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A STUDY DEMONSTRATING EFFICACY OF A PSYCHOANALYTIC PSYCHOTHERAPY FOR PANIC DISORDER: IMPLICATIONS FOR PSYCHOANALYTIC RESEARCH, THEORY, AND PRACTICE

Systematic research on psychoanalytic treatments has been limited by several factors, including a belief that clinical experience can demonstrate the effectiveness of psychoanalysis, rendering systematic research unnecessary, the view that psychoanalytic research would be difficult or impossible to accomplish, and a concern that research would distort the treatment being delivered. In recent years, however, many psychoanalysts have recognized the necessity of research in order to obtain a more balanced assessment of the role of psychodynamic psychotherapy and psychoanalysis in a contemporary treatment armamentarium, as well as to allow appropriate evaluation and potentially greater acceptance by the broader mental health and medical communities. In this context, studies were conducted of a psychodynamic treatment, Panic-Focused Psychodynamic Psychotherapy (PFPP), initially in an open trial and then in a randomized controlled trial (RCT) in comparison with a less active treatment, Applied Relaxation Training (ART; Cerny et al. 1984), for adults with primary DSM-IV panic disorder. The results of the RCT demonstrated the

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efficacy of PFPP in treating panic disorder, and also demonstrated that a psychoanalytic treatment can be systematically evaluated in a mode consistent with the principles of evidence-based medicine. Two specific features of the methodology, the development of the treatment manual and the operationalization of the adherence instrument, both core building blocks of contemporary psychotherapy outcome research, and their implications for psychoanalytic research are discussed in greater depth. The theoretical, clinical, and educational implications of the PFPP studies are elaborated, and suggestions are made for pursuing further outcome research of psychoanalytic treatments.

Research on the efficacy of psychoanalysis and psychodynamic psychotherapies has been very limited. There have been few randomized controlled trials (RCTs) of reliably reproducible (i.e., operationalized in manual form) psychoanalytic treatments for specific DSM-IV disorders or for other operationally well-defined symptom constellations (Leichsenring 2005; Leichsenring, Rabung, and Leibing 2004; Clarkin et al. 2004, 2007; Svartberg, Stiles, and Seltzer 2004). RCTs, which assess the efficacy of a specific treatment in comparison to a placebo or less active treatment, are the sine qua non of current evidence-based medical research. In contrast to psychoanalytic treatments, pharmacological interventions (Stein, Lerer, and Stahl 2005) and nonpsychoanalytic psychotherapies, including cognitive behavioral therapy and interpersonal psychotherapy, have demonstrated efficacy for a number of psychiatric disorders across multiple clinical trials (Gabbard et al. 2005). Some psychoanalysts have argued that RCTs have limited value for psychoanalytic research, as they are more difficult to implement with longer-term treatments that address a broad range of problems, such as characterological difficulties (Blatt 2001; Westen, Novotny, and Thompson-Brenner 2004).

Because of the lack of a research base, psychoanalysts have witnessed the gradual marginalization of psychoanalytic forms of therapy in treatment guidelines, such as those for depression (American Psychiatric Association 2000) and panic disorder (American Psychiatric Association 1998), and in psychology training programs and psychiatric residency education. In this context, Kernberg (2006a) has described several reasons to pursue research: "first of all, the scientific need to reassess and advance our knowledge; second, our social responsibility to reassure the public regarding the effectiveness of psychoanalysis and the psychoanalytically based psychotherapies we are developing, and to demonstrate

our ongoing efforts to increase the range and efficacy of these treatments" (p. 919). In addition, pressure has been mounting from medical and psychological practitioners who look askance at the lack of evidence supporting psychoanalytic treatments.

There are various reasons that such studies have been difficult to accomplish, including a belief among many psychoanalysts that psychoanalytic treatments have already adequately demonstrated effectiveness based on clinical experience (Busch 2006; Kernberg 2006b), a widespread view that psychoanalytic concepts and interventions are too complex to study in a systematic manner (Green 1996, 2000), and concerns that research protocols are disruptive of psychoanalytic treatments (Busch et al. 2001).

In addition, psychoanalysts have believed that analytic treatments cannot be manualized and that adherence cannot be assessed. Manuals function to operationally describe a treatment that can be reliably reproduced. Adherence rating scales can demonstrate whether the treatment described in the manual is in fact being delivered. Psychoanalysts have predicted that manualized treatments would constrict psychoanalysts in their therapeutic approach, reducing the effectiveness of the treatment (Blatt 2001). The limited research available does not support this concern. Vinnars et al. (2005) compared a manualized, time-limited supportive-expressive psychotherapy with a nonmanualized, community-delivered psychodynamic psychotherapy for the treatment of patients with personality disorder diagnoses. The authors did not find a significant difference in outcome between the two treatment conditions, and both led to reductions in the number of patients who met the criteria for personality disorder diagnoses, and in the severity of personality disorders and psychiatric symptoms. The manualization of longer-term treatments, including psychoanalysis, is a more daunting task.

Despite these concerns, the potential value of pursuing psychoanalytic research has increasingly been recognized (Fonagy 2003; Fonagy, Roth, and Higgitt 2005; Gabbard, Gunderson, and Fonagy 2002). Systematic studies can help determine for whom psychoanalytic treatments work (e.g., which types of patients with which disorders) and which therapeutic elements make the treatments most effective. Research of this kind can provide essential feedback to clinicians and help them improve outcomes. Systematic studies have the potential to settle questions about theory and clinical approaches that thus far have been debated only on the basis of authority, guild allegiance, and the exigencies of clinical experience

(Shedler 2006). Finally, the manualization of psychoanalytic treatments can allow for scientifically credible, reliably reproducible treatments that can be compared with other psychiatric and psychotherapeutic approaches, in order to help determine the relative utility of psychoanalytic treatments in today's therapeutic armamentarium. The studies of Panic-Focused Psychoanalytic Psychotherapy described below provide a demonstration of the value of such research.

STUDIES OF PANIC-FOCUSED PSYCHODYNAMIC PSYCHOTHERAPY (PFPP)

The PFPP studies, an open clinical trial and a randomized controlled trial, were conducted from 1997 to 2005 at Weill Cornell Medical College, using therapists who were Ph.D. psychologists or M.D.s after psychiatric residency, all of whom completed at least three years of psychoanalytic training in New York City area APsaA-approved psychoanalytic training programs. Although the therapists in the studies reported here were all psychoanalysts, therapists without psychoanalytic training have since learned PFPP, have participated in a subsequent study, and have been able to conduct the treatment well.

Therapist Training

All study therapists were given a twelve-hour therapist training course that focused on how to conduct PFPP in accord with the treatment manual. Initial cases were closely supervised. Monthly group supervisory meetings were held that included discussion of particular cases, with review of videotapes. All the therapists availed themselves of additional, individual supervision.

Description of Studies and Results

This research group initially conducted an open clinical trial of PFPP between 1997 and 2000 at Weill Cornell Medical College (Milrod et al. 2000, 2001). The open trial was not an efficacy study, as there was no comparison condition, but was designed to determine whether PFPP could be reliably delivered, and to assess its effects on patients with panic disorder. Twenty-one patients with primary DSM-IV panic disorder signed informed written consent forms and were treated with twenty-four sessions of PFPP over twelve weeks. No concurrent treatments were permitted

during this clinical trial, and patients who presented on ineffective anti-panic medications (i.e., who met symptomatic study entrance criteria while taking pharmacological agents) were tapered off of their medication regimens in order to gain access to the study. Four patients dropped out, and at termination sixteen of the remaining seventeen met "response" criteria (Barlow et al. 2000), a greater than 40 percent reduction in the Panic Disorder Severity Scale (PDSS; Shear et al. 1997). In addition to a significant reduction in symptoms of panic disorder, the patients demonstrated significant improvement in measures of psychosocial function, anxiety unrelated to panic, and depression. Notably, comorbid major depression, present in eight of twenty-one patients, remitted with PFPP as well. Clinical improvements were maintained at six-month follow-up, without intervening treatment.

Following the open trial, our group proceeded with a randomized controlled trial (Milrod et al. 2007) in which PFPP was compared with a less active psychotherapy, applied relaxation training (ART), to assess efficacy. RCTs are the gold standard for assessment of treatment efficacy, as subjects are randomly assigned to treatment and comparison groups, and both groups are treated identically except for the treatment intervention being studied (in this case PFPP vs. ART). Observed changes in symptoms after treatment can be reliably attributed to the effect of the studied intervention, rather than to possible population effects. Pill placebo is not an apt comparison for a psychotherapy, as it would not control for the time and attention patients receive. Particularly with anxious patients, it is important to determine whether they improve simply as a result of the therapist's care and attention, rather than as a result of the specific therapeutic intervention—hence the need for a comparison psychotherapy group.

ART was chosen as a comparison therapy because it has been shown to be a credible and efficacious treatment for panic disorder (Öst and Westling 1995), yet it is less efficacious than CBT (Beck et al. 1994; Craske, Brown, and Barlow 1991). CBT is not an apt initial comparison therapy because if the treatments were found to be equally effective, it would be difficult to determine whether both treatments were efficacious, or if the population studied was particularly responsive to treatment. Head-to-head trials of therapies presumed to be equally active, such as CBT and PFPP, require enough subjects to provide the statistical power to distinguish between the two therapies, each with a high response rate.

Because of the high response rates expected with CBT and PFPP, the number of subjects needed would be unfeasibly large. Therefore, an initial assessment of efficacy compared with ART was necessary before comparison of PFPP with CBT. As described below, PFPP was found to be more efficacious than ART in forty-nine subjects with primary DSM-IV panic disorder. The next step, comparing CBT with PFPP, must either be appropriately powered, or must also include a less active comparison condition to adequately determine the efficacy of the more active treatments. A study comparing CBT, PFPP, and ART in 233 subjects at two sites is currently under way.

ART begins with a three-session explanation/psychoeducation about panic disorder, and provides a treatment rationale. ART uses progressive muscle relaxation techniques in which attention is focused on particular muscle groups, with tension and relaxation practiced alternately. Home practice is required twice daily. By the sixth week, subjects apply relaxation skills to anxiety situations outside the office setting in a graduated manner.

In the efficacy study, treatments were designed to match in number and frequency of sessions and in the degree of therapist experience, making this treatment trial a conservative one, less likely to show differences between treatment conditions. Nonetheless, a significantly greater reduction in a broad range of panic symptoms was observed after PFPP, compared with ART, as assessed by the Panic Disorder Severity Scale, the primary outcome measure. Using the a priori definition of "response" (Barlow et al. 2000), PFPP demonstrated a significantly higher rate of response compared with ART: 73% vs. 39% ($p = .017$). PFPP also led to significantly greater improvement in psychosocial function, as measured on the Sheehan Disability Scale (SDS; Sheehan 1983): $p = .014$. The SDS is a self-report instrument using a visual analog scale in which the patient rates himself from 0 (not at all impaired) to 10 (extremely impaired) by symptoms in each of three areas: work or school, social life, and family life/home responsibilities.

DEVELOPMENT OF A TREATMENT MANUAL

Work on the PFPP manual was preceded by the development of a psychodynamic formulation of panic disorder (Busch et al. 1991; Shear et al. 1993; Milrod 1995), around which the PFPP (Milrod, Cooper, and Shapiro 1997) manual was constructed. The formulation incorporated the work of psychoanalytic theorists and clinicians (e.g., Freud 1926; Deutsch 1929),

as well as information derived from psychological studies of patients with panic disorder—e.g., parental perceptions, premorbid personality traits, defense mechanisms (Arrindell et al. 1983; Parker 1979; Kleiner and Marshall 1987; Busch et al. 1995). The formulation was informed by the authors' clinical experience, by a comprehensive psychoanalytic literature review of cases of panic disorder treated psychoanalytically (Milrod and Shear 1991), and by a series of psychodynamic videotaped interviews that were systematically assessed for the presence or absence of factors hypothesized to be relevant to panic (Busch et al. 1991; Shear et al. 1993). In the interviews, patients reported meaningful stressors preceding panic onset that were typically linked to childhood experiences and represented a threat to important attachments. They described their parents as variously temperamental, critical, frightening, demanding, and controlling, and they reported difficulty acknowledging and expressing angry feelings. Based on these clinical observations and studies, a formulation was developed that outlines a series of dynamics central to panic disorder (Milrod et al. 1997), including ambivalence about autonomy and dependency, fear of anger disrupting needed attachments, narcissistic humiliation surrounding panic, ego deficiencies, and sexual conflicts.

In developing the manual, a central goal was to maintain the essential features of a psychoanalytic treatment (free association, elucidating unconscious meanings and conflict, developmental exploration, interpretation, use of the transference) with adequate flexibility, while focusing on the specific underlying meanings of symptoms of panic disorder. For this purpose, cases were reviewed to delineate clinical approaches that the authors used in their own psychoanalytic treatment of panic disorder patients. An open-ended exploratory effort to unravel the unconscious, symbolic meanings of panic symptoms and unconscious conflicted fantasies was emphasized. Throughout the text, case vignettes with specific descriptions of therapy dialogue were employed to illustrate the treatment.

An example of how the manual guides the treatment without recommending verbatim interventions can be found in the description of the defense of "undoing," which is considered an important mechanism whereby many panic patients modulate conflicted anger: "Undoing serves a similar purpose to reaction formation: to reassure the patient (and the individual on whom he or she feels dependent) that any negative affect that becomes conscious or is expressed has been retracted or disavowed. The use of undoing presents an opportunity for therapists to point

out to patients how negative affects often must be disavowed immediately. This awareness can help patients acknowledge the intensity of their discomfort with the feelings they are tentatively expressing" (Milrod et al. 1997, p. 49). This description is then followed by a brief case vignette to provide an example of addressing this defense: "Ms. K . . . frequently used the defense mechanism of undoing. Patient: I got to where I really hated my husband—and believe me, I really love him. Therapist: I notice that whenever you describe your anger at your husband, you then say how much you love him. It's as if you reassuring yourself. Patient: Yes, you've mentioned that pattern before, and now I'm beginning to see what you mean. I guess I'm less comfortable with my anger at him than I thought I was" (pp. 49–50).

The authors identified approximate phases in the treatments that were used to structure the manual. Phase 1 involves initial exploration of circumstances and feelings surrounding panic, functioning much like some of Freud's descriptions of his exploratory approach in treating patients with conversion disorder (Breuer and Freud 1895). Phase 2 involves determination of specific dynamics underlying panic, which includes aspects of exploration of the transference. Phase 3 consists of a careful focus on response and reactions to termination. The manual describes, as Freud (Breuer and Freud 1895) did, that focusing on psychiatric symptoms, as opposed to the more contemporary psychoanalytic focus on character, can provide a wealth of information about patients' unconscious lives, and can be a fruitful route to understanding the patient. The manual allows for pursuit of a broad range of individual dynamics, including but not limited to the dynamics summarized in the general formulation above. It illustrates how individual sets of dynamics and defense mechanisms can contribute to the onset and continuation of panic disorder, and contains descriptions of psychodynamic techniques and approaches to these dynamics. The manual describes how these dynamics and defenses emerge in the transference and how the transference can be employed in the treatment of panic patients.

After the first draft of the manual was formulated, it was given to four psychoanalysts, all experts in treating anxiety, who had not been involved in its creation, for comment in an effort to ensure that the manual captured the way psychoanalysts in fact treat patients with panic disorder. All four felt the manual closely approximated their own psychoanalytic clinical work, suggesting that operationalizing these approaches need not create a rigid or nonpsychoanalytic treatment.

Adherence Rating

Adherence rating instruments are essential tools in contemporary psychotherapy outcome research (Gerber et al. 2006). They provide concrete demonstration that treating clinicians are actually delivering the treatment being studied. In the absence of a well-operationalized adherence rating protocol, therapists may inadvertently be conducting a treatment different from the one being studied, ultimately confusing outcome results. Critics of psychoanalytic research have cast doubt on the possibility of operationalizing psychoanalytic interventions in a way that allows adherence to be measured (see Green 1996). Successful adherence rating entails the development of a simple, operationalized description of psychoanalytic psychotherapy, the use of which allows independent raters to obtain similar results when rating the same session (see below). To accomplish this, specific essential components of the therapy must be clearly articulated.

On the PFPP adherence scale, it was necessary to have items differentiating psychoanalytic psychotherapeutic approaches from other psychotherapies. In nonpsychoanalytically based psychotherapies, therapists have preset agendas that determine the content of the session. In psychoanalytic psychotherapy, the therapist necessarily permits the patient to guide the session by following the patient's themes and associations.

It was also necessary to differentiate PFPP from open-ended, non-panic-focused psychoanalytic psychotherapy. Thus, one of the features captured by the PFPP adherence scale is that when the patient pursues topics other than anxiety and panic, the therapist brings the patient back to panic disorder and its associated dynamics. Based on our clinical experience, we consider this focus on panic symptoms to be a crucial component of what makes PFPP effective, though this has not been systematically assessed. The scale item reads as follows: "Relating intervening, seemingly unrelated concerns to the dynamisms connected to panic and anxiety. When the patient pursues topics other than anxiety and panic, the therapist eventually relates the information back to the dynamisms (conflictual issues, such as difficulties with separation or becoming angry) that have been identified as being central to the patient's panic disorder or episodic experiences of anxiety." Lower ratings are given to therapists who pursue patients' free associations and fail to bring the patient back to discussing panic dynamics. Another item is designed to assess whether the dynamics central to panic disorder are addressed by the therapist.

In the PFPP studies, assessment of adherence with this well-operationalized scale demonstrated excellent interrater reliability (ICC

[intraclass correlation coefficient] = .92), indicating that independent raters assessing the same sessions or therapeutic treatment obtain very similar results. The ICC is a measure of the degree of agreement among raters. The scale is so clearly articulated that it has been successfully used with the same ICCs by master's-level clinicians. Most of the study therapists have easily met adherence standards (Milrod et al. 2007).

Impact of the Manual and Adherence Rating on Research Psychoanalysts

The psychoanalytic therapists in our study initially expressed concern over whether use of a manual would limit their flexibility and whether they could meet adherence standards (Busch et al. 2001). However, once they were engaged in study therapies, their clinical impression was that neither manualization nor adherence standards were disruptive of the psychoanalytic psychotherapeutic process. Thus, while this question was not systematically studied, the "music" of the treatment did not appear to be impaired by use of a manual. These therapists had also expressed discomfort about the need to focus on panic symptoms and dynamics throughout the treatment, but grew increasingly impressed with the therapeutic power of this approach. Their concern about meeting adherence standards eased as their treatments were found in fact to have a high degree of adherence.

Despite their initial concerns, the therapists regarded their participation in the study in a positive light. Indeed, many experienced a research "cathexis," an intensity of focus on their work that they felt improved their treatments. Jimenez (2007) similarly noted gains for clinicians involved in research, including a "new empirical attitude," "greater conceptual clarity," and a "freedom to think with patients about the technical interventions best suited to helping them" (p. 662). Videotapes provided a valuable tool for group supervisory meetings. The presence of a videotaped record prevented the distortion of cases by therapists' "secondary revisions." For example, Bailey et al. (1998) found that supposedly exhaustive process notes taken from sessions that were also tape-recordred contained only a third of the material, with a greater rate of omission of the analyst's comments (Bucci 2001).

IMPLICATIONS OF THE STUDY RESULTS

The demonstration of efficacy of a psychoanalytic psychotherapy for a DSM-IV Axis I disorder in a scientifically credible randomized controlled trial, along with the effective use of a manual and adherence ratings, has

major implications for psychoanalysis and psychiatry. Opponents of psychoanalytic research must recognize that psychoanalytic treatments can be subjected to rigorous outcome research, just like other psychiatric treatments, while adherents of evidence-based medicine must recognize that psychoanalytic treatment is efficacious with panic disorder. Further studies should be conducted to determine which problems are amenable to psychoanalytic treatments, and what factors make these treatments effective for whom. In addition, comparisons with other psychiatric treatments, including cost-benefit analyses, will be essential.

THEORETICAL AND CLINICAL IMPLICATIONS

The PFPP efficacy study provides guidance on some clinical debates among psychoanalysts that is more compelling than clinical opinion or individual experience. For example, many analysts believe that brief treatments are less likely to be effective, because there is limited opportunity for working through conflicts or interpreting transference (Malan 1963). Few analysts, however, have studied time-limited psychotherapies.

Our study found that a course of twenty-four sessions of PFPP was effective in treating panic disorder and improving psychosocial function. In the course of their PFPP therapies, patients addressed intensely negative affect states within and without the transference, as well as conflicted feelings and fantasies. Our clinical impression is that time-limited psychoanalytic psychotherapy may have intensified the transference, potentially leading to more rapid symptomatic gains. Although brief psychotherapy limits the exploration of conflicts, this does not detract from the utility of this approach for these patients. Maintenance of treatment gains, as demonstrated by follow-up data after six months without treatment—see the PFPP open clinical trial (Milrod et al. 2001)—suggests that positive outcomes were not simply connected with an ongoing relationship with the therapist, or with avoidance of negative transferences.

Psychoanalytic clinical lore also argues against the utility of manualized and symptom-focused treatments, as they might disrupt the free-associative process, a technical mainstay of psychoanalytic therapy. Yet in our studies, symptom focus may have contributed to panic relief, though this was not specifically evaluated. The manualized approach allowed therapists to explore various aspects of the dynamic underpinnings of panic attacks, to develop an increasingly clear formulation of the dynamics, and to share this with the patient in a much more focused manner than they would have in a

non-symptom-focused therapy. Free association and the monitoring of associations remained central treatment tools. Ultimately, many aspects of free associations were usefully and meaningfully connected to symptoms of panic disorder, as well as to superficially less related conflicts and symptoms. To assess whether symptom focus is important to outcome, however, a systematic study would be required, comparing non-symptom-focused psychodynamic psychotherapy with PFPP.

Some psychoanalysts argue that the demonstration of efficacy for psychodynamic psychotherapeutic treatments adds to the scientific legitimacy of related techniques and to the practice of psychoanalysis (Busch 2006; Kernberg 2007). Others (Rutherford et al. 2007) have expressed concern that studies of focused psychodynamic psychotherapies. absent adequate studies of psychoanalysis itself, are inimical to the latter, as demonstrations of efficacy may further steer patients in the direction of brief focused treatments and away from psychoanalysis. Thus, research efforts should eventually be directed toward determining the indications and relative utility of both the psychodynamic psychotherapies and psychoanalysis.

FUTURE DIRECTIONS FOR PSYCHOANALYTIC RESEARCH

An understanding of the appropriate place of manualized treatments and efficacy trials, as utilized in the PFPP studies, other psychoanalytic efficacy studies of DSM-IV disorders (Clarkin et al. 2007), and nonpsychoanalytic psychotherapy outcome studies, can suggest future directions for psychoanalytic research. Possibilities might include (1) further development and testing of manualized treatments of psychoanalytic therapies and psychoanalysis for clearly defined psychiatric syndromes and disorders and (2) comparison of manualized psychoanalytic treatments with other psychotherapeutic treatments, as well as psychopharmacological approaches.

Testing Manualized Treatments of Psychoanalysis and Psychoanalytic Psychotherapies

The psychoanalytic field offers a variety of generally nonoperationalized treatments, including psychoanalysis and psychoanalytic psychotherapy. Nonetheless, the field has suffered from a "one size fits all" conception of clinical utility, in which psychoanalysis has been viewed as the gold standard for the treatment of almost every psychiatric and psychological difficulty, and psychodynamic psychotherapy has been viewed as a lesser

treatment, also across psychopathology. Further development of syndrome- or disorder-focused manualized psychoanalytic psychotherapies, like PFPP, is crucial if we are to evaluate, as we must, the relative utility of psychoanalytic treatments in specific clinical circumstances, including DSM-IV syndromes and disorders.

"Classical" psychoanalysis, involving four or five sessions a week, with the patient on the couch, should also be evaluated—using a sensible adaptation of scientifically credible standards (Rutherford et al. 2007)—for its efficacy in treating specific, operationalized psychiatric problems. Although efforts are under way to study the outcomes of psychoanalyses (Huber, Klug, and von Rad 2002; Knekt and Lindfors 2004; Rutherford et al. 2007), the length of time involved in a typical psychoanalysis, as well as the frequency of psychoanalytic sessions, complicates such studies. The complexity of this task raises the question whether psychoanalysis as a field might be better served by focusing initial outcome research on briefer psychoanalytic treatments for specific disorders or clinical syndromes (Busch 2006).

Testing Psychoanalytic Approaches in Comparison with Other Approaches

No single treatment can effectively treat all psychiatric disorders, and, as with all other forms of scientifically tested treatments for medical and psychiatric illnesses, individuals with specific illness combinations can be expected to respond differently to the range of available treatment options. To determine the proper place of psychoanalysis and psychoanalytic psychotherapies in the psychiatric armamentarium, it is essential that treatment trials begin to address these questions.

The outcome of efficacy studies comparing psychoanalytic with nonpsychoanalytic treatments is likely to have a significant impact on the future of psychoanalysis. For instance, psychoanalytic treatments may not be as effective for certain disorders (e.g., severe depression, schizophrenia) and may be more effective for others (e.g., anxiety disorders, personality disorders). This could lead psychoanalysts to focus clinical interventions and training more on the treatment of specific problems, and to improve the psychoanalytic clinical approach to specific disorders.

IMPLICATIONS FOR PSYCHOANALYTIC EDUCATION

The capacity to systematically study manualized psychoanalytic treatments, and the growing importance of systematic studies in contemporary approaches to mental health, suggest that at least a basic research education should

be provided in psychoanalytic institutes. Candidates should learn to understand the evidence-based literature. To aid in the survival of psychoanalysis as an academic/psychiatric discipline, analysts must be encouraged to develop research careers and be supported in them. If studies demonstrate a therapeutic advantage for manualized psychoanalytic treatments for specific patients and disorders, psychoanalytic institutes and psychoanalytic psychotherapy programs should consider offering training to psychoanalytic candidates in those treatments.

CONCLUSION

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

The PFPP study has important theoretical and clinical implications for psychoanalysis, highlighting the therapeutic value of brief psychoanalytic treatment—at least for DSM-IV panic disorder. In addition, studies such as this may increasingly have educational implications, in identifying treatment approaches that should be incorporated into the training of general psychiatrists, psychologists, social workers, psychoanalysts, and psychodynamic psychotherapists. We hope that the PFPP studies will generate enthusiasm and active encouragement within the psychoanalytic community for scientifically credible efficacy studies of psychoanalytic treatments, for a variety of disorders, in order to test and refine our basic theoretical and clinical assumptions.

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