the context of neglectful mothering) and overwhelmed her already vulnerable ego defenses. She became increasingly symptomatic in her attempt to cope with the stress of caring for her baby and the revived memories of emotional pain, death wishes, and guilt, which now were directed toward her husband, her baby, and herself. Diagnostically, it was important 1) to recognize the extent to which specific events had led these patients to regress in their capacity to cope with internal and external stimuli, 2) to determine their more usual coping capacities, and 3) to understand developmental and hereditary factors contributing to their ego strengths and vulnerabilities.

Both patients responded to psychodynamic treatment that helped them understand the meaning of their symptoms without further compromising their ego functioning. Ms. A. had ascribed an ominous meaning to the combination of her panic symptoms and medication side effects (that they indicated brain damage), but she had the capacity to make use of dynamic psychotherapy without medication. Because Ms. B. had more ego vulnerabilities due to developmental and possibly genetic factors, she required medication to tolerate the exploration of her childhood sexual abuse, her ambivalent relationship to her mother, and the repetition of her then-unconscious childhood trauma during adolescence. Once she understood and faced her feelings and memories in psychotherapy, Ms. B. was able to discontinue medication and remain symptom free during a second pregnancy several years later.

These cases illustrate the potential for dynamically oriented assessment and therapy to identify and remove obstacles to recovery through clarification and interpretation, resolving the multiple and confusing symptoms of some traumatized patients. Like Ms. A. and Ms. B., such patients may not readily respond to other forms of treatment. They may remain unnecessarily dependent on medication and/or remain vulnerable to recurrent symptoms. In an era of intense pressure from managed care to reduce treatment, focus on short-term goals, and use medication as a primary form of treatment, the potential efficacy of psychodynamic psychotherapies may be overlooked.

The focus of this article has been on patients who come to treatment suffering from acute symptoms and who are responding to recent events. However, modern analysts continue to effectively treat those traumatized patients who present with multiple chronic

symptoms and/or who suffer from more severe, protracted trauma.[54–56] Although such patients can be particularly challenging, much progress has been made, since Freud, in elucidating the impact of trauma on ego development and in differentiating those patients who respond well to psychoanalysis from those who are better treated with other forms of psychotherapy. Combination dynamic-supportive treatments, sometimes including medication and targeted cognitive-behavioral therapies, may be useful when ego vulnerabilities predispose patients to extreme regression.[57] Serotonergic antidepressants, not yet available at the time I treated Ms. B., may be particularly effective in modifying intense affects sufficiently to allow therapeutic work to proceed.[58] Techniques such as hypnosis or direct suggestion have been used to help patients with dissociative symptoms and fragile ego functioning cope with overwhelming affects and avoid self-destructive behavior.[59] For those traumatized patients with borderline personalities who function at a relatively high level, analytically oriented psychotherapy is often very useful.[60] Psychodynamic assessment of past and present ego functioning aids the clinician in determining the patient's suitability for psychodynamic psychotherapy or psychoanalysis, as well as the need for adjunctive medication or other forms of therapy. Psychodynamic treatment, if appropriately selected, will invariably lead to further elucidating the impact and meaning of traumatic events.

Treating traumatized patients can be very challenging for the therapist. Such patients tend to live out their experiences in action and have difficulty putting them into words. Like Ms. B., they often regress when a trauma is touched upon directly, and considerable clinical skill is required to determine when support, or further exploration, is indicated. Like Ms. A., such patients sometimes make defensive use of traumatic experiences to avoid recognizing other conflicts. Moreover, patients may be able to induce the therapist either to reenact the trauma or to become punitive and critical. In addition, the therapist listening to the experiences of a severely traumatized patient may feel overwhelmed and be at risk for withdrawing empathy, avoiding further exploration, or discharging the patient prematurely.

CONCLUSION

Traumatized patients benefit from an ego psychological approach to assessment and treatment in two ways. First, assessment of ego functioning provides information about the patient's vulnerabilities and strengths. It guides the clinician in determining both the patient's suitability for psychodynamic treatment and the need for adjunctive medication or other forms of therapy. Second, focus on the meaning of the patient's symptoms helps to identify traumatized patients who have repressed or avoided discussing upsetting experiences at the onset of treatment. This focus may elucidate the formerly obscure relationship of symptoms to traumatic events, as well as the dynamic meaning attributed to these events by the patient.

Patients who have become acutely symptomatic following specific events, who have some capacity for insight, and whose vulnerabilities are taken into account in treatment planning may respond quite rapidly to psychodynamic psychotherapy. By addressing the intrapsychic components to trauma, often missed in other therapies, psychodynamic treatment has the potential for clarifying and resolving the multiple and confusing symptoms that often characterize traumatized patients.

REFERENCES

1. van der Kolk BA, McFarlane AC, Weisaeth L (eds): Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body and Society. New York, Guilford, 1996
2. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th edition. Washington DC, American Psychiatric Association, 1994
3. Yehuda R, McFarlane AC: Conflict between current knowledge about posttraumatic stress disorder and its original conceptual basis. Am J Psychiatry 1995;

152:1705–1713
4. Carmen EH, Reiker PP, Mills T: Victims of violence and psychiatric illness. Am J Psychiatry 1984; 141:378–383
5. Warshaw MG, Fierman E, Pratt L, et al: Quality of life and dissociation in anxiety disorder patients with histories of trauma or PTSD. Am J Psychiatry 1993; 150:1512–1516
6. Goodwin JM, Cheeves K, Connell V: Borderline and other severe symptoms in adult survivors of incestuous abuse. Psychiatric Annals 1990; 20:22–32
7. Breslau N, Davis GC: Posttraumatic stress disorder in an urban population of young adults: risk factors for chronicity. Am J Psychiatry 1992; 149:671–675
8. David D, Giron A, Mellman T: Panic-phobic patients and developmental trauma. J Clin Psychiatry 1995; 56:113–117
9. Tomb DA: The phenomenology of post-traumatic stress disorder. Psychiatr Clin North Am 1994; 17:237–250
10. Hubbard J, Realmuto GM, Northwood AK, et al: Comorbidity of psychiatric diagnoses with posttraumatic stress disorder in survivors of childhood trauma. J Am Acad Child Adolesc Psychiatry 1995; 34:1167–1173
11. van der Kolk BA, Pelcovitz D, Roth S, et al: Dissociation, somatization, and affect dysregulation: the complexity of adaptation to trauma. Am J Psychiatry 1996; 153(7,Festschrift suppl):83–93
12. Moore BE, Fine BD (eds): Psychoanalytic Terms and Concepts. New Haven, CT, Yale University Press, and American Psychoanalytic Association, 1990
13. Wilson M: DSM-III and the transformation of American psychiatry: a history. Am J Psychiatry 1993; 150:399–410
14. Clarkin JF, Pilkonis PA, Magruder KM: Psychotherapy of depression: implications for reform of the health care system. Arch Gen Psychiatry 1996; 53:717–723
15. Rothbaum BO, Foa EB: Cognitive behavioral therapy for posttraumatic stress disorder, in Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body and Society, edited by van der Kolk BA, McFarlane AC, Weisaeth L. New York, Guilford, 1996, pp 491–509
16. McFarlane AC: Individual psychotherapy for posttraumatic stress disorder. Psychiatr Clin North Am 1994; 17:393–408
17. Kluft RP: The treatment of dissociative disorder patients: an overview of discoveries, successes, and failures. Dissociation 1993; 6(2/3):87–101
18. Brom D, Kleber RJ, Defares PB: Brief psychotherapy for posttraumatic stress disorders. J Consult Clin Psychol 1989; 57:607–612
19. Rose DS: Worse than death: psychodynamics of rape victims and the need for psychotherapy. Am J Psychiatry 1986; 143:817–824
20. Nader K, Pynoos R, Fairbanks L, et al: Children's PTSD reactions one year after a sniper attack at their school: Am J Psychiatry 1990; 147:1526–1530
21. Terr LC: Chowchilla revisited: the effects of psychic trauma four years after a school-bus kidnapping. Am J Psychiatry 1983; 140:547–623
22. Kessler RC, Sonnega A, Bromet E, et al: Posttraumatic stress disorder in the National Comorbidity Survey. Arch Gen Psychiatry 1995; 52:1048–1060
23. Herman JL: Trauma and Recovery. New York, Basic Books, 1992
24. Freud S: The ego and the id, in The Standard Edition of the Complete Psychological Works of Sigmund Freud, vol 19, translated and edited by Strachey J. London, Hogarth Press, 1961, pp 3–66
25. Simon B: "Incest—See under Oedipus Complex": the history of an error in psychoanalysis. J Am Psychoanal Assoc 1992; 40:955–988
26. Eissler KR: Comments on erroneous interpretations of Freud's seduction theory. J Am Psychoanal Assoc 1993; 41:571–584
27. Freud A: The Ego and the Mechanisms of Defence (International Psycho-Analytical Library). London, Hogarth Press, 1937
28. Hartmann H: The mutual development of the ego and the id. Psychoanal Study Child 1952; 7:9–30
29. Rothstein A (ed): The Reconstruction of Trauma: Its Significance in Clinical Work. Madison, CT, International Universities Press, 1986
30. Krystal H: Integration and Self-Healing: Affect, Trauma, Alexithymia. Hillsdale, NJ, Analytic Press, 1988
31. Vaillant GE (ed): The historical origins of Sigmund Freud's concept of the mechanism of defense, in Ego Mechanisms of Defense: A Guide for Clinicians and Researchers. Washington, DC, American Psychiatric Press, 1992, pp 3–28
32. Furst S (ed): Psychic Trauma. New York, Basic Books, 1967
33. Inderbitzin LB, Levy ST: Repetition compulsion revisited: implications for technique. Psychoanal Q (in press)
34. Cooper AM: Toward a limited definition of psychic trauma, in The Reconstruction of Trauma: Its Significance in Clinical Work, edited by Rothstein A. Madison, CT, International Universities Press, 1986, pp 41–56
35. Sugarman A (ed): Trauma and abuse: an overview, in Victims of Abuse: The Emotional Impact of Child and Adult Trauma. Madison, CT, International Universities Press, 1994, pp 1–21
36. Freud A: Comments on trauma: psychic trauma, in Psychic Trauma, edited by Furst S. New York, Basic Books, 1967, pp 235–246
37. Kahn MMR: The concept of cumulative trauma. Psychoanal Study Child 1963; 18:286–306
38. Kris E: The recovery of childhood memories in psychoanalysis. Psychoanal Study Child 1956; 11:54–88
39. Steele BF: Some sequelae of the sexual maltreatment of children, in Adult Analysis and Childhood Sexual Abuse, edited by Levine HB. Hillsdale, NJ, Analytic Press, 1990, pp 21–34
40. Sherkow SP: Consequences of childhood sexual abuse on the development of ego structure: a comparison of

child and adult cases, in Adult Analysis and Childhood Sexual Abuse, edited by Levine HB. Hillsdale, NJ, Analytic Press, 1990, pp 93–115
41. Terr LC: Childhood traumas: an outline and overview. Am J Psychiatry 1991; 148:10–19
42. van der Kolk BA (ed): The psychological consequences of overwhelming life experiences, in Psychological Trauma. Washington, DC, American Psychiatric Press, 1987, pp 1–30
43. Silk KR, Lee S, Hill EM, et al: Borderline Personality Disorder Symptoms and Severity of Sexual Abuse. Am J Psychiatry 1995; 157:1059–1064
44. Cahill C, Llewelyn SP, Pearson C: Long-term effects of sexual abuse which occurred in childhood: a review. Br J Clin Psychol 1991; 30:117–130
45. McFarlane AC, Yehuda R: Resilience, vulnerability and the course of posttraumatic reactions, in Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body and Society, edited by van der Kolk BA, McFarlane AC, Weisaeth L. New York, Guilford, 1996, pp 155–181
46. Lindy JD: Psychoanalytic psychotherapy of posttraumatic stress disorder: the nature of the therapeutic relationship in psychiatry, in Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body and Society, edited by van der Kolk BA, McFarlane AC, Weisaeth L. New York, Guilford, 1996, pp 525–536
47. Servan-Schreiber D, Cohen JD, Steingard S: Schizophrenic deficits in the processing of context. Arch Gen Psychiatry 1996; 53:1105–1112
48. Harris JC: Experimental animal modeling of depression and anxiety. Psychiatr Clin North Am 1989; 12:815–836
49. Kendler KS, Kessler RC, Walters EE, et al: Stressful life events, genetic liability, and onset of an episode of major depression in women. Am J Psychiatry 1995; 152:833–842
50. Maziade M, Caron C, Cote R, et al: Extreme temperament and diagnosis: a study in a psychiatric sample of consecutive children. Arch Gen Psychiatry 1990; 47:477–484
51. Tyson R, Tyson P: Psychoanalytic Theories of Development. New Haven, CT, Yale University Press, 1990
52. Glenn J: Psychic trauma and masochism. J Am Psychoanal Assoc 1984; 42:337–386
53. van der Kolk BA (ed): The role of the group in the origin and resolution of the trauma response, in Psychological Trauma. Washington, DC, American Psychiatric Press, 1987, pp 153–171
54. Gillman RD: Physical trauma and actual seduction, in The Reconstruction of Trauma: Its Significance in Clinical Work, edited by Rothstein A. Madison, CT, International Universities Press, 1986, pp 73–94
55. Levine HB (ed): Adult Analysis and Childhood Sexual Abuse. Hillsdale, NJ, Analytic Press, 1990
56. Sugarman A (ed): Victims of Abuse: The Emotional Impact of Child and Adult Trauma. Madison, CT, International Universities Press, 1994
57. Linehan MM, Tutek DA, Heard HL, et al: Interpersonal outcome of cognitive behavioral treatment for chronically suicidal borderline patients. Am J Psychiatry 1994; 151:1771–1776
58. van der Kolk BA, Dreyfuss D, Michaels M, et al: Fluoxetine in posttraumatic stress disorder. J Clin Psychiatry 1994; 55:517–522
59. Brenner I: The dissociative character: a reconsideration of "multiple personality". J Am Psychoanal Assoc 1994; 42:819–846
60. Goldstein WN: The borderline patient: update on the diagnosis, theory, and treatment from a psychodynamic perspective. Am J Psychother 1995; 49:317–337

Using Interpersonal Psychotherapy (IPT) in a Combined Psychotherapy/ Medication Research Protocol With Depressed Elders

A Descriptive Report With Case Vignettes

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One hundred eighty subjects at least 60 years of age with recurrent unipolar major depression were recruited to participate in a depression treatment protocol. All patients received drug therapy with nortriptyline (NT) and interpersonal psychotherapy (IPT) with an experienced clinician. Acutely, 81% of subjects showed a full response to combined treatment. In the initial 127 subjects, the most common problem areas in therapy were role transition (41%), interpersonal disputes (34.5%), and grief (23%). Case vignettes are presented and discussed. The combination of IPT and NT showed a powerful antidepressant effect. IPT was readily adaptable to the needs of depressed elders.

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The National Institutes of Health Consensus Conference on Geriatric Depression concluded that the current system of care delivery for depressed geriatric patients was "inadequate, fragmented, and passive" and argued for more research endeavors to refine promising psychosocial treatments, such as interpersonal psychotherapy, for geriatric depression.[1]

Although Sigmund Freud was pessimistic about using psychoanalysis with the aged,[2] many subsequent practitioners refuted that view and proceeded to publish case descrip-

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tions of geriatric cases with successful outcomes. The literature prior to the 1980s is primarily composed of such case reports, often richly descriptive but limited to the experience of single practitioners.[3–14] Recently, research efforts in psychotherapy have focused on the use of manual-based psychotherapies such as cognitive-behavioral therapy[15] (CBT) or interpersonal psychotherapy[16] (IPT) in order to standardize treatments by different practitioners and allow for meaningful comparison between groups of patients receiving different treatments.

In this article, we describe our collective experience treating 180 depressed elderly patients over the past 7 years in a controlled treatment trial, the Maintenance Therapies in Late-Life Depression (MTLLD) study. We begin with a brief background of the development of IPT and a description of the protocol within which it was used. Preliminary cross-sectional data are presented along with case vignettes to illustrate each IPT problem area.

Interpersonal psychotherapy of depression was developed about 25 years ago by Gerald Klerman, Myrna Weissman, and their colleagues in the New Haven–Boston Collaborative Depression Research Project. It was described by the authors as "a focused, short-term, time-limited therapy that emphasizes the current interpersonal relations of the depressed patient" (p. 5).[16] The focus of IPT is jointly agreed upon by patient and clinician and is broadly contained in one of four problem areas: abnormal grief, role transition, role dispute, or interpersonal deficit. The techniques of IPT are based on a long tradition of interpersonal psychotherapy, primarily developed in the Baltimore-Washington area, and on many empirical studies related to attachment bonds and significant life events.[17] Karasu[18] has published a comparison of IPT with other psychotherapies for depression, describing the major features, advantages, and limitations of the psychodynamic, cognitive, and interpersonal approaches.

The rationale for using IPT was initially described in a treatment manual and was subsequently published as a textbook,[16] which has been used to train clinicians in a variety of clinical and research settings. Over the years, IPT has been modified for use with specific populations, such as those with recurrent depression or depression in late life or adolescence.[19] IPT has been demonstrated empirically to be an effective form of treatment for acute and maintenance treatment of adults ages 18 to 60.[15,20]

METHODS

Description of the MTLLD Study

The Maintenance Therapies in Late-Life Depression study was conceived to attempt to reduce the high recurrence rate observed in geriatric depression by comparing the efficacy of the antidepressant nortriptyline (NT) with interpersonal psychotherapy and their combination as maintenance treatments under placebo-controlled, double-blind, random-assignment conditions. IPT was chosen because it was anticipated to be readily adaptable to the problems facing elders, particularly grief and role transitions. Furthermore, IPT is a manual-based psychotherapy that can be standardized and verified.

The MTLLD study enrolls elderly individuals with a history of recurrent depression during a current episode of major depression. Patients were excluded if they were bipolar, dementing, psychotic, diagnosed with neurodegenerative disease, or medically unable to be tried on NT or to travel for weekly visits. Since the goal of the study is to compare the efficacy of maintenance treatment, the first task is to maximally treat the current episode. All patients in the acute phase of the study therefore receive combined IPT and NT. All patients are seen weekly for 50 minutes of IPT for a minimum of 12 sessions. After achieving stable remission for 16 weeks, patients are then randomized for 3 years of maintenance follow-up on either NT or placebo in combination with either monthly IPT or a 15-minute medication check. For a

more detailed description of the MTLLD protocol, see Reynolds et al.[21] A report on the differential efficacy of these maintenance assignments will be available once the ongoing study is complete.

Teaching IPT to Protocol Psychotherapists

Teaching of the principles of IPT was carried out under the direction of senior clinicians, all of whom were highly experienced in its use from previous studies through direct collaboration with the developers of IPT. All therapists completed a 6-month didactic course (1½ hours per week) on the principles of IPT, including videotaped case vignettes. Each therapist was assigned two pilot cases, working with an individual supervisor on a weekly basis as well as alternately presenting videotapes for weekly group discussion and supervision. As the study progressed, the weekly case conference also served as an opportunity for ad hoc validation of the most appropriate focus of therapy. The pilot experience of Sholomskas et al.[22] recommended that therapists maintain an active stance, that they be prepared to help patients with practical problems such as finances or transportation, and that they maintain an awareness that options for change may be limited among elderly patients.

We expected our elderly subjects as a group to be struggling more frequently than younger subjects with issues of grief and loss and with role transitions such as retirement and relocation. Regarding role disputes, we tried to remain cognizant of the writings of Sholomskas and colleagues, who warned that elderly individuals may see themselves as having fewer options to make changes in role disputes than younger persons. Finally, we expected to find a disproportionate number of subjects in an elderly cohort confronting issues of aging, illness, and the perception of impending death.

RESULTS

Introducing IPT to Elderly Subjects

Many of our geriatric patients had little experience or understanding of psychotherapy prior to enrolling in the MTLLD study. They voiced their willingness to do anything to feel better but did not always come asking for psychotherapy in particular. Because IPT was a requirement of protocol participation, every effort was made to educate patients about the process and potential benefits of IPT. The vast majority of patients were able to learn and use the psychoeducational aspects of IPT and to use the time in therapy fruitfully.

The majority of patients worked very hard in therapy and reported reviewing sessions on their own and sometimes keeping notes. They voiced appreciation for the opportunity to have the psychotherapy sessions, since they often had no other confidant.

Overall, MTLLD therapists found fewer differences in applying IPT to elderly patients than anticipated. There was a range of psychological mindedness among our patients that was very similar to our experience with younger populations. On the whole, carrying out IPT was not more difficult with elders. A few patients could not tolerate full 50-minute sessions when acutely depressed, but most were easily engaged and very reliable about keeping appointments. Because few patients were still working, schedules were flexible and time was less restricted than with younger patients.

Dependency issues did arise infrequently when the maintenance phase approached and patients anticipated a 50% chance of no longer receiving psychotherapy. We were careful to handle termination according to the IPT principles of beginning discussion of these issues well in advance of transition times and by confronting them openly.

Cross-Sectional Data

Thus far, the combined use of IPT and NT has been shown to be a powerful treatment for

depression in elderly subjects, with a full response rate of 81% (defined as a score ≤ 10 for 3 consecutive weeks on the Hamilton Rating Scale for Depression[23] [Ham-D]). Mean pre/post Ham-D scores among responders were 21.9 (SD = 4.2) and 4.9 (SD = 2.8), respectively. Detailed reports of other preliminary outcome variables have been published elsewhere.[21,24,25]

The four major problem areas that serve as foci in IPT are 1) abnormal grief, 2) role transitions, 3) role disputes, and 4) interpersonal deficits. A detailed analysis of the first 127 patients showed a primary psychotherapy focus on role transition in 41%; a focus on grief in 23%; a focus on role disputes in 34.5%; and a focus on interpersonal deficits in 2 subjects. The role transitions that were associated with depression in our elderly patients, in descending rank order of frequency, are aging issues, retirement, declining health, "empty nest," loneliness, widowhood, relocation, ill significant other, marital change, work-related role transition, and dating. A secondary focus of role transition was identified in 57% of patients (in 41% of those with grief as a primary focus and in 32% of those with interpersonal dispute as a primary focus). The breakdown of losses precipitating grief, in rank order, was as follows: spouse, adult child, parent, sibling, close friend, nephew, and multiple family members. The problematic relationship in the 44 subjects with a primary focus on role disputes was most frequently with a spouse, followed by interaction with children, multiple family members, and, in one case each, a sibling and a close friend. For a detailed account of clinical and demographic correlates of IPT foci, see Wolfson et al.[23]

Case Vignettes

Role transition, illustrated in the following vignette, was the most frequent problem we encountered. As the role transition crisis abated in the early phase of treatment, the focus of IPT changed to role dispute.

The tasks of the IPT therapist in a role transition are to 1) elucidate the lost role, 2) facilitate the expression of emotion surrounding it, 3) encourage the development of social skills suitable for the new role, and 4) seek social supports to help maintain the new role.

Case 1: Role Transition/Role Dispute. Mr. A., a 61-year-old white, married professional, presented in his third episode of major depression. He reported previously seeing a psychiatrist for "advice" during a midlife crisis but not finding it very helpful.

Mr. A. described how his professional practice partner had recently retired, leaving him with an office he could not afford. Gradually, a picture came into focus of a man with deep ambivalence about his chosen profession and a pattern of financial negligence in paying debts and collecting fees that was nearly bankrupting him. Mr. A. explicitly stated that his ambivalence toward starting again with another practice versus taking up other employment or choosing retirement was particularly depressing to him. A focus on role transition seemed most appropriate at the outset.

After several sessions exploring various options and providing him an opportunity to ventilate his feelings about his work-related ambivalence, Mr. A. finally decided to invest in a new office, found a young partner, and opened a new practice. His goal was to retire in 5 years. His depression gradually improved over the ensuing 3 months.

During his IPT treatment, Mr. A.'s wife was diagnosed with cancer. She was successfully treated with chemotherapy and achieved a rapid remission, but her tolerance for her husband's behavior was diminishing. She became more confrontational regarding his pattern of "forgetting" to fulfill his responsibilities, which now seemed more pronounced since her treatment had left her greatly weakened and more of the day-to-day responsibility of running their affairs fell into Mr. A.'s hands. She once telephoned out of desperation, complaining about his behavior in light of their dire financial circumstances. Gradually, a pattern of passive deferral or passive aggression toward his wife became clear, and a shift in the focus of IPT to role dispute seemed appropriate. A few conjoint sessions were deemed necessary to deal with the crisis of his wife's cancer diagnosis. During these sessions, Mrs. A.'s accusations of a

long-standing pattern of passive aggressive behavior and convenient forgetfulness were not denied by Mr. A. Their relationship had developed a homeostasis that rested upon Mrs. A.'s ability to continually rescue her husband when his negligence caught up with him. The inclusion of his wife in these conjoint sessions helped to reveal more fully the patient's lifelong character pathology. His "forgetfulness" became so problematic that Mr. A. and his wife requested neuropsychological testing because she was afraid he might be showing early signs of dementia. The test results were negative for significant cognitive impairment.

Since IPT does not seek to change personality structure per se, his IPT therapist continued to focus in very practical ways on the day-to-day tasks as they related to role disputes with his wife. On review with Mr. A. of the list of his day-to-day responsibilities, he appeared to be more forthcoming about his long-standing pattern of avoiding responsibilities. With continued review of these issues, Mr. A. began to take more responsibility for the running of the household. He became more attentive to his wife's needs and more honest with her about what he was willing and able to do. Mr. A.'s wife confirmed that he seemed better at "hearing her" and she now felt she was receiving more of the support she sorely needed to cope with her cancer.

The vignette of Mr. A. illustrates a case of shifting focus from role transition (work transition) to role dispute (marital conflict). The long-standing character traits of passivity and passive aggression were acknowledged by the IPT therapist but addressed only through persistent reevaluation of here-and-now themes. The crisis of his wife's diagnosis of cancer caused Mr. A. to more fully confront his long-standing, maladaptive behavior patterns. His IPT therapist was able to help him see the relationship of these behaviors to the role dispute with his wife and to seek alternative strategies that were more appropriate.

Role disputes that were ameliorated by work, child care, or independent activity often proved to be more difficult when one spouse became ill or dependent or if retirement or children leaving home required a couple to spend more time together, as the following case vignette illustrates.

Case 2: Role Transition/Role Dispute/Abnormal Grief. Mrs. B., a white, married 64-year-old, presented in her fourth episode of major depression, never having had any previous experience in psychotherapy. She had recently retired from her position as a health care provider. She was extremely anxious and guarded at the onset of therapy and reported an almost complete remission of depressive symptoms in the first week. The clinical staff was intuitively skeptical of this "flight into health" and was able to convince her to stay in the program. Within several weeks, her symptoms returned and her Ham-D score was as high as it had been initially. She was extremely anxious and had a difficult time engaging actively in therapy. After a cautious start, the educational component of IPT began to pay off and she began to engage more actively. Gradually, she began talking about her difficulties in adjusting to retirement. These included difficulties in time management, learning to manage money, and setting boundaries on her availability for baby-sitting her grandchildren. The first 5 to 8 sessions focused on these role transition issues.

Once Mrs. B. began to feel somewhat better and a therapeutic bond formed, she began to reveal deep-seated resentments toward her husband. She requested that we shift our focus away from her problems with retirement and onto her role disputes with her husband. Each situation that Mrs. B. brought to therapy manifested an underlying imbalance of power and control. Mrs. B. described her husband as a benign dictator. Her IPT therapist explored specific instances of the power imbalances she described and her usual response of failing to ask for what she wanted because she "knew" he would become upset if she disagreed with him. After exploring alternative strategies and the potential consequences of greater assertiveness, Mrs. B. vowed to attempt to speak up more and be more clear about her needs. The interpersonal disputes worsened with these initial attempts, as did her own internal dissonance. With continued confrontation and clarification of this pattern, Mrs. B. recognized her own responsibility in allowing her husband to "rule the roost" and the great difficulty she had in asserting herself. With the continuing support of her IPT therapist, Mrs. B. made persistent attempts to assert herself more clearly and was both surprised and delighted to find her husband

more willing than she had imagined to share in decision making. With practice, she eventually became more comfortable with her newly acquired role. Through her work in IPT, Mrs. B. was able to learn to be more aware of her role in her marital discord and to accept more personal responsibility for their joint problems. The net effect of these efforts led to improved marital communication.

As the interpersonal dispute with her husband improved, Mrs. B. revealed another dimension of her interpersonal life that related to her depression. Her sister, who was her primary confidant, had died several years earlier, and Mrs. B. felt that she had never properly grieved for her. This was due, in part, to complex dynamics in her family, such as family secrets that only she and her sister shared, as well as Mrs. B.'s unwillingness to allow herself to "let go" and really mourn, since her primary role in the family had always been to take care of others. With gentle encouragement Mrs. B. was able to step out of her role as caregiver and to express a great deal of her grief and pain. She chose to share some of the family "secrets" that had played a role in her buried grief for her sister. Her father was much older than her mother and developed Parkinson's disease while many of the children were still small. Since her father was unable to continue working, her parents took in boarders to generate income. Her revelation of the family secret that her mother had several love affairs with her male boarders was followed by extreme self-doubt and worry that she was being disloyal to her family for talking about this "secret."

Mrs. B. spoke of her difficulty trusting the confidence of her sister, who also knew of the "secret." Mrs. B. had wanted many times to discuss it with her sister but had never done so. The issue of trust was explored at length, and Mrs. B. expressed her appreciation for having the opportunity to discuss these issues in a "safe" forum where there were no ramifications in her personal life. The issues of trust, shame, embarrassment, and loyalty were each explored in turn, since they were key to unlocking her buried, incomplete grieving for her late sister.

Her IPT therapist was able to tie Mrs. B.'s feelings surrounding grief for her sister to her current situation (and thus return the focus to the present) by helping her to explore ways in which she might become more flexible in her roles with important people in her life now and learn to ask for support from others when she needed it.

The role of the IPT therapist is to explore problem interpersonal relationships and search for ways in which they might be handled better. Mrs. B.'s IPT therapist recognized her problem trusting others and encouraged her to learn to ask for more from others within her significant relationships.

Early in treatment, this patient demonstrated the "flight into health" phenomenon because of her anxiety about "opening up." Her IPT therapist, through patient and persistent psychoeducational efforts, convinced her of the safety of sharing her interpersonal difficulties as she saw them. Mrs. B.'s initial complaints indicated a role transition focus (retirement), followed by psychotherapeutic work centered on her role disputes in her marriage. After progress handling the first two problems, a third, more briefly explored focus on unresolved grief was made possible by her bolstered confidence that she could trust her therapist with her most deeply held secrets.

Issues arising from old traumas might be expected to surface more often in elderly patients because they have more years of accumulated experience. IPT does not set out to elucidate early life experiences or uncover traumas per se, as one might in psychodynamic or psychoanalytic therapies; however, when patients bring them up, it is appropriate in IPT to encourage the ventilation of feelings around the old trauma. Mrs. B. clearly needed to share the long-held family secret that was connected to her unresolved grief for her sister. After allowing her to express her feelings about the matter, her IPT therapist gently brought her back to the present and connected the issue to her current problems by posing questions to her about how she might learn to ask for more support and understanding from others instead of continuing a pattern of silent suffering.

We expected to encounter difficulty coping with grief and loss in our elderly subjects and frequently did so. We have previously written at length about our experiences using IPT for grief in elders.[26] The following vignette illus-

trates one presentation of abnormal grief.

Case 3: Abnormal Grief/Role Dispute. Mr. C., a white, single 64-year-old, reported a history of persistent depressive symptoms for 3 years prior to his admission to the MTLLD study. Mr. C. had never married but was very close to his siblings and their families. Mr. C. was a health care professional and, as such, regularly assumed the role of caregiver with his entire family's medical problems. He was particularly close to his 10 nephews, with whom he especially enjoyed playing golf.

Four years prior to his presenting for help, one of his nephews died of leukemia at age 37. A month afterward, another nephew, also in his thirties, died suddenly from a cerebral aneurysm. In 1988 one of his brothers died, and a year later a second brother died. Shortly after that, one of his great-nephews (age 25), died in a car accident. Mr. C. said, "I have been grieving for the last three years." To make matters worse, as a result of prostate cancer treatment, colon resection, and recent carpal tunnel surgery, he himself could not play golf for an entire season.

The IPT focus, abnormal grief, was complicated by several factors. In addition to being distressed by his own limiting illnesses, Mr. C. was resentful of being continually thrust into the role of liaison with various health care providers who were caring for his ill relatives, a role he found to be extremely stressful but to which he could never say no. Additionally, although other family members, especially the parents and spouses of the deceased, received support and acknowledgment of their losses, no one seemed to recognize the depth of his losses. He was "only the uncle," although it became clear that he shared a special bond with his nephews.

His IPT therapist offered a safe, supportive forum to express all of his feelings of sadness for his lost relatives, as well as his negative feelings that his grief was not being legitimized by other family members and that he was being taken for granted as a health care liaison despite his own medical problems and restrictions. With continued confrontation of his role in allowing the status quo to remain, he expressed a willingness to be more assertive in declining some of the expected obligations he no longer felt he could fulfill. The self-perception that he had to "give more" as "only an uncle" to feel worthy of inclusion in the family was challenged, resulting in the acknowledgment that his own problems were just as deserving of family attention and support.

By first acknowledging the legitimacy of his grief, IPT offered Mr. C. the opportunity to openly grieve, to talk about how he experienced his nephews' deaths not only as the "family nurse," but also as their beloved uncle. He also learned that he could relieve his resentment at being overburdened by his family's medical needs by being more assertive in his expectations that he be included as a full-fledged family member complete with his own problems, not just "the uncle."

DISCUSSION

In our experience, IPT in combination with nortriptyline shows a high degree of utility with depressed geriatric patients. We were impressed with the ability of our patients as a group to learn from the psychoeducational components of IPT, to become working partners in psychotherapy, often without prior experience, and to use IPT to modify interpersonal problems.

A shift of focus during IPT occurred in 57% of our subjects. In the case vignettes, Mr. A.'s job-related role transition and his wife's cancer diagnosis forced a confrontation with long-standing maladaptive behavior in his marital relationship. Mrs. B. revealed her long-standing resentments toward her husband only after exploring her difficulties adjusting to retirement. Mr. C. struggled with the grief of multiple losses through death before confronting his resentment toward various family members who assumed he would be their health care liaison. Perhaps a more crisis-oriented therapy with limited sessions would not have allowed for these secondary role disputes to emerge; however, in our view the secondary focus on role disputes is often the most important focus that is "saved for last"—after more temporary adjustments in coping have been made and after patients have developed the required rapport to approach more worrisome or deep-seated problems in their relationships. In other words, role transitions are easier to

handle if important relationships are viewed as working well, and vice versa.

Regarding spousal role disputes, perhaps we are seeing an age cohort effect, since divorce would have been more frowned upon in the earlier years of these couples' marriages than in recent times. Couples with severe marital strains may have found ways to cope, however tenuous, only to find their tried and true strategies were failing as the stresses of late life accumulated. One-third of the patients with a primary focus of role dispute showed a secondary focus of role transition. Perhaps an unavoidable role transition precipitated a shift of a tenuously balanced relationship into one with a serious role dispute. It is not difficult to imagine the stresses of a new medical illness or the approach of retirement precipitating more disputes between spouses.

The clinical impressions of the 5 participating IPT psychotherapists treating these 180 patients over the past 7 years were that IPT required no major modification and was no more difficult to carry out than IPT with younger patients. There were certainly instances when financial, legal, medical, transportation, or housing problems arose and required exploration and sometimes practical recommendations for appropriate assistance. These instances were seen somewhat more frequently than with younger patients, but they did not significantly interrupt or overshadow the focal work in IPT. The reader should bear in mind that elderly subjects with significant memory loss or dementia, who would be expected to require even more assistance, were excluded from the protocol.

In preparing to work with depressed elderly patients, we found a review of principles of gerontology highly useful to familiarize ourselves with and be able to anticipate common problems and needs of elderly patients in general. A background course in gerontology or a year or more of experience working with elders is highly recommended for clinicians interested in applying IPT to elderly patients.

Although the use of nortriptyline with IPT, in our experience, has been a powerful antidepressant combination for elders with recurrent depression, we cannot comment on the differential effects of these two treatments as acute treatments. Report of the comparative efficacy of IPT, nortriptyline, and their combination as maintenance treatments will follow upon completion of the MTLLD protocol.

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REFERENCES

1. NIH Consensus Development Panel on Depression in Late Life: Diagnosis and treatment of depression in late life. JAMA 1992; 268:1018–1024
2. Freud S: On psychotherapy (1905), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, vol 7, translated and edited by Strachey J. London, Hogarth Press, 1953, pp 255–268
3. Lazarus L: Clinical Approaches to Psychotherapy With the Elderly. Washington DC, American Psychiatric Press, 1984
4. Kockott G: Psychotherapy in advanced age in psychogeriatrics: an international handbook, edited by Bergener M. New York, Springer Publishing, 1987
5. Miller M: Using psychoanalytically oriented psychotherapy with the elderly. Jefferson Journal of Psychiatry 1986; 4:13–21
6. Muslin CJ: The transference of the therapist of the elderly. J Am Acad Psychoanal 1988; 16:295–313
7. Miller M: Opportunities for psychotherapy in the management of dementia. J Ger Psychiatry Neurol 1989; 2:11–17
8. Berezin M: Psychodynamic considerations of aging and the aged. Am J Psychiatry 1972; 128:33–41
9. Kroetsch P, Shamoian CA: Psychotherapy for the elderly. Medical Aspects of Human Sexuality 1986; 20:123–127
10. Ursano RJ, Hales RE: A review of brief individual psychotherapies. Am J Psychiatry 1986; 143:1507–1517
11. Goldfarb AI, Turner H: Psychotherapy of aged persons, II: utilization and effectiveness of brief therapy.

Psychotherapy of Aged Persons 1953; 916–921
12. Wasylenki DA: Psychodynamics and aging. Can J Psychiatry 1982; 27:11–17
13. Meerloo J: Psychotherapy with elderly people. Geriatrics 1955; 10:583–587
14. Safirstein SL: Psychotherapy for geriatric patients. New York State Journal of Medicine 1972; 72:2743–2748
15. Elkin I, Shea T, Watkins JT, et al: National Institute of Mental Health Treatment of Depression Collaborative Research Program: general effectiveness of treatments. Arch Gen Psychiatry 1989; 46:971–982
16. Klerman GL, Weissman MM, Rounsaville BJ, et al: Interpersonal psychotherapy of depression. New York, Basic Books, 1984
17. Cornes CL: Interpersonal psychotherapy of depression (IPT), in Handbook of the Brief Psychotherapies, edited by Wells R, Giannetti V. New York, Plenum, 1990, pp 261–276
18. Karasu TB: Toward a clinical model of psychotherapy for depression, I: systematic comparison of three psychotherapies. Am J Psychiatry 1990; 147:133–147
19. Klerman G, Weissman MM (eds): New Applications of Interpersonal Psychotherapy. Washington, DC, American Psychiatric Press, 1993
20. Frank E, Kupfer DJ, Perel JM, et al: Three-year outcomes for maintenance therapies in recurrent depression. Arch Gen Psychiatry 1990; 47:1093–1099
21. Reynolds CF, Frank E, Perel JM, et al: Combined pharmacotherapy and psychotherapy in the acute and continuation treatment of elderly patients with recurrent major depression: a preliminary report. Am J Psychiatry 1992; 149:1687–1692
22. Sholomskas AJ, Chevron ES, Prusoff BA, et al: Short-term interpersonal psychotherapy (IPT) with the depressed elderly: case reports and discussion. Am J Psychotherapy 1983; 37:552–566
23. Hamilton M: A rating scale for depression. J Neurol Neurosurg Psychiatry 1960; 23:56–62
24. Wolfson L, Miller M, Houck P, et al: Foci of interpersonal psychotherapy (IPT) in depressed elders: clinical and outcome correlates in a combined IPT/nortriptyline protocol. Psychiatry Res 1997; 7:45–55
25. Miller MD, Silberman RL: Using interpersonal psychotherapy with depressed elders, in A Guide to Psychotherapy and Aging: Effective Clinical Interventions in a Life-stage Context, edited by Zarit SH, Knight B. Washington, DC, American Psychological Association, 1996, pp 83–99
26. Miller MD, Frank E, Cornes C, et al: Applying interpersonal psychotherapy to bereavement-related depression following loss of a spouse in late life. J Psychother Pract Res 1994; 3:150–162

The Relationship Between Therapist–Client Modality Similarity and Psychotherapy Outcome

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Although disparate views have been published, the theory underlying multimodal therapy suggests that therapist–client similarity would be most advantageous for treatment outcome and client satisfaction. To explore this question, 19 different therapist–client pairs were followed over 12 sessions of psychotherapy. Clients were evaluated with the Brief Symptom Inventory (BSI) after sessions 1 and 12 to determine psychotherapy outcome. Similarity was determined by computing D э ^{2} statistics on therapists' and clients' responses to the Structural Profile Inventory (SPI). Similarity on the SPI predicted psychotherapy outcome, showing a statistically significant relationship with the Global Severity Index of the BSI.

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In clinical psychology's quest to fulfill G. L. Paul's[1] charge to psychotherapy researchers, "*What* therapy, by *whom*, is most effective for *this* individual with *that* specific problem and under *which* circumstances?" (p. 111; italics in original), research has shown that it is not only important to study each of these factors individually, but that it is also important to combine them. The study of therapist–client similarity has thus arisen. Out of this tradition of research, two opposing schools of thought have developed: one suggesting that therapist–client similarity results in optimized outcomes, and one suggesting that dissimilarity optimizes treatment outcomes.

The position favoring similarity appears to have evolved from observations that therapist and client demographic and personality characteristics such as gender, race, personality, and mental health have a "profound impact" on psychotherapeutic process and outcome.[2] Some research in this area has gone so far as to suggest that most of the variance in outcome is a result of therapist and client variables and that little is actually a result of the specific techniques used.[3,4]

It has also been suggested that client–therapist similarity aids in the genesis and maintenance of rapport.[5] Psychotherapy is an

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interpersonal sharing and communication experience. Therefore, the more similar the client–therapist dyad, the greater the likelihood of the communication being clear and readily understood.[6] Dormarr et al.[7] demonstrated that the clearer and more consistent the communication between the therapist and client, the more positive the treatment outcome. Cummings et al.[8] found that when therapists and clients agreed in their recollections of which session events were important, psychotherapy sessions were generally rated as more effective by both clients and therapists.

Strong support for this position comes from studies of length of psychotherapy as a function of client–therapist similarity. Mendelson and Geller[9] studied therapists and clients in a college counseling center. Similarity/dissimilarity was determined on the basis of Myers-Briggs Type Inventory (MBTI) profiles. Dissimilarity was associated with increased dropout rates and increased premature termination rates. Purportedly, clients were unable to build rapport with highly dissimilar therapists and left therapy because of dissatisfaction.

Much of the support favoring dissimilarity comes from the perspective that psychotherapy is an educational experience. There is a large body of literature[10,11] suggesting that the "active ingredient" of psychotherapy is the set of new or compensatory skills acquired during the process. For education to be effective, the "student" must be presented with some information that is new or that is presented in a different way. In psychotherapy, clients must be able to learn something novel and different from their therapists that they would not ordinarily learn on their own. Therefore, therapists who are too similar to their clients will be unable to present a different perspective or any new learning.[12] Even studies that have shown the importance of client–therapist similarity have demonstrated that extreme similarity appears to be a deterrent to successful psychotherapeutic outcome for precisely this reason.[7]

The study of the effects of therapist–client matching of personality variables is not new to the science of psychotherapy. In the early 1970s a flurry of research activity was generated on the topic of the A-B dichotomy.[13–16] According to this theory, certain therapist personality variables, differentiable through the administration of the Strong Vocational Interest Blank, could predict outcome efficacy with neurotic versus psychotic patients. However, this theory has not been validated empirically.[17]

More recently, Beutler and Clarkin[18] developed a system for systematically targeting therapeutic interventions for specific clients with specific problems in specific circumstances. This integrative model is based on four primary classes of events and variables, which therapists can consider and use to theoretically choose optimal psychotherapeutic techniques to maximize treatment outcome. These four primary classes are Patient Predisposing Variables (diagnosis, personal characteristics, environments/circumstances), Treatment Context (setting, mode or format, frequency and duration), Relationship Variables (personal compatibility matching, enhancing of the therapeutic alliance), and Strategies and Techniques (focal targets of change, level at which goals of treatment are mediated, way of conducting the actual therapeutic work).

It is the third of these classes, Relationship Variables, that is most appropriate to this report. Among the dimensions of compatibility discussed by Beutler and Clarkin are demographics, interpersonal response patterns, personal beliefs, and attributions. (See their chapter 9 for a comprehensive discussion of therapist–client personal and personality matching in the optimization of psychotherapy outcome.[18])

Multimodal therapy[19] explains human functioning in terms of seven independent yet interactive dimensions, referred to by the acronym BASIC-I.D. These seven spheres of functioning—Behaviors, Affects, Sensory, Imagery, Cognitions, Interpersonal, and "Drugs"/biological factors—either singly or in combination can explain fully the realm of human experience and functioning.[19]

The modality of Behaviors can best be described as one's orientation to action. People

who score high on the Behaviors modality scale are generally described as active, energetic, and busy. They are often goal-oriented and often choose to act on a problem rather than studying it in depth first. People who score high on the Affects modality consider themselves emotional. They feel things deeply and rely on their emotions and intuitions. People who score high in the Sensory modality are very tuned in to their physical sensations. They are keenly aware of smells, tastes, sights, kinesthetics, and sounds, similar to the conceptualization of the strongly right brain–dominant individual. People who score high on the Imagery modality are good at thinking in pictures. They may be more likely to fantasize or daydream and can often think three-dimensionally. People who score high in the Cognitions modality consider themselves logical, rational, and contemplative. People who score high in the Interpersonal modality derive energy from interpersonal relationships. These are "people persons" who like to socialize, mingle, and be in groups. People who score high in the Biochemical factors are health conscious. They avoid unhealthy habits and take care of their bodies. They do not resort to substance use to cope. People who are having psychological problems will experience them across all modalities. Consequently, for optimal treatment outcome, therapy must focus on the significant manifestations in all seven modalities.

In Multimodal therapy, clients are thoroughly assessed in all seven areas of functioning. All of their strengths and clinical symptoms in all modalities are carefully cataloged. The Multimodal Treatment Plan is developed by matching specific, empirically documented psychotherapeutic techniques to each of the client's target clinical symptoms. Multimodal therapy agrees with other disciplines and psychological views[20,21] in recognizing that it is the techniques that are of prime importance in psychotherapy.[19]

Modality scores are important in the study of behavior. They determine an individual's functioning preferences. According to the theory and clinical observation of multimodal theory,[19,20] one's "dominant modality" (having the highest score on the Structural Profile Inventory [SPI]) will be the sphere of functioning in which one will be most likely to react, especially in times of stress. The implications of this finding for marital and other interpersonal relationships are that when individuals share dominant modalities, their communication will most likely be clearer and a more productive interpersonal relationship will result.[22–24]

Dominant modalities can be determined through the application of several different assessments. The Structural Profile was originally a verbally administered tool[25] that consisted of describing the seven modalities and requesting the client's self-rating for each. Straightforward in its approach, the Structural Profile is a quick and easy way to obtain a general and global picture of a client's modality functioning. However, to gain further insight into the nuances of a client's modality functioning, the 35-item SPI was created.[19] The reliability and validity of SPI were demonstrated in a study by Landes,[26] who showed internal consistency and test-retest reliability, as well as concurrent validity, for the Affects, Sensations, Cognitions, and Interpersonal Relations modality scales through correlations with the MBTI. Recently, the SPI has been shown to have even higher reliability scores than previously demonstrated, and, through a correlation with the Vocational Preference Inventory, validity has been established for the Affects, Sensations, Imagery, and Interpersonal Relations modalities, with some indication of validity established for the Behaviors modality.[27]

Research has already demonstrated that therapists' theoretical stances are consistent with their own modality structures on the SPI[22] and that clients' perceptions of their psychological difficulties can be similarly predicted from their SPI scores.[24] The implications of these findings are that psychotherapists are likely to employ specific techniques that are consistent with their own modality structures and clients, likewise, are apt to see techniques consistent with their own modality structures as more pertinent to their issues. Herman[23] has

already demonstrated that when therapists and clients differ in their modality structures, early psychotherapy impact suffers. It is therefore intuitive to assume that psychotherapy outcome will suffer similarly. This is not a radical idea in psychotherapy research. McConnaughy[28] discussed in detail the impact of a therapist's personality style on the style, form, and content of the psychotherapy practiced. Lazarus[29] has recently reviewed the necessity of approaching the client on his or her own terms. Rogers had covered this same topic extensively for years previously,[30] although employing a much more limited model.

This study was designed to explore the importance of therapist–client similarity from the holistic and comprehensive viewpoint of multimodal therapy. For this purpose, the SPI, the primary psychometric of multimodal therapy, was used to determine a measure of similarity. It was hypothesized that therapist–client similarity on the Multimodal Structural Profile Inventory would result in more successful psychotherapy outcomes than would therapist–client dissimilarity.

METHODS

Subjects

Therapists were recruited by mailing letters to the directors of eight clinics in New York, New Jersey, Pennsylvania, and Indiana. Although initially 45 therapists agreed to participate, a total of only 19 therapist–client pairs did participate in this study. Therapists were primarily female (74%). The average age of the therapists was 32.8 years (SD = 6.8, range 23–46). Most of the therapists (74%) were still in advanced degree programs (Ph.D., Psy.D., Ed.D., or psychiatry residency), and they had an average of 3.96 years of experience (SD = 3.9, range 0–12). Half of the therapists were married (47%), and most were Caucasian (68%).

Clients were also primarily female (84%). Their average age was 27.0 years (SD = 8.6, range 18–49). Half of the clients were college students (47.4%). Several clients had master's degrees (26.3%), and a few had professional degrees. Of the nonstudents, some were employed and some were not. Most of the clients (74%) were single, 21% were married, and 5% were divorced. Most clients were Caucasian (74%).

Clients were excluded from participation if they were actively psychotic, actively substance dependent, or organically impaired. Clients had to be literate to the extent that they were capable of reading and answering the research questions in order to participate. Only clients 18 years or age or older were recruited for participation. Family and marital therapy clients were not recruited, so as to optimize concentration on the interactions between therapists and individual therapy clients. Each therapist was asked to participate only once with one individual client.

Procedures

Therapist–client similarity was determined through administration of the Multimodal Structural Profile Inventory, Version 3.[19] Psychotherapeutic outcome was determined by use of the Brief Symptom Inventory[31] (BSI). Correlations between the BSI and the Symptom Checklist–90 (SCL-90) are high enough that the BSI can be considered interchangeable with the SCL-90, sharing the same reliability and validity characteristics.[32] Concurrent validity for the BSI has been established through correlations between the SCL-90 and several other assessments, including the Minnesota Multiphasic Personality Inventory (MMPI),[33] rendering the SCL-90 a frequently used outcome measure in psychotherapy research.[9,34,35]

The Multimodal SPI[19,22–24,26,28,36] is a 35-item self-report questionnaire that asks clients to rate their perceptions of their modality functioning according to a seven-point Likert scale. The SPI assays an individual's functioning in the realm of Behaviors (e.g., "I keep busy doing things"), Affects (e.g., "In making a decision, I often let my emotions be the key factor in determining what I should do"), Sensation, Imagery (e.g., "I am tuned in to my sensations:

what I see, hear, taste, smell, and touch"), Cognitions (e.g., "I tend to plan things and think about them a great deal"), Interpersonal Relationships (e.g., "I have several close or intimate friends"), and Biological/Physical factors (e.g., "I follow good nutrition habits"). Scale scores can range from 5 (indicating poor functioning in the modality area or a preference against using that sphere of functioning) to 35 points (indicating high functioning in the modality area or a preference to use that sphere of functioning, that is, a dominant modality).

The BSI[37] is a 53-item questionnaire that factors into nine clinical scales (Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism) and two summary scales, the General Severity Index (GSI) and the Positive Symptom Distress Index (PSDI). The GSI provides information about the general level of psychological symptomatology the client is experiencing, whereas the PSDI provides information about the severity of the specific symptoms the client endorses. All scales of the BSI can be analyzed by their raw scores (which range from 0, indicating an absence of psychopathological symptoms, to 4, indicating high levels of psychopathological symptoms) or can be converted to scaled scores, with a mean of 50 and a standard deviation of 10.

Both therapists and clients also completed a brief demographics questionnaire requesting information such as age, gender, race, occupation, and marital status. In addition, the therapists' demographics questionnaire requested philosophical orientation, degree sought, and years of psychotherapeutic experience.

Once therapists agreed to participate in this study, they were sent packets containing all the materials they would need. In addition to self-addressed return envelopes containing the intake materials and the session #12 questionnaires, therapists were provided with a detailed instruction sheet, two copies of their own consent form, the therapist SPI and therapist demographics questionnaire, two copies of the client consent form, and an "intake consent form." The intake consent form, requesting only the therapist's name, the name of the clinic, and the therapist's signature to affirm that the client had signed his or her consent form, was included to ensure the client's anonymity. The experimenter thus did not receive the names of any of the clients. Therapists were instructed to complete and return their own consent form, SPI, and demographics sheet upon receipt of the research materials.

When therapists met with their next new client for the first time, they were instructed to explain the study and seek the client's consent for participation. Interested clients were then asked to read and sign both copies of the Client Consent Form, which described the study in detail. Although there were no enforcement mechanisms to ensure that therapists would participate with their next new random client, many of the participants were recruited through training clinics where clinicians saw only one or two clients per year. This was one of the major causes of the high dropout rate: many clients chose to not participate, regardless of the clinician's interest.

After the client signed the consent form, the therapist completed the Intake Consent Form (described above) and gave the client the Session #1 packet, which contained the BSI, the SPI, and the Client Demographics sheet in a self-addressed stamped envelope. Clients were instructed to complete and return these questionnaires immediately after the first session.

After the twelfth therapy session, the clinicians were instructed to remind their clients about the study and request that they complete the Session #12 packet, which contained the SPI and BSI in a self-addressed stamped envelope. Clients were instructed to complete these materials immediately after the twelfth therapy session.

According to the research protocol, therapists were instructed to administer exactly the same course of treatment that they would have followed had they not participated in the study. Clients were also informed that participation in this study would not alter the course or form of treatment that they would receive.

Statistical Analyses

Consistent with Cronbach and Glesser,[38] therapist–client difference values were computed by using SPI modality scores corrected for elevation and scatter ($D\text{ə}^2$), converting them essentially to *z*-scores. The process begins by first obtaining a mean modality score [$x = (B + A + S + I + C + I. + D.)/7$], called the "profile elevation," and a standard deviation of the modality scores, called the "profile scatter," for both therapist and client. Each modality score is then subtracted from this mean score, correcting it for "elevation" (e.g., $B' = B - x$). Modality scores (corrected for elevation) are then corrected for "scatter" by dividing them by the standard deviation of the modality scores (e.g., $B\text{ə} = B'/SD$). These steps are performed independently for both the therapist and client SPI scores. $D\text{ə}^2$ scores are computed by subtracting the client modality scores from the therapist modality scores, squaring the differences, and adding them together: $D\text{ə}^2 = (B\text{ə}_t - B\text{ə}_c)^2 + (A\text{ə}_t - A\text{ə}_c)^2 + (S\text{ə}_t - S\text{ə}_c)^2 + (I\text{ə}_t - I\text{ə}_c)^2 + (C\text{ə}_t - C\text{ə}_c)^2 + (I.\text{ə}_t - I.\text{ə}_c)^2 + (D.\text{ə}_t - D.\text{ə}_c)^2$. The reader is referred to Cronbach and Glesser[38] for a more in-depth description of the process and rationale for the use of this statistic. Using the $D\text{ə}^2$ statistic, the larger the obtained value, the greater the degree of dissimilarity (and thus the lesser the degree of similarity).

This conversion process prevented contamination of the dependent measure (the raw SPI scores). Uncorrected raw SPI modality scores have been found to be predictive of clients' symptomatology, as measured by BSI symptom scores, but SPI modality scores corrected for elevation and scatter have not.[36] Thus, an additional strength of the SPI is that it can be used to roughly measure the nature and severity of a client's clinical symptoms.

In the analyses of therapeutic outcome, regression equations were computed by using the GSI scores from the session #12 BSI as the dependent measure of outcome. The independent measures in these equations were corrected therapist–client similarity scores ($D\text{ə}^2$) from the SPI and GSI scores from the Session #1 BSI (to obtain a pretreatment baseline). Only GSI scores were used in the analyses of outcome, rather than the nine different symptom clusters, in an attempt to avoid making a type I error. Because only 19 outcome packets were collected, it was determined that there were insufficient data for these nine separate analyses.

RESULTS

Descriptively, therapist–client similarity scores (SPI D-scores corrected for elevation and scatter) were found to range from 1.11 to 4.89 (mean = 3.50, SD = 1.02), with larger numbers signifying greater differences between therapists and clients in modality functioning. Mathematically, the largest difference ($D\text{ə}^2$) possible between two individuals on the SPI is 5.29.

To demonstrate that this was a valid study of therapy and that the BSI was an appropriate instrument for examining outcome, *t*-tests for paired samples were computed on the GSI scores, comparing pretreatment to posttreatment. A significant decrease in symptomatology was observed ($n = 18$, $t = 2.12$, $P = 0.04$), from 1.18 (SD = 0.65, standard error = 0.15) before treatment to 0.93 (SD = 0.64, standard error = 0.15) after treatment. Therapist–client similarity was not found to be predictive of clients' initial levels of psychopathology in analyses of intake GSI scores ($R = 0.22$, $R^2 = 0.04$, $P = 0.09$). This is consistent with findings that SPI scores corrected for elevation and scatter are not predictive of psychopathology.[36]

Outcome, as measured with the GSI, was not affected by the therapist's years of experience ($R = 0.21$, $R^2 = 0.04$, $P = 0.45$) or by the therapist's status as a student or a professional ($F = 0.69$, df = 1,16, $P = 0.41$).

Analyses of the relationship between client–therapist similarity on the Multimodal SPI and psychotherapy outcome confirmed the experimental hypothesis. In the regression analysis, a significant relationship was observed between therapist–client similarity on the SPI and outcome as determine by pretreat-

ment to posttreatment GSI scores ($R = 0.79$, $R^2 = 0.63$, $P = 0.03$, $\beta = 0.37$). The more similar the therapist and client, the lower the degree of reported psychopathology at psychotherapy outcome.

Given the high dropout rate encountered in this study, some post hoc analyses were conducted to explore the relationship between therapist–client similarity on the SPI and dropout, as well as between several of the demographic variables and dropout. In these analyses, it was observed that dropout could not be predicted by D^2, D'^2, or $D\mathfrak{d}^2$ statistics or by most therapist demographic data. When analyses of variance were computed exploring the relationships with the length of treatment (the number of sessions attended by the client), there was a surprising finding that the age of the therapist ($F = 6.42$, df = 1,45, $P < 0.01$) and the therapist's years of experience ($F = 5.58$, df = 1,45, $P = 0.02$) were predictive of early dropout from therapy. The surprising aspect was that it was the older, more experienced therapists who were more likely to have clients leave therapy prior to the twelfth session.

DISCUSSION

When therapists and clients are more similar in their modality orientation, there appears to be a concomitant improvement in psychotherapy outcome associated with this degree of similarity. Why might this be the case? Does similarity lead to the enhancement of rapport? Does similarity improve and clarify communication? Does similarity make it easier for the therapist to choose interventions that will be more helpful to the client?

It has already been demonstrated that there is a relationship between a therapist's modality structure and his or her adherence to a particular camp of psychotherapeutic thought.[22] And what is a treatment theory other than a template with which to make choices about technique selection?[39] It would therefore be considered apparent that the therapist's modality structure plays an important role in determining the psychotherapeutic techniques likely to be used. However, this study did not follow therapy process, only outcome, and thus this conclusion cannot be drawn from the results of this study.

Psychotherapy is an active process. Regardless of the therapist's philosophical orientation, it is the application of administered techniques that results in change and symptomatic relief. These techniques must be communicated and perceived in order for them to have any true efficacy. Techniques can be administered (and perceived) by only two means: verbally and behaviorally. Similarity of modality structure between therapists and clients has already been demonstrated to be an important predictor of the establishment of rapport in early psychotherapy.[23] Thus, even if therapists choose the same techniques and practice psychotherapy exactly the same regardless of their philosophical orientation, it appears that the techniques will be presented more clearly, be more "on target," and have a greater degree of efficacy when therapists and clients are more similar in their modality orientation. Frank[40] postulated that in order for psychotherapy to be effective, clients must perceive it as being effective. Because clients will be more likely to perceive and explain their own psychopathology in terms of their own modality functioning,[24] this would suggest that when clients and therapists are similar in their modality functioning, clients will perceive the psychotherapeutic interventions used as being more "on target" and thus more effective and pertinent in treating their issues. Even if more dissimilar therapists are able to eventually modify their delivery, or even if more dissimilar clients are able to eventually translate or make use of what they receive from their therapist, the loss of productive therapy time apparently takes its toll in attenuated outcome levels. Regardless of the mechanism underlying the process, modality similarity between therapists and clients does appear to have a positive effect on the effectiveness of psychotherapy outcome.

It therefore appears that when therapists and clients have similar modality structures, not only will session impact be experienced by

clients as more positive, arousing, engaging, and deep, but also clients will be likely to achieve a greater degree of symptomatic relief. There was some indication, based on the computed regression lines, that in the case of extreme dissimilarity, clients might even report increased symptoms after a course of psychotherapy. We would not expect this finding actually to be validated, since it is more likely that clients would probably terminate therapy (or be hospitalized) before worsening to the extent suggested by the regression line.

The results of this study suggest that despite the therapist's theoretical orientation, and regardless of the specific techniques employed in psychotherapy, the match between the therapist's and client's modality orientation will have significant implications for psychotherapy outcome. It was especially interesting to note that this phenomenon occurred regardless of the therapist's status as a student, or even his or her years of experience.

The conclusions of this study may seem to be somewhat attenuated and artificial because a measurement after 12 sessions was defined as "outcome." After all, this was not truly "outcome"—clients were not terminated or considered "cured" at the end of 12 sessions. The decision to collect "outcome" data after the twelfth session was driven mostly by the fact that most of the clinics at which data were collected had a 12-session limit on treatment. The results of this study may not give a picture of total symptom reduction at the "close" of therapy, but they do give a clear idea of the speed and efficiency with which symptom reduction may occur as a function of the therapist–client modality match. Other weaknesses of this study concern the small sample size and the fact that most clinicians were still in training. It may be difficult to fathom generalizing from a subject pool of 19 therapist–client pairs to the field of psychotherapy in general. However, it must be noted that even with the small sample size, the observed effect was quite robust.

Some brief discussion of the high dropout rate is appropriate. In some cases, subjects dropped out of the study because the clients dropped out of therapy. In other cases, subjects dropped out of the study because the client or therapist "forgot" to participate. In other cases, subjects dropped out of the study because treatment goals were met earlier than session 12. It was expected, given the work of Mendelson and Geller,[9] that therapist–client dissimilarity ($D\mathfrak{d}^2$ scores) would predict dropout rates. That these dropout rates could not be so predicted was a surprising finding and is not easily explainable.

It may be beneficial in future research to examine this finding with a larger sample size, or perhaps with specific, homogeneous subject populations. Such more detailed analyses and explorations may provide even more understanding of the phenomenon of therapist–client matching.

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REFERENCES

1. Paul GL: Strategy of outcome research in psychotherapy. Journal of Consulting Psychology 1967; 31:109–118
2. Norcross JC: All in the family? On therapeutic commonalities. Am Psychol 1981; 36:1544–1545
3. Lambert MJ: Implications of psychotherapy outcome research for eclectic psychotherapy, in Handbook of

Eclectic Psychotherapy, edited by Norcross JC. New York, Brunner/Mazel, 1986, pp 436–462
4. Smith ML, Glass GV, Miller TI: The Benefits of Psychotherapy. Baltimore, MD, Johns Hopkins University Press, 1980
5. Hunt DD, Carr JE, Dagadkis CS, et al: Cognitive match as a predictor of psychotherapy outcome. Psychotherapy 1985; 22:718–721
6. Foon AE: Locus of control and clients' expectations of psychotherapeutic outcome. Br J Clin Psychol 1986; 25:161–171
7. Dormaar M, Dijkman CIM, de Vries M: Consensus in patient–therapist interactions. Psychother Psychosom 1989; 51:69–76
8. Cummings AL, Martin J, Hallberg E, et al: Clients' and counselors' experiences of important events in counseling. Paper presented at the 99th annual convention of the American Psychological Association, San Francisco, CA, 1991
9. Mendelson GA, Geller MH: Similarity, missed sessions, and early termination. Journal of Counseling Psychology 1967; 14:210–215
10. Baron J, Baron JH, Barber JP, et al: Rational thinking as a goal of therapy. Journal of Cognitive Psychotherapy: An International Quarterly 1990; 4:293–302
11. Persons JB: The process of change in cognitive therapy: schema change or acquisition of compensatory skills? Cognitive Therapy and Research 1993; 2:123–137
12. Mahoney MJ, Norcross JC: Relationship styles and therapeutic choices: a commentary on the preceding four articles. Psychotherapy 1993; 30:423–426
13. Kemp D: Routenizing art: implications of research with the A-B scale for the practice of psychotherapy. Journal of the American College Health Association 1970; 18:238–240
14. Seidman E: A and B subject–therapists' responses to videotaped schizoid and neurotic prototypes. J Consult Clin Psychol 1971; 37:201–208
15. Beutler LE, Johnson DD, Neville C, et al: Accurate empathy and the A-B dichotomy. J Consult Clin Psychol 1972; 38:372–375
16. Green M: The effectiveness of A and B college males as interviewers, as response-biasers, and as verbal conditioners with schizophrenic and neurotic patients. Doctoral dissertation, University of Kentucky, Lexington, KY. Dissertation Abstracts International 1971; 33-02(B):0915
17. Razin A: The A-B variable: still promising after 20 years? In Effective Psychotherapy: A Handbook of Research, edited by Gurman A, Razin A. New York, Pergamon, 1978, pp 291–324
18. Beutler LE, Clarkin JF: Systematic Treatment Selection. New York, Brunner/Mazel, 1990
19. Lazarus AA: The Practice of Multimodal Therapy (updated edition). Baltimore, MD, Johns Hopkins University Press, 1989
20. DeRubeis RJ, Feeley M: Determinants of change in cognitive therapy for depression. Cognitive Therapy and Research 1990; 14:469–482
21. Crits-Cristoph P, Cooper A, Luborsky L: The accuracy of therapists' interpretations and the outcome of dynamic psychotherapy. J Consult Clin Psychol 1988; 56:490–495
22. Herman SM: Predicting psychotherapists' treatment theories by multimodal structural profile inventory responses: an exploratory study. Psychotherapy in Private Practice 1992; 11(2):85–100
23. Herman SM: Therapist–client similarity on the Multimodal Structural Profile Inventory as a predictor of early session impact. J Psychother Pract Res 1997; 6:139–144
24. Herman SM, Cave SK, Kooreman HE, et al: Predicting clients' perceptions of their symptomatology by Multimodal Structural Profile Inventory responses. Psychotherapy in Private Practice 1995; 14(1):23–33
25. Lazarus AA: The Practice of Multimodal Therapy. New York, Macmillan, 1981
26. Landes AA: Development of the Structural Profile Inventory. Psychotherapy in Private Practice 1991; 9(2):123–141
27. Herman SM: A demonstration of the validity of the Multimodal Structural Profile Inventory through a correlation with the vocational preference inventory. Psychotherapy in Private Practice 1992; 11(3):71–80
28. McConnaughy EA: The person of the therapist in psychotherapeutic practice. Psychotherapy 1987; 24:303–314
29. Lazarus AA: Tailoring the therapeutic relationship, or being an authentic chameleon. Psychotherapy 1993; 30:404–407
30. Rogers CR: Client-centered therapy, in American Handbook of Psychiatry, vol 3, edited by Arieti S. New York, NY, Basic Books, 1959, pp 183–200
31. Derogatis LR: Brief Symptom Inventory. Baltimore, MD, Clinical Psychometric Research, 1975
32. Derogatis LR, Melisaratos N: The Brief Symptom Inventory: an introductory report. Psychol Med 1983; 13:595–605
33. Derogatis LR, Rickels K, Rock AF: The SCL-90 and the MMPI: a step in the validation of a new self-report scale. Br J Psychiatry 1976; 128:280–289
34. Steer RA, Platt JJ, Rainert WF, et al: Relationships of

SCL-90 profiles to methadone patients' psychosocial characteristics and treatment response. Multivariate Experimental Clinical Research 1989; 9:45–54
35. Talley PF, Strupp HH, Morey LC: Matchmaking in psychotherapy: patient–therapist dimensions and their impact on outcome. Journal of Counseling and Clinical Psychology 1990; 58:182–188
36. Herman SM: The diagnostic utility of the Multimodal Structural Profile Inventory. Psychotherapy in Private Practice 1994; 13(3):55–62
37. Derogatis LR, Spencer PM: The Brief Symptom Inventory (BSI): Administration, Scoring and Procedures Manual, I. Baltimore, MD, Clinical Psychometric Research, 1982
38. Cronbach LJ, Glesser GC: Assessing similarity between profiles. Psychol Bull 1953; 50:456–473
39. Messer S: Behavioral and psychoanalytic perspectives at therapeutic choice points. Am Psychol 1986; 41:1261–1272
40. Frank JD: Persuasion and Healing: A Comparative Study of Psychotherapy (revised edition). Baltimore, MD, Johns Hopkins University Press, 1973

Insurance companies have commonly discriminated against the treatment of psychiatric illness. Although there has been some degree of parity regarding inpatient treatment (at least historically), very few insurance policies have customarily reimbursed outpatient psychiatric services at the same level that they reimburse outpatient nonpsychiatric medical treatment.[1] For many years, there has been a particular stigma attached to psychotherapy that appears to derive from several myths: 1) psychotherapy is not a real treatment; 2) psychotherapy is simply hand-holding that any nontrained professional could do; 3) there is no evidence supporting the efficacy of psychotherapy; and 4) if psychotherapy is available to the public as a component of a standard benefits package, "everyone" will use it and it will "break the bank."

Because of these perceptions, it has always been an uphill battle to arrange payment for psychotherapy through third parties. One of the strongest arguments in the many skirmishes associated with that battle has been the so-called cost-offset argument. In brief, this is the argument that expenditures on medical and surgical care will be reduced following the provision of outpatient psychiatric services, especially psychotherapy. The classic article featured in this issue of the Journal has been one of the most influential contributions to this argument. Mumford and her colleagues performed a meta-analysis of 58 controlled studies of the effects of outpatient psychotherapy on subsequent medical utilization. Eighty-five percent of those studies reported a decrease in medical utilization following psychotherapy. Of these studies, 26 were naturalistic time-series studies that compared medical care utilization before and after psychotherapy, with each individual serving as his or her own control. Thirty-two studies were experimental in design, using either random assignment or some matching scheme to place patients with specific treatment conditions. Twenty-two of those 32 studies examined the effects of the psychotherapeutic intervention on patients who were hospitalized for medical crises. In this subgroup, inpatient hospitalization was reduced approximately 1.5 days below the average of 8.7 days for the control group. Five of the studies provided data that permitted an unbiased examination of the effects of psychotherapy on inpatient as well as outpatient medical care utilization. The average change was a decrease in inpatient utilization of 73.4% and a decrease in outpatient utilization of 22.6%.

In this same report, the investigators examined the claims files of the Blue Cross and Blue Shield Federal Employee Program from 1974 through 1978. During that time period, 53% of federal employees were insured by this program, thus providing the largest fee-for-service database available. Examination of the group of subscribers that used mental health treatment compared with those who did not found a significant cost-offset effect, primarily from the lowering of inpatient medical charges for the mental health group. Another significant finding from this analysis was that about 1.5% of persons covered actually received some form of mental health services in any one year during the 5-year period.

In drawing their conclusions, the authors stressed that it is erroneous to assume that the reduction in medical services linked to psychotherapy is a result of keeping "the worried well" from having access to medical outpatient services. They stressed that individuals who receive mental health services are physically sicker and suffer from more chronic disease than people who do not use

psychiatric services. To assume that the impact of outpatient psychotherapy is simply a substitution of one outpatient service for another has no basis in the data.

Much has changed in the years since the appearance of this article. The cost-offset argument has fallen out of favor to a large extent. First, with the dramatic impact of managed care in reducing the length of hospital stays, the decrease in inpatient expenditures, which is where most of the savings lie in the cost-offset paradigm, is much less impressive. One of the most influential studies has been the Rand Health Insurance Experiment,[2] in which families at six sites in four states were randomly assigned to a variety of different health insurance plans with varying coinsurance rates. In this elegantly designed study involving 5,809 persons, no cost offset could be demonstrated for those who used mental health treatment. Although hospitalization was not included in the measurement of cost offset, the investigators also pointed out that since there was such small utilization of outpatient psychiatric services, it was difficult to show much of an impact of the treatment.

Another factor in the decline of the cost-offset argument has been the observation that in many cases the reduction in medical and surgical services cannot be demonstrated until the 12 months after the psychotherapy.[3] Government policymakers, managed care organizations, corporations, and insurance companies tend to plan only for a 12-month budget year. An offset that will occur in the next budget year may be of little interest. Another concern about the cost-offset argument is that it has the potential to trivialize the serious impairment associated with psychiatric disorders.[4] In other words, an assumption inherent in the notion of cost offset is that it makes good economic sense to provide insurance coverage for psychiatric treatments only because they can lower costs of medical treatments for illnesses that are more "real." The psychiatric suffering in and of itself is not viewed as worthy of the same investment as nonpsychiatric illnesses. In fact, at least one state legislature has even introduced a bill that stipulates that mental health treatments can be covered only insofar as they reduce the cost of other medical treatment.

The other aspect of the cost-offset argument that has been criticized is that it ignores the profound cost in disability and impaired work performance and the cost incurred in mortality stemming from mental illness. The current thinking today is that a much broader notion of cost-effectiveness needs to be taken into account when considering the impact of psychotherapy.[5] Direct costs related to the actual expenditures for delivery of the treatment are only one aspect of an economic assessment. The other aspect is indirect costs associated with problems on the job, disability, and loss of productivity related to the illness. There is also a shift away from emphasizing only cost while minimizing effectiveness.[6,7] In other words, within this paradigm there is often a small increase in direct treatment costs, but there may be quite a substantial payoff from that small investment because of the much greater improvement in the indirect costs. This conceptual model is in keeping with a movement in the health economics field to measure cost-effectiveness as involving all costs in the broadest frame of reference possible.

Recently, a panel of 13 scientists and scholars made consensus recommendations on cost-effectiveness analysis.[8] They stressed that the societal perspective

on cost-effectiveness must be the standard, not the narrow interests of an insurance company or managed care firm. They argued for a model of cost-effectiveness that "considers everyone affected by the intervention, and all health effects and costs that flow from it are counted, regardless of who had experienced them. Health effects include both benefits and harms, even when these occur in people who are not the intended recipients of the intervention. Resource costs include all resources used, whether or not money changes hands" (p. 1174).[8]

Research into the costs and benefits of mental health treatment continues actively, and this report by Mumford and colleagues paved the way for a variety of other studies that have demonstrated psychotherapy to be efficacious and cost-effective for many patients.[5]

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REFERENCES

1. Sharfstein SS, Stoline AM, Goldman HH: Psychiatric care and health insurance reform. Am J Psychiatry 1993; 150:7–18
2. Manning WG, Wells KG, Duan N, et al: How cost sharing affects the use of ambulatory mental health services. JAMA 1986; 256:1930–1934
3. Goldberg ID, Krantz G, Locke BZ: Effect of a short-term outpatient psychiatric benefit on the utilization of medical services in a prepaid group practice medical program. Med Care 1970; 8:419–428
4. Krupnick JL, Pincus HA: The cost-effectiveness of psychotherapy: a plan for research. Am J Psychiatry 1992; 149:1295–1305
5. Gabbard GO, Lazar SG, Hornberger J, et al: The economic impact of psychotherapy: a review. Am J Psychiatry 1997; 154:147–155
6. Clark RE: Searching for cost-effective mental health care. Harvard Review of Psychiatry 1996; 4:45–48
7. Wells KB, Sturm R: Care for depression in a changing environment. Health Aff 1995; 14:78–89
8. Russell LB, Gold MR, Siegel JE, et al: The role of cost-effectiveness analysis in health and medicine. JAMA 1996; 276:1172–1177

A New Look at Evidence About Reduced Cost of Medical Utilization Following Mental Health Treatment

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The literature on the phenomenon that the cost of outpatient psychotherapy may be offset by savings in medical expenditures began with a West German study of persons who had psychoanalysis or psychoanalytic psychotherapy and whose use of hospitalization for a 5-year period was less than that of a control group.[1] This study and the subsequent literature were reviewed by Jones and Vischi, who concluded that the effect of psychotherapy was to reduce

use of medical services by about 20%.[2] A meta-analysis of 15 controlled offset studies up to 1978 that included some reviewed by Jones and Vischi yielded an estimate of the cost-offset effect between 0% and 14%.[3] The range of estimates reflects methodologic flaws in many studies.

A meta-analysis of controlled studies of the effect of "psychologically informed intervention" on patients following heart attack or facing surgery showed that patients provided with information—about their condition, what to expect, and how to further recovery—or who were given emotional support did better than control subjects on most outcome indicators.[4] Thirteen of these experimental studies included days in hospital as an outcome indicator, and their combined results showed that psychologically treated patients were discharged about 2 days sooner than were persons not so treated. Devine and Cook, from a meta-analysis of 49 controlled experiments of the effects of psychoeducational interventions with surgical patients, reported 1.31 fewer hospital days for patients receiving mental health services than for patients provided only the usual medical management.[5]

Since our last review of the cost-offset literature in 1978, the number of controlled studies has increased to 58 suitable for meta-analysis.[1,6–62] It is feasible now to study the variables associated with reduced medical utilization following mental health treatment. A second resource, the massive fee-for-service research data base derived from the health insurance claims files of the Blue Cross and Blue Shield Federal Employees Program (FEP), provides a complementary perspective for studying the same variables. When we use these two large sets of data, each with special strengths that may compensate for weaknesses in the other, we can attempt to answer the same questions from two distinctly different perspectives.

Method 1: Meta-Analysis of the Cost-Offset Literature

Meta-analysis is a quantitative procedure for summarizing findings across studies.[4,63] It makes use of any of several summary statistics that convert diverse findings from individual studies to a common base that is free of scale.

To update our literature search we began with the comprehensive list of references provided by Jones.[64] We called Medlars and Index Medicus searches for January 1979 through July 1982, reviewed *Excerpta Medica* from January 1979 to July 1982, and obtained Automated Subject Citation Alert and PsycSCAN searches for cost-offset topics and key authors. We also searched *Dissertation Abstracts* and obtained microfilms of relevant entries. Finally, we surveyed reports from published lists of grants and contracts of government agencies and checked usable studies through *Citation Index* from 1979 to 1982. By May 1983 we had located 58 cost-offset studies suitable for meta-analysis (see Table 1). Of these, 27 were doctoral dissertations, unpublished government grant or contract reports, or reports from private industry. The relatively large portion of unpublished studies should alleviate the fear that meta-analysis of published studies may be biased by the generally positive results of studies that are published. Eighteen additional cost-offset studies were not included in the meta-analysis because the data provided were insufficient or the design was inadequate to assess the impact of mental health treatment on utilization of medical services.[65–83]

"A New Look at Evidence About Reduced Cost of Medical Utilization Following Mental Health Treatment," by Emily Mumford, Herbert J. Schlesinger, Gene V. Glass, Cathleen Patrick, and Timothy Cuerdon (*American Journal of Psychiatry* 1984; 141:1145–1158, copyright © 1984 American Psychiatric Association), is reprinted by permission. Introduction copyright © 1998 American Psychiatric Press, Inc.

RESULTS 1

General Cost-Offset Effects

Table 1 displays the characteristics and findings of the 58 studies of effects of outpatient psychotherapy on subsequent medical care utilization. The outcomes of all of the studies ranged from a 72.4% increase to –181.6% (decrease) in use of medical services following psychotherapy. Eighty-five percent of all of these studies reported a decrease in medical utilization following psychotherapy.

Twenty-six of these studies were naturalistic, time-series studies that compared persons' medical care utilization before and after psychotherapy. Each person served as his or her own control. Some of the studies also used comparison groups of persons who did not have psychotherapy. These studies did not assign patients to treatment groups randomly. Of the 26 time-series studies, all but six were conducted in prepaid clinic settings. This subset of studies yielded an average effect size of –33.10% (95% confidence interval is –57% to –20%). The weight of the findings from these 26 studies might be thought impressive considering that such naturalistic studies avoid the confounding problems of Hawthorne effects.[84] On the other hand, the studies are open to other challenges.

First, the meaning of results from most such time-series studies has been challenged because experimental and comparison groups were selected differently. The medical care utilization of experimental subjects was recorded on "relative time" before and after the time of first mental health treatment. But the utilization data of comparison subjects were collected before and after an arbitrarily selected date. We expect that utilization of medical services may rise before the individual's entry into mental health treatment as a function of the same sense of distress that eventuated in his or her seeking mental health care. Thus the pre-psychotherapy utilization of the experimental groups might represent a peak or near peak. The medical care utilization of the mental health-treated group would be expected to fall from its peak regardless of benefits from the psychotherapy, since what goes up, in statistics as in nature, must come down. In contrast, for the control group there would be no such expectation either for a rise or fall. Thus results favoring the experimental group over the control group might be explainable in terms of statistical regression to the mean.

Self-selection for psychotherapy is also frequently invoked as a reason to question the findings of naturalistic studies. Random assignment to treatments is a cornerstone of methods developed in the biological sciences. But since self-selection for psychotherapy might well be regarded as part of that treatment, new methods to provide a functional equivalent of random assignment are called for. In the meantime, rather than simply dismissing the results of such a large number of studies, one can view the potential biasing effects of self-selection as an empirical matter to be settled by data.

Thirty-two studies were experimental in design, assigning patients to treatment conditions either randomly or through some matching scheme. Of these, 22 experiments determined the effects of psychological intervention on patients hospitalized for medical crises, with patients assigned randomly to a group receiving relevant information, emotional support, or both, or to a comparison group receiving only the standard medical regimen.

Analyzing only these 22 studies that are not vulnerable to bias resulting from self-selection or misinterpretation of the phenomenon regarding regression to the mean, we find that on the average these modest psychological interventions reduced inpatient hospitalization approximately 1.5 days below the control groups' average of 8.7 days. This effect is in the same direction as, although slightly smaller than, our earlier finding of about 2 days on the basis of 13 studies.[4]

In a comparison of the outcome measures of these 22 experimental studies that used random assignment to treatments with

the 26 time-series studies in which patients had selected psychotherapy, the studies using random assignment yielded an average percent change of –10.4%. The 26 studies relying on self-selection yielded an average percent change of –33.1%. The offset effect is smaller when self-selection is ruled out by random assignment, but it appears both under conditions of random assignment and with self-selection of treatment. Devine and Cook[5] performed a similar test in their meta-analysis of cost-offset effects of mental health treatment among surgical patients and concluded that the method of subject assignment was not systematically related to the size of estimates of effect.

Outcome Indicators: Outpatient Versus Inpatient Medical Utilization

Of the 48 estimates of the effects of mental health treatment on outpatient medical utilization, only five came from experimental studies. Of the 71 estimates of the effect of mental health treatment on inpatient utilization 62 came from experimental studies. The question is hopelessly confounded with study methodology and must be approached in a different way.

Five studies[20,23,46,55,57] provided data that permit an unconfounded examination of the effects of psychotherapy on inpatient as well as outpatient medical care utilization. In all but one, the reduction in inpatient medical utilization exceeded the reduction in outpatient utilization. The average change was –73.4% for inpatient utilization and –22.6% for outpatient utilization. Only one study[20] was an exception to this pattern. If one assumes that these five studies were drawn from a population of studies for which it is hypothesized that there is a 0.50 probability of inpatient utilization being reduced more than outpatient utilization, then the four "successes" (inpatient reduction greater than outpatient) in five "trials" have a probability less than 0.10 of being equaled or exceeded under the hypothesis.

These five studies have strengths and weaknesses that are complementary. On balance they permit the conclusion that the offset effect is likely to be greater for inpatient medical care utilization than for outpatient utilization. As we shall see, analysis of insurance claims will strengthen this impression.

Age of Patients as a Mediating Factor in Cost-Offset Effects

Most of the cost-offset studies did not report findings by age of patient; we found only two cost-offset studies of older people that were suitable for meta-analysis.[29,39] Neither of these dealt with outpatient psychotherapy, possibly reflecting a misleading bias that older patients do not profit from outpatient psychotherapy. There are, of course, many case reports and studies of positive benefits of mental health treatment for geriatric patients. For example, Godbole and Verinis[67] compared the effects of two forms of psychotherapy in a study of 61 hospitalized patients and reported benefits for both treatment groups as assessed by improvement in rating forms completed by nursing staff and author/therapists.

National statistics show the same trend as the research literature. In 1980 persons age 65 years and older constituted 11% of the population and accounted for 29% of all health expenditures.[85] Yet they received a disproportionately small portion (2% to 4%) of outpatient mental health services.[86] These figures suggest underutilization of mental health services by this age group. Older people may be less likely than other age groups to be referred for mental health treatment, although their needs may be greater and benefits would seem to be significant.

Levitan and Kornfeld[39] provided psychiatric consultation to 24 elderly patients hospitalized for fractured femur and compared their hospital stays with those of a comparison group of 26 patients hospitalized for the same reason without psychiatric intervention in the same months of the previous year

in the same hospital. Length of stay for the intervention group was 12 days shorter than the mean of 42 days for the control group, and twice as many of the patients who had been provided consultation returned home rather than being discharged to a nursing home or otherinstitution.

Hill[29] studied 40 cataract surgery patients between the ages of 50 and 91 years. They were randomly assigned to a behavioral training group, a sensory information training group, a combined behavioral and sensory training group, or a comparison group that received no special preparation. We would not expect important differences in length of stay, since the mean hospital stay for all four groups of patients was only a little over 3 days. However, a second outcome variable—first venture from home after discharge—did show significant differences in the expected direction. The "combined" group ventured out soonest from home, and both other treatment groups ventured out sooner than the comparison group.

Since we could find only two studies that directly addressed the impact of age on the offset effect, we measured its impact indirectly through meta-analysis of the 23 studies that did report the mean age of subjects. In 15 inpatient studies the mean age of the patients was 48.14 years, and the correlation between the mean age listed in each study and the effect size was –0.44, indicating that older subjects benefit more. In four outpatient studies that used visits to the doctor as the outcome measure, the mean age of the patients was 30.53 years, and the correlation between mean age and effect size was –0.31. In four alcohol outpatient studies the mean age of the clients was 35.8 years, and the correlation between mean age and effect size was –0.78. Thus in three different settings with three different populations a consistent finding emerges: Older people tend to have greater offset effects following mental health treatment.

Method 2: Analysis of Health Insurance Claims Files

The claims files of the Blue Cross and Blue Shield FEP from 1974 through 1978 contain the medical care charges for a national sample of 6.7 million federal employees, retirees, survivors, and family members. About 53% of all federal employees were insured by FEP during these years, providing the largest fee-for-service data base available. The procedures for transforming the claims files to research files are described elsewhere.[87] About 1.5% of persons covered received some form of mental health services in any 1 year during the 5-year period, or about 3.9% during the 5 years. This proportion is consistent with other reports that 1% to 1.8% of general medical patients receive psychiatric treatment in a 1-year period.[88,89]

Previous work[87] has shown a dose-response relationship for psychotherapy and medical care utilization, with a cost-offset effect becoming clear after about six psychotherapy visits. In the present study, therefore, we examined the medical utilization of a group of persons who had at least seven outpatient mental health treatment visits beginning in 1975 but no psychiatric inpatient claims at any time. We compared their medical care utilization with that of a randomly selected subset of persons who filed no mental health claims throughout the 5 years of the data base. Each person in both groups was drawn from a contract that was active from 1974 through 1978 and was required to have at least one medical claim of any size in 1975 to enter the study. The data thus represent persons who made at least minimal use of medical care services. About 19% of contracts filed no claims during the 5 years. To ensure that differences in death rates would not bias the results, each person over age 55 had to have at least one claim of any kind in 1978, the last year of the data base.

This method of comparison avoids capitalizing on statistical regression to the mean,

since both groups were compared on calendar time and had the same requirement to enter the study, a medical claim in 1975. We were thus able to compare the medical care utilization of the two groups for 1 year before the year of the entry requirement and for 3 years following it, which is also the year in which each person in the treatment group began a first episode of outpatient psychotherapy with or without drugs.

RESULTS 2

Evidence of General Cost-Offset Effects

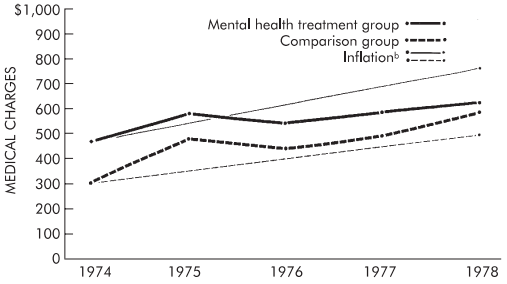
Figure 1 shows that in 1974, the year before the start of mental health treatment, the medical charges for the treatment group were markedly higher than those for the comparison group, a finding consistent with the literature that suggests excess morbidity from physical disease among the mentally ill[90,91] and our earlier findings.[87] The medical charges of both groups rose in 1975 in part as an artifact of selection—each person was required to have at least one medical claim in that year. The medical care charges of both groups then fell in 1976 and rose again at a slower rate from 1976 to 1978. Following mental health treatment, the medical care charges of the treatment group increased more slowly than the average inflation rate of 13.6% per year. In contrast, the charges of the comparison group increased faster than the inflation rate. If we adjust the means for 1975–1978 for the difference between the groups in 1974, the adjusted means of the treatment group were significantly lower than those of the comparison group during each of these 4 years ($t = -3.21, -2.44, -2.69$, and -3.77, respectively, $P < 0.05$).

The treatment group was younger than the comparison group (33.6 years versus 39.4 years) and contained more females (59.6% versus 53.2%). Since use of medical services increases with age, is higher for females, and varies geographically, it is possible that differences in utilization favoring the mental health group could be explained by these variables. Therefore we adjusted the means of the mental health treatment and comparison groups for age, sex, and regional differences by the method of unweighted means analysis.[92] Removing the "nuisance variables" in this way did not alter the general form of the findings. The adjusted means were different, but the pattern of differences was not affected. Therefore the following analyses will be based on actual means whose meanings are perhaps intuitively easier to grasp.

Cost-Offset Effects in Claims Files: Outpatient Versus Inpatient Medical Utilization

Figure 2 compares the outpatient and inpatient medical care charges of the persons whose total medical charges were graphed in Figure 1. Outpatient charges include physician office visits, outpatient laboratory charges, and prescription drugs. Inpatient charges include all medical charges incurred while the patient was hospitalized, e.g., hospital bed, physician fees, and other charges billed separately during

FIGURE 1. Total medical charges of persons with seven or more outpatient mental health treatment visits from 1974 through 1978 but no inpatient psychiatric claims ($N = 6,629$) and a random sample of persons with no mental health treatment claims ($N = 32,450$).[a]



[a]All persons were required to have at least one medical claim in 1975, and those over age 55 at least one claim in 1978.
[b]The inflation rate was 13.6%/year.

the hospitalization.

It is clear that in every year the mental health group spent more in outpatient charges than the comparison group. The curves are nearly parallel. After adjustment of the means for 1975 through 1978 for differences between the two groups in 1974, the only significant difference between them occurred in 1975 and favored the comparison group. The mean inpatient medical care charges of the mental health group were also higher than those of the comparison group in 1974. But in 1978 they were lower, and in the intervening years they were nearly indistinguishable. After adjustment of the means for differences in 1974, the mental health group had significantly lower inpatient medical care charges in every subsequent year. The cost-offset effect that we saw in adjusted total medical charges was primarily the result of a lowering of inpatient medical charges for the mental health group.

Cost-Offset Effects in Claims Files as Mediated by Patients' Age

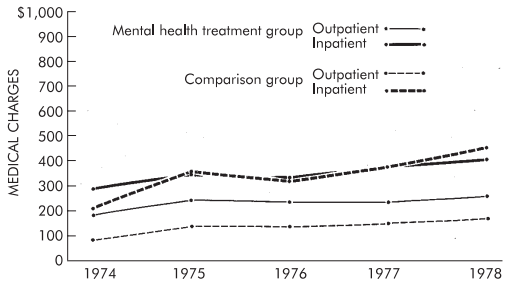
An examination of the cost-offset effect for narrow age subsets is complicated by the necessarily small sizes of these groups and the high variances characteristic of medical claims data. Since most persons obtain medical care only occasionally, claims data consist mostly of zero entries. Claims generally range from a few dollars to several hundred dollars, with a few much larger entries. In small groups, a single person with extraordinarily high medical claims can increase the variance considerably and complicate the interpretation of differences among group means. We can avoid this problem by removing the extreme cases, defined as persons with total medical charges over $20,000 in a single year, from both the mental health and comparison groups.

Removing the extreme cases from both groups lowered the mean of each group by only a few dollars and reduced the size of both groups by only 0.4%. Thus variance and standard errors were minimized without altering the general form of the findings.

To emphasize the relative differences in medical care utilization of age subsets, Figure 3 displays differences between the mean inpatient medical charges of the treatment group and the comparison group for four age groups. Figure 4 presents the same differences for outpatient medical utilization. Negative differences (below the zero line) indicate that the treatment group had lower charges than the comparison group. A falling curve, whether above or below the zero difference line, indicates a cost-offset effect. Graphing differences in this way removes the inflation component, since it affects both groups equally.

A comparison of figures 3 and 4 shows that the cost-offset effects seen for total medical charges resulted largely from lowered inpatient medical charges. Further, the oldest age group among the mental health treatment persons, those over 55, clearly showed the most dramatic decrease in hospital charges; in 1974 they had average inpatient medical charges more than $160 higher than those of the comparison group. In 1978 they were spending $70 less. This finding cannot be explained by selective dropout, since all persons in the oldest age groups were required to have at least one

FIGURE 2. Inpatient and outpatient medical charges for persons with at least seven outpatient mental health treatment visits from 1975 through 1978 but no inpatient psychiatric claims ($N = 6,629$) and a random sample of persons with no mental health treatment claims ($N = 32,450$).[a]



[a]See footnote a in Figure 1.

claim in 1978.

Figure 4 shows that the differences in outpatient medical charges of all the age groups remained fairly constant over the 5 years and that the expenditures of the mental health group were higher in every year than those of the comparison group. The slight dips in the curve of the oldest age group reflect the fact that those over age 55 in the mental health treatment group had significantly lower outpatient charges in 1975 and 1977 ($t = -4.31$ and -1.99, respectively, $P < 0.05$).

These findings for fee-for-service health insurance subscribers are generally in accord with findings derived from our meta-analyses of studies done in organized medical care settings and hospitals using both experimental and time-series methods.

DISCUSSION

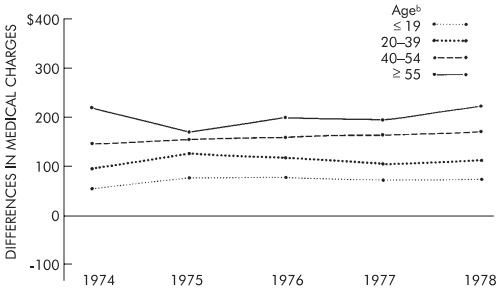
Retrospective analysis of health insurance claims data and meta-analyses of time-series studies and prospective controlled experimental studies converge to provide evidence of a general cost-offset effect following outpatient psychotherapy. The widespread and persistent evidence of reduced rate of increase of medical expense following mental health treatment argues for the inseparability of mind and body in health care, and it also argues specifically for the likelihood that mental health treatment may improve patients' ability to stay healthy enough to avoid hospital admission for physical illness.

The clearest cost-offset effect appears largely in the reduction of inpatient rather than outpatient costs. As we noted in an earlier study,[87] inpatient charges account for 75% of total medical charges and substantial savings would have to result from reduced hospitalization. Older patients show larger cost-offset effects than younger ones. These findings could be surprising to anyone believing that mental health treatment is necessarily more effective for younger than older people. The findings could also be surprising if one had assumed that reduction of medical services associated with

FIGURE 3. Differences in mean inpatient charges for four age groups of persons with at least seven mental health treatment visits from 1974 through 1978 but no inpatient psychiatric claims and a random sample of persons with no mental health treatment claims.[a]

[a]See footnote a in Figure 1. Persons with total medical charges exceeding $20,000 in any one year were excluded.
[b]The sample sizes for the mental health treatment and comparison groups were as follows: 19 years or younger, 1,746 and 8,183, respectively; 20–39 years, 2,387 and 7,521; 40–54 years, 1,871 and 10,363; and 55 or older, 595 and 6,252.

FIGURE 4. Differences in mean outpatient medical charges for four age groups of persons with at least seven mental health treatment visits from 1974 through 1978 but no inpatient psychiatric claims and a random sample of persons with no mental health treatment claims.[a]



[a]See footnote a in Figure 1. Persons with total medical charges exceeding $20,000 in any one year were excluded.
[b]See footnote b in Figure 3.

psychotherapy is a function of keeping "the worried well" from "cluttering outpatient services." We have presented more detailed evidence elsewhere to show that recipients of mental health services suffer more chronic disease and are physically sicker than people who do not use psychiatric services.[3,87,93] The effects of outpatient mental health treatment cannot be explained as simple substitution of one outpatient service for another.

Older people generally use more medical services and more expensive inpatient services, leaving more room for cost reductions. But other factors may also contribute. Many older people have special mental health needs following emotionally distressing events such as suffering physical disease; experiencing loss of friends, spouse, social status, or income; being victims of crime; or being forced to relocate. The 1975 Harris survey showed that 8% of the respondents 65 and older said they had no close person to talk to, compared with 5% of the respondents under 65.[94] Older men and women often have multiple social problems and more than one chronic disease or disability. Yet on average they are seen for a shorter period of time by their doctors during outpatient visits.[95] Older people may also be in jeopardy because their lives lack the structure of a daily work routine and the supportive social networks associated with employment. The older patient—even if voluble about physical symptoms or peeves—may not volunteer much about emotional distress to a much younger physician, who also may not inquire about such problems when examining an elderly patient. Such a situation is not promising for early detection of need for mental health intervention, nor is it optimal for active cooperation between patient and physician in the effective management of chronic illness that would minimize need for hospitalization.

In view of the needs of the older population, planned psychological intervention may have special advantages. Provision of mental health services to older people could serve to shore up flagging determination to follow medical advice and to stay healthy and socially engaged. Evidence from one study of patient education and support for hypertensive patients reported that the special program had a more positive influence on compliance among elderly than among young patients.[96]

In view of the evidence from the literature and from our studies of health insurance claims, underutilization of mental health services by the elderly may result in needless suffering among the elderly and needless cost to society.

REFERENCES

1. Duehrssen A, Jorswiek E: An empirical and statistical inquiry into the therapeutic potential of psychoanalytic treatment. Der Nervenarzt 1965; 36:166–169
2. Jones KR, Vischi TR: Impact of alcohol, drug abuse and mental health treatment on medical care utilization. Med Care 1979; 17(Dec suppl)
3. Mumford E, Schlesinger HJ, Glass GV: A Critical Review and Indexed Bibliography of the Literature up to 1978 on the Effects of Psychotherapy on Medical Utilization. Report to NIMH, Contract NIMH-MH-77-0049. Rockville, MD, NIMH, 1978
4. Mumford E, Schlesinger HJ, Glass GV: The effects of psychological intervention on recovery from surgery and heart attacks: an analysis of the literature. Am J Public Health 1982; 72:141–151
5. Devine EL, Cook TD: A meta-analytic analysis of effects of psychoeducational interventions on length of post-surgical hospital stay. Nurs Res 1983; 32:267–274
6. Andrew JM: Recovery from surgery, with and without preparatory instruction, for three coping styles. J Pers Soc Psychol 1970; 15:223–226
7. Archuleta V, Plummer OB, Hopkins KD: A Demonstration Model for Patient Education: A Model for the Project "Training Nurses to Improve Patient Education": Project Report. Boulder, CO, Western Interstate Commission for Higher Education, June 1977
8. Budd S, Brown W: Effect of a reorientation technique on postcardiotomy delirium. Nurs Res 1974; 23:341–348
9. Budman SH, Wertlieb D, Budman S, et al: Maximizing the offset of medical utilization via psychological services: a strategy for intervention. Cambridge, MA, Harvard Community Health Plan, 1979
10. Budman SH, Demby A, Randall M: Psychotherapeutic Outcome and Reduction in Medical Utilization: A Cautionary Tale. Cambridge, MA, Harvard Community Health Plan, 1980
11. Christopherson B, Pfeiffer C: Varying the timing of

information to alter pre-operative anxiety and post-operative recovery in cardiac surgery patients. Heart Lung 1980; 9:854–861
12. Cohen F: Psychological preparation, coping and recovery from surgery (doctoral dissertation). Dissertation Abstracts International 1976; 37:454B
13. Davis HS: The role of a crisis intervention treatment in the patient's recovery from elective surgery (doctoral dissertation). Dissertation Abstracts International 1973; 36:3490B
14. Delong RD: Individual differences in patterns of anxiety arousal, stress-relevant information and recovery from surgery (doctoral dissertation). Dissertation Abstracts International 1971; 32:554B
15. Edwards D, Bucky S, Coben P, et al: Primary and secondary benefits from treatment for alcoholism. Am J Psychiatry 1977; 134:682–683
16. Egbert LD, Battit GE, Welch CE, et al: Reduction of postoperative pain by encouragement and instruction of patients. N Engl J Med 1964; 270:825–827
17. Felitti VJ: Diagnosis in Large Populations. San Diego, CA, Kaiser Permanente, 1980
18. Felton G, Huss K, Payne EA, et al: Preoperative nursing intervention with the patient for surgery: outcomes of three alternative approaches. Int J Nurs Stud 1976; 13:83–96
19. Florell JL: Crisis intervention in orthopedic surgery (doctoral dissertation). Dissertation Abstracts International 1971; 32:3633B
20. Follette WT, Cummings NA: Psychiatric services and medical utilization in a prepaid health plan setting. Med Care 1967; 5:25–35
21. Fortin F, Kirouac S: A randomized controlled trial of preoperative patient education. Int J Nurs Stud 1976; 13:11–24
22. Goldberg ID, Krantz G, Locke BZ: Effect of a short-term outpatient psychiatric therapy benefit on the utilization of medical services in a pre-paid group practice medical program. Med Care 1970; 8:419–428
23. Goldberg ID, Allen G, Kessler L, et al: Utilization of medical services after short-term psychiatric therapy in a pre-paid health plan setting. Med Care 1981; 19:272–286
24. Goldensohn SS, Fink R: Mental health services for Medicaid enrollees in a prepaid group practice plan. Am J Psychiatry 1979; 136:160–164
25. Graves RL, Hastrup J: Effects of psychological treatment on medical utilization in a multi-disciplinary health clinic for low income minority children. Dallas, TX, University of Texas Health Science Center, 1978
26. Gruen W: Effects of brief psychotherapy during the hospitalization period on the recovery process in heart attacks. J Consult Clin Psychol 1975; 43:223–232
27. Hankin JR, Steinwachs DM, Elkes C: The impact on utilization of a copayment increase for ambulatory psychiatric care. Med Care 1980; 18:807–815
28. Hart RR: Recovery of open heart surgery patients as a function of a taped hypnotic induction procedure (doctoral dissertation). Dissertation Abstracts International 1975; 36:5259B
29. Hill BJ: Sensory information, behavioral instructions and coping with sensory alteration surgery (doctoral dissertation). Dissertation Abstracts International 1979; 40:2381B
30. Hitchcock LS: Improving recovery from surgery: the interaction of preoperative interventions, coping processes and personality variables (doctoral dissertation). Austin, TX, University of Texas Department of Psychology, 1982
31. Jacobson JM, O'Rourke PJ, Wolf AE: Impact of a diabetes teaching program on health care trends in an Air Force medical center. Milit Med 1983; 148:46–47
32. Jameson J, Shuman LJ, Young WW: The effects of outpatient psychiatric utilization on the costs of providing third-party coverage. Med Care 1978; 16:383–399
33. Johnson JE, Rice VH, Fuller SS, et al: Sensory information, instruction in a coping strategy and recovery from surgery. Res Nurs Health 1978; 1:4–17
34. Johnson JE, Fuller SS, Endress MP, et al: Altering patients' responses to surgery: an extension and replication. Res Nurs Health 1978; 1:111–121
35. Kennecott Copper Corporation: Insight: A Program for Troubled People. Salt Lake City, UT, Utah Copper Division, 1970
36. Kessler L: Episodes of psychiatric care and medical utilization (doctoral dissertation). Baltimore, Johns Hopkins University School of Hygiene and Public Health, 1978
37. Kogan WS, Thompson DJ, Brown JR, et al: Impact on integration of mental health service and comprehensive medical care. Med Care 1975; 13:934–942
38. Langer EJ, Janis II, Wolfer JA: Reduction of psychological stress in surgical patients. Journal of Experimental Social Psychology 1975; 11:155–165
39. Levitan SJ, Kornfeld DS: Clinical and cost benefits of liaison psychiatry. Am J Psychiatry 1981; 138:790–793
40. Lindeman CA, Stetzer SL: Effects of preoperative visits by operating room nurses. Nurs Res 1973; 22:4–16
41. Lindeman CA, Van Aernam B: Nursing intervention with the presurgical patient: the effects of structured and unstructured preoperative teaching. Nurs Res 1971; 20:319–332
42. Longobardi PG: The impact of a brief psychological intervention on medical care utilization in an army health care setting. Med Care 1981; 19:665–671
43. Lucas RH: The affective and medical effects of different preoperative interventions with heart surgery patients (doctoral dissertation). Dissertation Abstracts International 1976; 36:5763B
44. Lunn CR: Remarks at the Ontario Blue Cross Symposium on Alcoholism in Industry. Toronto, Ontario, Blue Cross, 1976
45. McHugh JP, Kahn MW, Heiman E: Relationships between mental health treatment and medical utilization among low-income Mexican-American patients: some preliminary findings. Med Care 1977; 15:439–444
46. Mechanic D, Cleary PD, Greenley JR: Distress syndromes, illness behavior, access to care and medical utilization in a defined population. Med Care 1982; 20:361–372

47. Olbrisch ME: Evaluation of a stress management program for high utilizers of a pre-paid university health service. Med Care 1981; 19:153–159
48. Olendzki MC: Health Services Utilization and Cost Pre- and Post-Mental Health Treatment in Organized Fee-For-Service Health Care Settings. Report to NIMH, Contract 278-80-0010(DB). Rockville, MD, NIMH, 1982
49. Ortmeyer JA: Anxiety and repression coping styles and treatment approaches in the integration of elective orthopedic surgical stress (doctoral dissertation). Dissertation Abstracts International 1978; 38:5536A
50. Patterson DY, Bise B: Report Pursuant to Contract 282-77-0219-MS. Report to NIMH. Rockville, MD, NIMH, 1978
51. Pickett C: Locus of control and intervention strategies with surgical patients (doctoral dissertation). Dissertation Abstracts International 1979; 40:2381B
52. Plotnick DE, Adams KM, Hunter HR, et al: Alcoholism Treatment Programs Within Prepaid Group Practice HMO's: A Final Report. Rockville, MD, National Institute on Alcohol Abuse and Alcoholism, 1982
53. Regier DA, Goldberg ID, Burns BJ, et al: Epidemiological and health services research findings in four organized health/mental health settings. Presented at the ADAMHA Health Maintenance Organization Conference. Rockville, MD, ADAMHA, 1977
54. Risser NL, Strong A, Bither S: The effect of an experimental teaching program on post-operative ventilatory function: a self-critique. West J Nurs Res 1980; 2:484–500
55. Rosen JC, Wiens AN: Changes in medical problems and utilization of medical services following psychological intervention. Am Psychol 1979; 34:420–431
56. Schmitt FE, Woolridge PJ: Psychological preparation of surgical patients. Nurs Res 1973; 22:108–115
57. Sherman RM, Reiff S, Forsythe AB: Utilization of medical services by alcoholics participating in an outpatient treatment program. Alcoholism 1979; 3:115–120
58. Smith JC: The effects of the provision of psychotherapy on medical utilization in a pre-paid student health center (doctoral dissertation). Boulder, CO, University of Colorado Department of Education, 1980
59. Surman OS, Hackett TP, Silverberg EL, et al: Usefulness of psychiatric intervention in patients undergoing cardiac surgery. Arch Gen Psychiatry 1974; 30:830–835
60. Uris JS: Effects of Mental Health Utilization and Diagnosis on General Medical Care Utilization in a Prepaid Clinic Setting. Boulder, CO, Western Interstate Commission for Higher Education, 1974
61. Van Steenhouse AL: A comparison of three types of pre-surgical psychological intervention with male open heart surgery patients (doctoral dissertation). Dissertation Abstracts International 1978; 39:1449A
62. Wilson JF: Determinants of recovery from surgery: pre-operative instruction, relaxation training and defensive structure (doctoral dissertation). Dissertation Abstracts International 1977; 38:1476B
63. Glass GV, McCaw B, Smith ML: Meta-analysis in Social Research. Beverly Hills, CA, Sage, 1981
64. Jones KR (ed): Report of a Conference on the Impact of Alcohol, Drug Abuse and Mental Health Treatment on Medical Care Utilization: Publication (ADM) 81-1180. Bethesda, MD, Department of Health and Human Services, 1980
65. Abbott MM: Consequences of short term psychotherapy with wives of first myocardial infarction patients (doctoral dissertation). San Diego, CA, California School of Professional Psychology, 1979
66. Diehr P, Williams SJ, Shortell SM, et al: The relationship between utilization of mental health and somatic health services among low income enrollees in two provider plans. Med Care 1979; 17:932–952
67. Godbole A, Verinis JS: Brief psychotherapy in the treatment of emotional disorders in physically ill geriatric patients. Gerontologist 1974; 14:143–148
68. Harrington RL: Systems Approach to Mental Health Care in a HMO Model. NIMH Grant MH-24109, Final Report. Rockville, MD, NIMH, 1981
69. Hayami DE, Freeborn DK: Effect of coverage on use of an HMO alcoholism treatment program, outcome, and medical care utilization. Am J Public Health 1981; 71:1133–1143
70. Healy KM: Does preoperative instruction make a difference? Am J Nurs 1968; 68:62–67
71. Hegyvary ST, Chamings PA: The hospital setting and patient care outcomes. J Nurs Adm 1975; 5:29–32, 36–42
72. Hoeper E: Observations on the impact of psychiatric disorder upon primary medical care, in Mental Health Services in General Health Care, vol 1: Institute of Medicine Publication 70-004. Washington, DC, National Academy of Sciences, 1979
73. Holder HD, Hallen JB: A Study of Health Insurance Coverage for Alcoholism for California State Employees: Third Year Experience Summary: Report RP0228. Rockville, MD, National Institute on Alcohol Abuse and Alcoholism, 1978
74. Johns M, Boras KW, Harrison J, et al: Benefit-Cost Analysis of Alcoholism Treatment Centers. Prepared by the JWK International Corporation, Annandale, VA, for the National Institute on Alcohol Abuse and Alcoholism, Contract ADM 281-75-0031. Rockville, MD, NIAAA, 1976
75. Johnson BA, Johnson JE, Dumas RG: Research in nursing practice: the problem of uncontrolled situational variables. Nurs Res 1970; 19:337–342
76. Johnson JE, Dobbs JM, Leventhal H: Psychosocial factors in the welfare of surgical patients. Nurs Res 1970; 19:18–29
77. Johnson JE, Hill VH: Sensory and distress components of pain. Nurs Res 1974; 23:203–209
78. Kogan WS, Thompson DJ, Brown JR, et al: Impact of integration of mental health service and comprehensive medical care. Med Care 1975; 13:936–942
79. Koulouch FT: Role of suggestion in surgical convalescence. Arch Surg 1962; 85:144–155
80. Lindeman CA: Nursing intervention with the presur-

gical patient. Nurs Res 1972; 21:196–208
81. Norfleet MA, Burnell GM: Utilization of medical services by psychiatric patients. Hosp Community Psychiatry 1981; 32:198–200
82. Patterson V, Levene H, Breger L: A one-year follow-up of two forms of brief psychotherapy. Am J Psychother 1977; 21:76–82
83. Sclare AB, Balfour MB, Crocket JA: Group psychotherapy in bronchial asthma. J Psychosom Res 1957; 2:157–171
84. Roethlisberger F, Dickson W: Management and the Worker. Cambridge, MA, Harvard University Press, 1939
85. Department of Health and Human Services: Health, United States, 1981. Hyattsville, MD, Office of Health Research, Statistics and Technology, 1981
86. Glasscote RM, Gudeman JE, Mills DG: Creative Mental Health Services for the Elderly. Washington, DC, Joint Information Service of the American Psychiatric Association and the Mental Health Association, 1977
87. Schlesinger HJ, Mumford E, Glass GV, et al: Mental health treatment and medical care utilization in a fee-for-service system: outpatient mental health treatment following the onset of a chronic disease. Am J Public Health 1983; 73:422–429
88. Locke B, Krantz G, Kramer M: Psychiatric need and demand in a pre-paid group practice program. Am J Public Health 1966; 56:895–904
89. Fink R, Goldensohn S, Shapiro S, et al: Treatment of patients designated by family doctors as having emotional problems. Am J Public Health 1967; 57:1550–1564
90. Innes G, Millar WM: Mortality among psychiatric patients. Scott Med J 1970; 15:143–148
91. Babigian HM, Odoroff CL: The mortality experience of a population with psychiatric illness. Am J Psychiatry 1969; 126:470–480
92. Glass GV, Stanley JC: Statistical Methods in Education and Psychology. Englewood Cliffs, NJ, Prentice-Hall, 1970
93. Schlesinger HJ, Mumford E, Glass GV: Mental health services and medical utilization, in Psychotherapy: From Practice to Research to Policy, edited by Vandenbos G. Beverly Hills, CA, Sage, 1980
94. Harris L and associates: The Myths and Reality of Aging in America. Washington, DC, National Council on Aging, 1975
95. Keeler EB, Solomon DH, Beck JL, et al: Effect of patient age on duration of medical encounters with doctors. Med Care 1982; 20:1101–1108
96. Morisky DE, Levine DM, Green LW, et al: Health education program effects on the management of hypertension in the elderly. Arch Intern Med 1982; 142:1835–1838

Book Reviews

Treatment Outcomes in Psychotherapy and Psychiatric Interventions

By Len Sperry, Peter Brill, Kenneth Howard, and Grant Grissom
New York, Brunner/Mazel, 1996, 236 pages, ISBN 0-87630-826-4, $27.95

Reviewed by K. Roy MacKenzie, M.D.

Cost-effectiveness of treatment approaches is a preoccupation of clinical practice today. The skeptic would say that in practice this means a preoccupation with cost and a passing curtsey to effectiveness. Psychotherapy finds itself somewhat at risk in this environment because of the popular notion that most people who seek and receive psychotherapy are not that critically ill and probably get too much treatment even if they are. In response to these pressures there has been a major effort to document accountability through the use of formal measures of outcome. Paul Fink, in his foreword to this book, puts it this way: "Outcome studies are the most critical path to destigmatizing mental illness and bringing more individuals who require help into the care system."

The most common way of describing the tension between effectiveness and cost is in terms of the dose-response curve that looks at outcome in relationship to the number of sessions. The researcher who has probably done most to popularize this measure is Ken Howard, one of the authors of this book.[1] Howard was one of the founders of the Society of Psychotherapy Research, now a thriving international organization. Somewhat paradoxically, the managed care industry is implementing programs today that are based on findings from the outcome literature that date back many years. It comes as a shock to many clinicians to learn that the current trend toward time-limited formats is actually in keeping with a well-documented understanding of the dose-response curve.[2]

The first section of the book provides a succinct survey of the paradigm shift that has occurred in regard to the interface between treatment decisions by the clinician and clinical outcome. This overview begins with an attempt to understand why formal research endeavors have failed to provide clinically useful answers. In short, this section addresses the difference between efficacy (as measured in formal controlled randomized studies) and effectiveness (as measured by studying results in a regular clinical setting).

The point is also effectively made that simple pre/post measures are inadequate for providing an informed opinion on the process of change. A strong case is made for sequential measures of clinical status that follow a predictable course.[3] The authors suggest that a shift is required from generic treatment to prescriptive treatment. The latter requires that clinicians be able to draw on a spectrum of treatment models and choose or combine among them on the basis of a careful multidimensional assessment.

The second section addresses five specific aspects of a behavioral health service system that have strategic importance in service utilization and clinical outcome. The first focus is on *outpatient psychotherapy.* Examples are presented from instruments the authors have developed that provide a multidimensional measurement of change. Clinical examples are provided of patients who have better or worse outcomes and how tracking of sequential changes might be used to predict outcome. This notion of in-treatment feedback to the clinician is a fundamental and important aspect of the system. Expected change curves can be used to assess a given patient's response in comparison to a large sample with similar characteristics and problems. These change curves can also be used to compare treatment models, treatment sites, and individual clinicians.

Another chapter is devoted to the complex task of measuring change in an *inpatient population.* This is an important challenge given the high pressure to move patients

quickly out of the hospital into less intensive care areas. Although somewhat technical, this chapter is important reading for any clinician operating within an inpatient facility environment. The authors critique some current measurement instruments and propose one of their own that is still under development.

A similar review is provided of the measurement challenges in *substance abuse* treatment programs. Once again the authors dissect the problems that have to be addressed and provide some thoughtful solutions, although these solutions are at an earlier stage of development. Substance abuse is another major contributor to the use of intensive clinical resources, and therefore there is a high payoff for maximizing cost-effectiveness of clinical services.

The final two chapters deal with advantages of *combined treatment* with psychotherapy and medications and with treatment within a *primary care setting*. The tone shifts in these chapters to deal more with "best practices" ideas with a view to selection of the most appropriate treatment model and the prevention of relapse. This material provides a useful perspective for both the clinician and the administrator and highlights the importance of how a service is organized in promoting consistent quality of care. The material is geared toward the role of mental health services within a medical setting. This is an important orientation because of the likelihood of behavioral health carve-out organizations being integrated into general medical service structures.

In addition, the book cites numerous examples of the use of *group psychotherapy* formats for the treatment of common disorders. This is likely to be an important area of change, with group becoming the default mode for many psychological treatments.[4] The authors note both the effectiveness of groups and their acceptability if introduced properly.

The examples provided in the book are drawn from the COMPASS data system developed by the authors. Thus, other sources would be required for a more comprehensive guide to possible measurement tools.[5,6] It is also useful for the reader to bear in mind that the techniques being described are still in the early stages of development. For example, the exact shape of the dose-response curve is controversial, although there is general agreement that about 75% of patients entering the mental health service system are improved by the 6-month point.[7] The hope of accurate prediction of what sort of patient will respond to what sort of treatment in what time frame remains to be confirmed. Nevertheless, the goal of achieving greater uniformity and accuracy through the use of outcome data remains worth pursuing.

Well written by experts and innovators in the field of measurement in health care settings, this book goes well beyond psychotherapy programs in its attention to broader service system design. The authors' expertise is evident in their ability to home in on core issues quickly. They have provided an informed overview of how clinical programs are being expected to merge outcome information with service system design. This should be mandatory reading for clinicians and administrators alike.

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REFERENCES

1. Howard KI, Kopta SM, Krause MS, et al: The dose-effect relationship in psychotherapy. Am Psychol 1986; 41:159–164
2. Lambert MJ, Bergin AE: The effectiveness of psychotherapy, in Handbook of Psychotherapy and Behavior Change, 4th edition, edited by Bergin AE, Garfield SL. New York, Wiley, 1994, pp 143–189
3. Howard KL, Lueger RJ, Maling MS, et al: A phase model of psychotherapy: causal mediation of outcome. J Consult Clin Psychol 1993; 61:678–685
4. MacKenzie KR: Time-Managed Group Psychotherapy: Effective Clinical Applications. Washington, DC, American Psychiatric Press, 1997
5. Ogles BM, Lambert MJ, Masters KS: Assessing Outcome in Clinical Practice. Boston, Allyn and Bacon, 1996

6. Lyons JS, Howard KI, O'Mahoney MT, et al: The Measurement and Management of Clinical Outcomes in Mental Health. New York, Wiley, 1997
7. Kopta SM, Howard KL, Lowry JL, et al: Patterns of symptomatic recovery in time-unlimited psychotherapy. J Consult Clin Psychol 1994; 62:1009–1016

Textbook of Psychoanalysis

Edited by Edward Nersessian and Richard G. Kopff, Jr.
Washington, DC, American Psychiatric Press, 1996, 726 pages, ISBN 0-88048-507-8, $110.00

Reviewed by Arnold D. Tobin, M.D.

This large volume promises much, and, remarkably, it manages to deliver on much of that promise. It is indeed a comprehensive textbook on psychoanalysis, organized in five sections: the theories of the mind, psychopathology, treatment, research, and special problems. The authors include a group of renowned analysts and teachers. The orientation is clinical and classical.

The problems of an edited textbook are well addressed. As could be expected, the material is not integrated, since the authors were given free rein in presenting their topics. The editors have pulled all of the material together with excellent introductory statements as well as a superb introduction to the book itself. In fact, it would be well worth the time just to read what the editors presented. In their material, they have also addressed the issue of readership and broadened the base so that there is something for anyone at any level of analytic sophistication, from beginning student to fully trained analyst. They have also shared with us the problems of putting together such a textbook.

The rest of the book has much to recommend it as well. The first section, on theories of the mind, includes chapters by Arlow and Rangell. Both give a clear presentation of classical analysis (my orientation). These first chapters, with the editors' introduction, prepare the reader for what is to come.

Grotstein's article on object relations presents an excellent overview as he bridges from classical analysis to "classical" object relations. He does so by sacrificing the newer ideas to a fuller explication of the whole field of object relations, which results in a very readable historical perspective. He includes a quick rundown of the important object relations theorists at the end of the chapter. The article on self psychology, standing by itself, is far from adequate in presenting that point of view, but it serves as an introduction. I would have preferred more of the early ideas of Kohut, which for me form the basis of self psychology and would again give the historical/developmental perspective. Both of these chapters make up for what they lack by presenting the important ideas and their proponents.

The section on the theory of psychopathology again is well introduced. Brenner's article sets the tone; his ideas are presented impressively and in his own special way. Here, as throughout the book, each chapter's purpose has been allowed to shape the form and to some extent the content, which makes the reading more interesting.

The article on neuroses I found to be too ambitious, trying to cover too much ground. The use of cases, while good, would be more effective if the original cases of Freud had been included at some length to demonstrate the dynamics. The intent was for each author to present Freud by using that author's own material and perspectives. I would argue that more use should be made of Freud throughout the book, but especially in this chapter. These cases should be well known to everyone interested in the field, and thus they should be not only included, but presented as central.

The chapter on character disorders written by the editors is a gem. Along with their introduction, it gives a clear overview of the section. The next three chapters share an orientation and present comprehensive overviews of their subjects—the borderline syndrome, depression, and schizophrenia. They do an admirable job of including the main ideas in a historical format. The results are

very understandable explications—just what a textbook should provide. I had trouble with the chapter on sexuality, but this reflects the current state of confusion about that topic. The same was true of the last chapter, which is on the psychoanalytic interface with psychosomatics.

In the section on treatment, again well introduced, an outstanding article by DeWald holds the section together. He covers the field, and we finally are given some of the basic concepts that underlie classical analysis. In this chapter are included many of the important concepts that one needs to understand psychoanalytic therapy. The concepts have arrived a little late in the book, but not too late. Should this chapter come earlier, or be referred to earlier? In any event, the reader is finally fully informed by this remarkably well-organized chapter. The reader should make sure to read DeWald's chaper, along with the introductions referred to above, even if all else is omitted. The other articles in this section take up various aspects of treatment, including the combination of psychoanalytic therapy with other modalities so important these days. The chapter on technique I found too idiosyncratic for my taste. The last, on termination, was very good and straightforward.

The last two sections were a dropoff. The articles on research reflect the present state of affairs: psychoanalysis simply does not know what to do in this area, and the book cannot make up for that—or can it? Maybe simply an overview presenting the problems of research in our area would do better. The way the topic is presented, one is left with the nakedness of our inadequacy, which may be for the best after all. The final section on special issues is introduced by the editors honestly: they note that it is really a section to introduce the issues of reevaluation and reassessment and that its purpose is to point the way toward the future.

What is left out of this textbook also needs consideration. Societal problems are referred to via a discussion on trauma in the last chapter but are not taken up in detail. It is unfortunate that an area like criminality and delinquency is left out, since psychoanalysis has given us so much understanding in this area. The same is true for the interface between the arts and analysis. That is a very important area in the academic scene, where Freud and psychoanalysis are alive and well. The same is true in the many academic areas involving the study of humans in groups, such as anthropology.

Child analysis as such is omitted. Here, I agree with the editors. That part of the field is in trouble and lacks clear direction. It is a problematic area best avoided for the present. There are many references to child development, however, and that is an area that might be augmented in the future.

Another consideration is that this book represents American and to some extent British psychoanalysis. In my experience with analysts from around the world, I have been impressed by the greater use that is made elsewhere of Klein, Bion, Foucault, and Lacan, and not Kohut or some of our other gurus. But then, this is an American book, and we do not have to lead/colonize the world—or do we need to simply recognize them more?

I see this book as one in process. We should all feel free to offer suggestions and help refine articles and the issues that the book addresses. For me the book is excellent, showing the strengths of psychoanalysis as well as the weaknesses. And the most glaring weakness is the lack of the original spirit of a crusade. We may have lost that—but since that excitement now exists in the academic setting, let us now turn around and borrow it back and present it in the future as part of us.

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In Appreciation of Our Reviewers (2)

The list of reviewers that appeared in the Fall 1997 issue was incomplete. Here is the full list, along with our thanks to the peer reviewers for their outstanding efforts on behalf of the Journal during its sixth year of publication. We continue to receive expressions of gratitude from authors about the thoroughness and helpfulness of our peer review process.

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