

THE EFFECTIVENESS OF PSYCHOANALYTIC PSYCHOTHERAPY: THE ROLE OF TREATMENT DURATION, FREQUENCY OF SESSIONS, AND THE THERAPEUTIC RELATIONSHIP

This is an effectiveness study of treatment outcome that relies on patients' perception of their mental health during and after psychoanalytic psychotherapy. Ninety-nine outpatients attending the IPTAR Clinical Center (ICC) responded to the Effectiveness Questionnaire (EQ) adapted from that developed by *Consumer Reports*. Effectiveness is studied from various perspectives. Findings indicated (1) an incremental gain in effectiveness scores from six to over twenty-four months of therapy; (2) an incremental gain with greater session frequency from one to two or three weekly sessions; (3) facilitation of effectiveness by the experience of a positive relationship with the therapist; (4) an interplay between clinical syndrome and treatment conditions. A method giving clinical validity to the quantitative findings is described. Brief summaries of two recorded interviews reveal differential reconstruction of events that had occurred during treatment. The findings are discussed from the vantage point of two hypotheses: cognitive dissonance and internalization of therapeutic experience.

Psychoanalysis today finds itself not in a situation of crisis, but surely in one of reorganization. Within such a climate, the objective documentation of our clinical enterprise should be accorded high priority. This is true not only from the vantage point of our public image

in a world increasingly dominated by managed care, but also in terms of our own satisfaction as practicing analysts and our investment in the morale of the next generation of analysts. And yet, the history of analytically oriented outcome research has been a varied one. It is not possible to offer here an adequate review of outcome research relevant to psychoanalysis or psychoanalytic therapy. The interested reader is referred to excellent comprehensive reviews by Bachrach et al. (1991), Doidge (1997), and Kantrowitz (1997). Here we will only sketch out some selected historical highlights.

The historical beginnings of systematic psychoanalytic research can be found in Fenichel's statistical report (1930) on the therapeutic activities of the Berlin Psychoanalytic Institute from 1920 to 1930. Not only were there impressively high rates of substantially improved and cured patients, but the very definition of cure reflected the optimism of the era. Cure was seen in the "strictest" terms, and results included not only symptom relief, but completely rational and understandable character changes that were identified retrospectively.

742 Fenichel's work set the stage for the systematic evaluation of the efficacy of psychoanalysis within the confines of a given institute. Decades later in the United States, beginning in the 1950s and 1960s, we find the projects of the Columbia University Psychoanalytic Clinic, the Boston Psychoanalytic Institute, and the New York Psychoanalytic

Norbert Freedman is a training analyst and chair of the Research Committee at IPTAR. Professor, SUNY Health Science Center, Downstate; and Adjunct Professor, Postdoctoral Program, NYU. Joan Hoffenberg is chair of the Research subcommittee of the IPTAR Clinical Center; faculty, SUNY Health Science Center, Downstate; and faculty and supervisor, Metropolitan Training Institute for Psychoanalytic Psychotherapy. Neal Vorus is a member of the Research Committee and candidate at IPTAR; Adjunct Assistant Professor, John Jay College of Criminal Justice (CUNY); and on the faculty, Metropolitan Institute for Psychoanalytic Psychotherapy. Allan Frosch is Codirector of the IPTAR Clinical Center; supervisor, at the CUNY Ph.D. program in Clinical Psychology; and an IPA training analyst.

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Institute (Bachrach et al. 1991; Doidge 1997). These studies were based predominantly on the work of analytic candidates. Moreover, they were based largely on clinic records, and while in some instances patient ratings or independent ratings of the clinical record were used, these studies relied most heavily on the treating analysts' judgment. These projects reported treatment effects on substantial samples of patients and yielded impressive improvement rates, from 60 to 90 percent (Bachrach et al. 1991). However, there were serious methodological limitations inherent in these studies, as recently summarized by Kantrowitz (1997).

The field of treatment evaluation was shaken in the 1950s by the very critical report of Eysenck (1952). This virulent attack has since been effectively refuted (Doidge 1997), but the impact of Eysenck's challenge led to a new wave of methodologically sophisticated research. From the late 1950s onward, two efforts stand out.

First was a project at the University of Chicago culminating in the volume *Psychotherapy and Personality Change* (Rogers and Dymond 1954). Indeed, this study remains an exemplar of systematic treatment research based on a known population, a common theoretical framework, a known set of interventions, specification of independent and control conditions, and a host of innovative evaluative methods including wire recordings of sessions, independent coding of process, application of the Q-sort method, and evaluation of outcome at termination as well as at posttermination follow-up points.

The seminal study of more specifically psychoanalytic treatments during this period was the comprehensive evaluation of both psychoanalysis and psychoanalytic psychotherapy at the Menninger Clinic. It too resulted in a host of novel and imaginative methods of assessment, and an extensive literature has emerged from it. Highlights of its findings were presented in Wallerstein's *Forty-two Lives in Treatment* (1986).

Both the Chicago and the Menninger projects were guided by the belief that every bit of good process is also a good outcome. Such studies led to a wealth of new assessment procedures—PERT (Gill and Hoffman 1982), FRAMES (Dahl 1988), CCRT (Luborsky and Crits-Christoph 1990), and Referential Activity (Bucci 1997), to cite just a few—with each method reflecting a belief as to what matters most in effective treatment. This work has crystallized in the ongoing efforts of the Collaborative Analytic Multisite Project (CAMP), headed by Wallerstein, which sets itself the task of applying multiple process

measures to a common database of audio-recorded analytic sessions. In addition, decades of work have culminated in Luborsky's current efforts to apply the CCRT and other methods of coding text to more than fifteen recorded and completed psychoanalyses, with the outcome of each case evaluated using the Health-Sickness Ratio as a measure of change (Luborsky, personal communication).

What is largely missing from these evaluations is the study of the role of conditions of treatment exposure as an independent source of variance. If we reject the notion of random assignment of cases to treatment or no treatment (as is the practice in psychopharmacological research that relies on a placebo vs. active drug comparison), then we must find some other condition that captures variation in treatment intensity. Duration and session frequency are obvious conditions crucial to analytic work.

744 Systematic observations on the quantitative aspects, length and intensity of treatment exposure, have been relatively sparse. The studies from the Columbia, Boston, and New York Institutes consistently report better treatment outcomes for patients in psychoanalysis with greater treatment lengths. The greater efficacy rates for patients treated with analysis, as against those for psychotherapy, may reflect a relationship between session frequency and outcome. However, because the two groups also differ systematically in analyzability and in form of treatment, it is difficult to assess the relative impact of intensity of treatment exposure as against that of subject differences or form of treatment proffered.

Howard et al. (1986), in their introduction of the "dosage" model, made an important methodological advance. The concept of treatment dose has also been examined by Kachele in Germany. Howard initially reported a twenty-six-session optimal dose effect and a plateau thereafter. A later, more rigorous study from the same research group noted an optimal psychotherapy effect at fifty-eight sessions (Kopta et al. 1994). Congruent findings of a duration effect for patients with personality disorders in dynamic psychotherapy lasting up to one year were reported by Hogland (1993) in Norway; this effect was also noted two years and four years after termination. A major objective of the present report is to corroborate these findings of a "duration" effect and to go beyond them.

More recently, a new round of outcome research has been undertaken in Europe, giving rise to studies with particular bearing on the

evaluation of the impact of session frequency. A stellar effort is the Stockholm Psychotherapy and Psychoanalysis Project (Sandell 1996; Sandell, Bromberg, and Lazar 1999), which relies on methodology never before used. The researchers studied large groups of patients in psychoanalysis conducted four or five times per week, or in once- or twice-a-week psychotherapy. Patients were evaluated at various points in treatment, at termination, and at posttermination, using objective assessments (SCL-90, Scale of the Sense of Self-Cohesion, and a scale of social adaptation). Comparisons were made with a “normative” control population. Results indicated that in both treatment groups there was a similar reduction in symptomatology. Differences did emerge after successive follow-ups. At three years posttermination, there was a substantial relationship between treatment dose (both duration and frequency) and outcome.

Congruent findings have been obtained by Target and Fonagy (1994) in a retrospective study conducted at the Anna Freud Centre, as well as by Heinicke and Ramsey-Klee (1986), but these studies deal exclusively with child and adolescent patients. To our knowledge, only the Swedish studies provide persuasive support for the role of session frequency in the treatment of adults.¹ This issue frames the second major objective of the present paper.

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Outcome research has a Rashomon quality, in that it can be viewed from several perspectives: that of the analyst observer, that of the independent researcher, and that of the patient’s direct experience. Much previous work has focused on the first two. Now attention must be given to the patient as consumer, satisfied or not. Does the patient feel that therapy or analysis has made a difference in his or her life?

This is the notion of effectiveness, as distinct from efficacy, as proposed by Seligman (1995). This effectiveness model has injected a new perspective into outcome research and, with it, the direct participation of the patient as a unique source of evaluation. This approach found

¹It may be added that projects similar to the Swedish studies are under way in countries that have the benefit of national health insurance and that provide a context that makes such research possible. We in the United States, with the emphasis on privatization and the impact of managed care, are not as fortunate; here the burden falls on individual psychoanalytic societies. IPTAR, the Institute for Psychoanalytic Training and Research, has allocated its resources to create a section that pursues a comprehensive program of research encompassing three spheres of empirical investigation: (1) outcome studies of the effectiveness of psychoanalytic psychotherapy; (2) studies of the therapy process; and (3) studies of recorded psychoanalyses. The present paper is the first in a series reporting this research.

application in the recent *Consumer Reports* study (Seligman 1995, 1996) a nationwide survey in which forty-two hundred respondents who had received some form of individual psychotherapy completed a questionnaire about their treatment experience. Not only was the rate of satisfaction high, but there was a progressive increment with length of treatment exposure. We shall build on this report.

We were fortunate to receive from *Consumer Reports* not only the items of their questionnaire, but their scoring methodology (M. Kotkin, personal communication). What is presented here is in part a replication of the *Consumer Reports* study on a new, independently drawn sample of patients. Moreover, in this study all patients were treated with specifically psychoanalytic psychotherapy by therapists with analytic training. Going beyond a replication effort, we will treat the data in a manner specifically responsive to issues of special concern to psychoanalysts and to patients in psychoanalytic treatment.

746 In addition, we have a methodological advantage over the *Consumer Reports* study in that we are dealing with a known population from a single clinical center, with a known group of therapists, all with similar analytic training. Because we are in a position to compare the attributes of responders to those of the clinic population overall, we can evaluate a treatment modality within a single psychoanalytic community, as did Rogers and Dymond over four decades ago.

It is in this context that we present an empirical study of treatment outcome. It is an effectiveness study that relies on patients' perceptions of their mental health during and after psychoanalytic psychotherapy. Our approach was guided by a series of questions: (1) What is the impact of treatment exposure (i.e., duration) on treatment outcome? (2) What is the impact of session frequency on treatment outcome? (3) What is the role of both duration and frequency on the evolving treatment relationship? (4) Is there an interaction among clinical syndrome, duration, frequency, and outcome?

TREATMENT SETTING, PATIENTS, AND RESEARCH METHODOLOGY

Treatment Setting

The research was conducted under the auspices of the IPTAR Clinical Center (ICC), a component of the IPTAR Society. The ICC was established in 1993 to serve a population that is in need but cannot

afford ongoing psychological services. It is a community-oriented mental health center whose goal is to maintain the treatment of every patient accepted to its natural completion without regard to financial considerations. Patients are seen in the private offices of clinic therapists or, if necessary, at the IPTAR offices. The ICC is a low-cost facility, and most treatment is paid for out of pocket, without third-party payments. The ICC is a freestanding clinical center whose forty-five therapists are either in training or are members of the IPTAR Society. Under the supervision of IPTAR members, which is provided free, ICC therapists see on average a hundred patients annually in over six thousand hours of psychoanalytic psychotherapy.

Data Collection

Work on this project began in September 1996. All patients, past and current, were contacted by letter and asked to participate in a study of the effectiveness of the psychotherapy they had received at the ICC. They completed the Effectiveness Questionnaire (EQ), which was adapted from the questionnaire used in the national sample by *Consumer Reports* (1995). Two hundred forty questionnaires were sent out and 99 returned, a rate of 41 percent. This return rate should be evaluated in light of the fact that (1) we followed *Consumer Reports* procedures and (2) ICC therapists were not involved in the data collection and did nothing to encourage compliance. Within that context 41 percent is a satisfactory rate of return; Seligman (1995) reports a return rate of only 13 percent for the *Consumer Reports* study.

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All aspects of our study were designed not to intrude on the privacy of the treatment relationship. The IPTAR Research Committee notified the therapists of the intent of the project, but they played no part in implementing patient compliance. Recall Validation, described below, begins only *after* the patient has terminated, thus yielding “retrospective reconstructions” of what has happened in the course of therapy.

Sample Description

The sample for this study was drawn from the total patient population of the Clinical Center. Comparisons were made between the demographic profile of the clinic patient census for 1996 and the research sample. Demographic characteristics of the 1996 clinic sample are presented in Tables 1A and 1B.

**TABLE 1A: DEMOGRAPHIC CHARACTERISTICS:
RESEARCH SAMPLE AND CLINIC POPULATION**

	<u>N=99 Sample</u>		<u>1996 Clinic Statistics</u>	
<u>Gender</u>	Female	67%		69%
	Male	33%		31%
<u>Age</u>	<35	63%	<2	2%
	35–44	20%	13–19	1%
	45–54	14%	20–29	41%
	55–64	2%	30–39	36%
	>65	1%	>50	7%
<u>Marital</u>	Single	74%		72%
	Divorced	13%		9%
	Married	11.7%		17.8%
	Widowed	1.3%		
<u>Education</u>	HS	5.2%		7%
	in College	16.9%		15%
	BA/BS	18.2%		32%
	Grad Schl	29.2%		32%
	Post-MA	22.1%		25%
<u>Primary Language</u>	English	75.3%		77%
	Spanish	3.9%		10%
	French	2.6%		
	Other	3.9%		13%
	Unspecified	14.3%		
<u>Ethnicity</u>	White	58.4%		65%
	Afr.Amer.	13%		14%
	Hispanic	7%		10%
	Asian	5.2%		7%
	Unspecified	16.4%		4%
<u>Medication</u>		(27.4%)		(31%)
	Antidepressants	15 patients		25 patients
	Antianxiety	5		2
	Mood Stabilizer	0		2
	Antipsychotic	1		1

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**TABLE 1B: DEMOGRAPHIC CHARACTERISTICS:
RESEARCH SAMPLE AND CLINIC POPULATION**

	<u>N=99 Sample</u>	<u>1996 Clinic Statistics</u>
<u>Previous Treatment</u>		
	66%	40%
<u>Previously Hospitalized</u>		
	8%	4%
<u>Frequency of Sessions</u>		
1/week	55%	52%
2/week	32%	38%
3/week	8%	8%
4/week	2%	—
missing	3%	2%
<u>Duration of Treatment</u>		
		<u>1997 Data</u>
< 1 month	1.1%	3.5%
1–3 months	6.4%	15%
4–6 months	13.8%	6%
7–11 months	19.1%	10.5%
1–2 years	38.2%	30.5%
2+ years	21.3%	34%
<u>Diagnosis Features at Intake</u>		
Depressive Reaction	58.2%	3.5%
Anxiety Reaction	16.9%	15%
Personality Disorder	11.7%	6%
Adjustment Reaction	3.9%	10.5%
Schizophrenia	2.6%	30.5%
Bipolar Disorder	1.3%	34%
Eating Disorder	1.3%	34%
Somatoform Disorder	1.3%	34%
Substance Related	1.3%	34%
Unspecified	1.2%	34%

The demographic data for the Responder Group, our research sample (n=99) can be seen in Tables 1A and 1B. There are considerable similarities between the 1996 clinical center sample and the research sample. The demographic profile from the research sample reveals that it, too, was predominantly female, young (under thirty-five), single, college-educated, and English-speaking. Duration of treatment exposure ranged from one month to over two years, with 38 percent in treatment for from one to two years and 21 percent over two years. Again, similar to the total patient population, 55 percent of the sample is being seen once a week, with 32 percent going twice and 8 percent three times. Diagnostically, too, the sample is similar to the overall patient population. Initial diagnostic impressions include dysthymic reactions, anxiety reactions, and adjustment and personality disorders, as well as substance abuse problems and, in small numbers, more severe pathology. Twenty-eight percent of Responder Group patients were on psychopharmacological medication, largely antidepressants.

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Instruments

The Effectiveness Questionnaire (EQ) consists of twenty-eight items asking patients in simple language to identify the problems that brought them into treatment; qualities of the treatment setting (frequency and duration); attitudes toward their therapist; and perceptions of the outcome of their treatment. The EQ is a shortened version of the questionnaire developed by *Consumer Reports* and is used with their permission and their scoring system.

Measures

Measures for several variables were used to quantify patients' responses.

Effectiveness Score (ES). The major outcome variable is the Effectiveness Score (see Table 2). This score comprises three parts, each derived from separate questions on the EQ, and is identical to the outcome measure used by *Consumer Reports*. The first part is *specific improvement*, how much the treatment helped the respondent with "the problems that led me to therapy." The six-point scale was transformed into a 0–100 scale, with "made things a lot better" as 100, "somewhat better" as 80, etc. This measure is also known as Focal Symptomatic Gains. The second part is *satisfaction* with one's therapist. The six-point scale was converted by the same

transformation into a 0–100 scale. Third is *global improvement*, how respondents felt at the time of the survey, compared with how they felt when they began treatment. A similar transformation to a 0–100 scale was made by comparing the earlier and later scores. Thus, a person who improved from “very poor” to “very good” would score 100, while a person regressing from “very good” to “very poor” would score 0.

TABLE 2
EFFECTIVENESS SCORE AND ITS COMPONENTS

The following items are converted to a 100-point scale and added together for a possible 300 points.

1. How much do you feel your therapy helped with the specific problem that led you to therapy?

- 1= made things a lot better
- 2= made things somewhat better
- 3= made no difference
- 4= made things somewhat worse
- 5= made things a lot worse
- 6= not sure

2. Overall, how satisfied are you with your therapist’s treatment of your problems?

- 1= completely satisfied
- 2= very satisfied
- 3= fairly well satisfied
- 4= somewhat dissatisfied
- 5= very dissatisfied
- 6= completely dissatisfied

3. Emotional state at beginning of treatment subtracted from current emotional state.

- 1= Very poor: I barely manage to deal with things.
- 2= Fairly poor: Life usually is pretty tough for me.
- 3= So-so: I have my ups and downs.
- 4= Quite good: I have no serious complaints.
- 5= Very good: Life is much the way I like it to be.

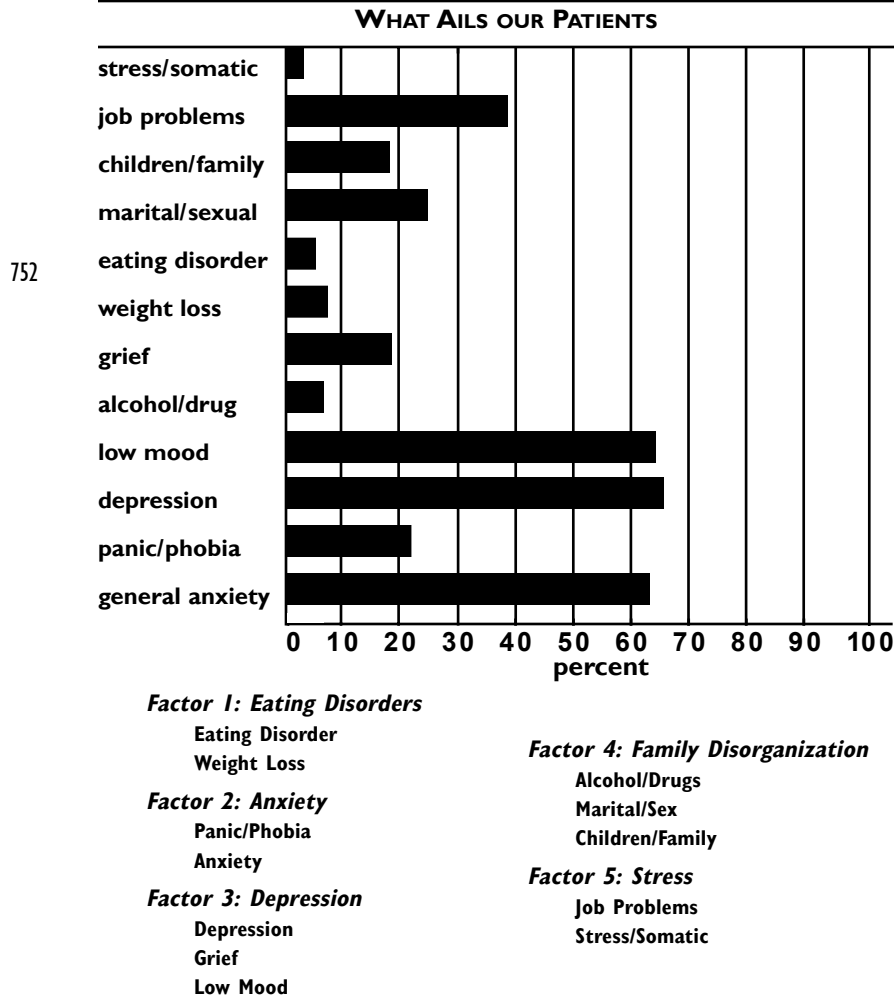
Possible points=300
Mean=209
Std. Dev.=42

Range=190
Minimum=97.5
Maximum=287.5

The three parts of the score are added together to create the Effectiveness Score, which can range from 0 to 300. For our patient sample, ES scores ranged from 97 to 287, with a mean of 209. Seligman (1995) wrote that the aim of this multivariate measure was to provide a single estimate of effectiveness based on these three items, as it was felt that no single measure of therapy effectiveness would do.

Adaptive Life Gains. We developed a second outcome variable from items on the EQ to assess gains in concrete aspects of living. We call

TABLE 3: PREVALENCE OF PATIENT CONCERNS AND CLINICAL SYNDROME: FACTOR ANALYSIS



this the Index of Adaptive Life Gains. Here a patient rates changes in ability to relate to others; being productive at work; coping with everyday stress; enjoying life more; personal growth and insight; self-esteem and confidence; and alleviating low moods. Each choice could be scored from 1 (made things a lot better) to 5 (made things a lot worse).

Profile of Clinical Constellations. In order to describe our treatment sample in terms of clinically meaningful constellations, patients' responses to the first question of the EQ were tabulated. Question 1 asks responders to check any of twelve problems for which they "sought help from [their] therapist." Table 3 shows the distribution of problems checked by our respondents. As can be noted, there is a wide spectrum of concerns and problems identified, with low mood, depression, and anxiety having the greatest frequency.

In order to form clinically meaningful groups from the symptoms checked, we carried out a factor analysis. Using orthogonal rotation, five factors were extracted, and these were labeled based on the cluster of complaints with the highest loading for each. The factors are (1) eating disorders (including weight loss and anorexia and bulimia); (2) anxiety (including general anxiety, panic attacks, and phobias); (3) depression (including depression, frequent low moods, and grief); (4) family disorganization (including alcohol and drug problems, marital or sexual problems, and problems with children or other family members); and (5) stress (including job problems and stress-related problems). Patients were assigned factor scores based on their loading on each of the five factors and were placed in homogeneous groups with respect to their highest factor score.²

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Relationship Indices (PRI, NRI, ORI)

The relationship indices are calculated from items within the EQ descriptive of patients' perception of and experience with their therapist. These items are different from those used to calculate the ES.

In the Positive Relationship Index (PRI) the patient appraises his or her experience of the therapist as supportive, responsive, empathic, and/or insightful. Items making up this index ask the patient whether the therapist was "easy to confide in", "generally reassuring," etc.

²As should be clear from our description, these clinical groups are based purely on a statistical analysis of questionnaire responses dealing with self-reported presenting complaint, and are not meant to represent diagnoses according to DSM-IV or any other formal diagnostic system.

These two indices combined, and weighted equally, create the Optimal Relationship Index (ORI).

In the Negative Relationship Index (NRI) the patient's critical assessment of the therapist as judgmental, rude, controlling, condescending, defensive, and/or discouraging is described. Here, for example, patients are asked whether the therapist was "too judgmental or controlling," "condescending or rude," etc.

EFFECTIVENESS, TREATMENT DURATION, AND SESSION FREQUENCY

In the contemporary array of multimodel psychoanalytic perspectives there is a range of presumed psychic experiences that unfold during psychotherapy. We may ask, to paraphrase a current title, "What do therapists really want?" (Sandler and Dreher 1996). The answer is to facilitate the reworking of pathological compromise formations, to help find a good or good-enough object, to define boundaries and recognize defenses, to provide a stable frame of safety for the development of a cohesive self, to arrive at insight, to recognize that symptoms are symbols, and to create a sense of meaning in the context of a therapeutic relationship. Each of these diverse modes of therapeutic action requires time and sustained treatment exposure if it is to be effective, and herein lies part of the common ground of all psychoanalytic psychotherapies (Wallerstein 1992).

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The issue of treatment duration and session frequency is not simply a matter of clinical theory, economics, or social reality, but is a crucial consideration in the evaluation of the process itself. It introduces the notion of incremental treatment effectiveness. It deals not simply with "before and after," or "treatment versus no treatment," but instead with how much more effort yields how much more result. Because time and intensity have particular methodological implications, we would reject a study that introduces a "wait" or "no treatment" control condition. We would also be critical of a design that assigns patients randomly to two treatment conditions, say minimal or maximal frequency, because random assignment introduces an element of artificiality by ignoring the fact that duration and frequency are choices that emerge out of clinical considerations negotiated within the therapeutic couple. It is our view (along with Seligman 1995) that such choices are integral to the therapeutic process and therefore cannot be decided

extraneously without distorting the treatment method. Instead, we favor examination of the issue of time and frequency within an ongoing treatment setting, with minimal intrusion of research demands on the clinical process.

Thus, the ideal method for studying the cumulative effect of duration and frequency on treatment effectiveness would involve a naturalistic, open-ended clinical setting in which one can observe patients at various points in treatment. Such observations can be quite systematic: one can evaluate successive groups of patients having varying levels of treatment exposure, and can conduct follow-up studies in which patients' retrospective appraisal of their terminated treatment can be noted. In our research we follow both paths and ask questions concerning the effects of duration and frequency, and the combined effects of both on outcome.

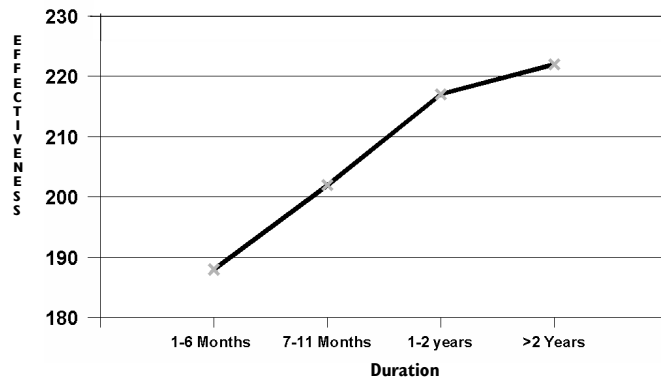
Duration

Our evaluation of the impact of duration proceeded in successive phases. The overall impact of treatment exposure was first considered, and then specific time periods in the course of therapy. It was possible to study different treatment durations because patients who responded to the questionnaire had been in treatment for varying lengths of time, ranging from those just beginning therapy to others who had been in treatment for over two years. Patients were thus assigned to groups based on whether they had been in therapy for less than one month, one to six months, seven to eleven months, one to two years, or over two years. Our choice of these treatment increments was determined by the original *Consumer Reports* study.

The overall impact of treatment exposure on effectiveness was noted by a correlation of .28 ($p < .005$), indicating increasing Effectiveness Scores with increasing treatment durations from one month to over thirty-two months. Next we delineated the impact of varying lengths of time in treatment on Effectiveness Scores: first six months, then seven to eleven months, then twelve to twenty-four months, and finally twenty-five months and beyond. The results are depicted in Table 4. Using Analysis of Variance (ANOVA), a procedure for assessing the statistical significance of differences between multiple groups, we found that these duration increments differed significantly. Multiple-range tests yielded the following differential treatment effects: mean Effectiveness Scores for patients receiving up to six months of psychotherapy compared

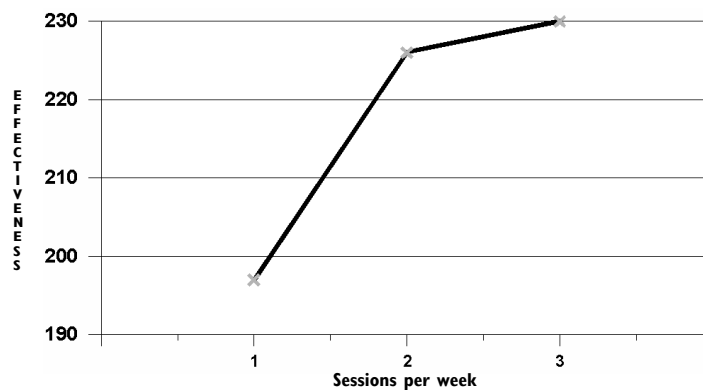
with patients receiving seven to eleven months revealed no significant differences between the groups; however, significant differences were found in mean Effectiveness Scores between patients receiving up to six months of psychotherapy and twelve to twenty-four months and then again for patients receiving up to six months and over twenty-five months.

**TABLE 4: TIME IN TREATMENT AND MEAN EFFECTIVENESS SCORE:
ANALYSIS OF VARIANCE (N=86)
EFFECT OF DURATION ON TREATMENT EFFECTIVENESS**



F=2.76 (3, 83) p<.05

**TABLE 5: FREQUENCY AND MEAN EFFECTIVENESS SCORE:
ANALYSIS OF VARIANCE (N=84)
IMPACT OF TREATMENT FREQUENCY ON EFFECTIVENESS**



F=6.62 (82,2) p<.005

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These findings of the relationship between duration of treatment and patients' perception of an effective clinical course are consistent with the hypothesis of an incremental treatment effect. It is also a finding of Seligman's earlier report and thus constitutes a replication of that study, now on an independently drawn sample of patients. All other analyses of data in this study go beyond the Seligman report and are directly inspired by specific concerns raised in the appraisal of psychoanalytic psychotherapy.

Session Frequency

What is the impact of session frequency regardless of duration? In Table 5 we note mean Effectiveness Scores for patients receiving varying levels of treatment frequency. The Effectiveness Scores respectively are: for once per week (195.3), twice per week (225.4), and three times per week (230.4). Analysis of variance showed these groups to differ significantly ($F=6.62$; $p<.005$). Further, multiple-range tests demonstrated significant differences between once-a-week sessions compared to both twice and three times a week, but not between two and three sessions weekly.

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To test the limit of the impact of session frequency on Effectiveness Scores, the focus is on patients who have had a meaningful treatment exposure, here defined as a duration of seven months or more. An identical analysis of variance was carried out. Mean Effectiveness Scores for once, twice, and thrice weekly sessions for patients in treatment seven months or longer paralleled the effect noted in the sample as a whole ($F=5.10$; $p<.01$). The choice of the restricted range of treatment exposure was guided by clinical reasons, in that the first six months are often a turbulent period with more frequent dropouts, whereas after seven months the treatment relationship tends to become more stable. Findings support the idea that under these more stable conditions added frequency yields incremental gain. Thus, we can conclude that increased sessions make a difference, a finding with specific relevance to psychoanalytic psychotherapy.

Joint Effect of Frequency and Duration

To further assess the relation of treatment parameters to outcome we used linear multiple regression, which allowed us to construct a model using frequency and duration together as predictors of effectiveness. We found the combined predictive power of frequency and duration

to be quite significant ($F=6.71$; $p<.005$). Further, by partialing out the linear relation between duration and frequency, we determined that these variables account for separate portions of the variance in effectiveness. Thus, we can conclude that in the sample as a whole, frequency and duration contribute to outcome in qualitatively different ways.

Duration, Frequency, and Quality of Effectiveness

In order to complete the analysis of a potential incremental trajectory, qualities of the patient's perception of clinical change were examined. It will be recalled that the Effectiveness Score has three components: specific improvement (how much the treatment helped with the problem that led the patient to therapy); satisfaction with the therapist's treatment of the problem; and global improvement (how respondents felt at the time of the survey compared to when they began treatment).

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Duration was not significantly related to global improvement or to symptomatic gain, but there was a significant relationship between duration and the patient's satisfaction with the therapist's treatment of his/her problems ($F=2.42$; $p<.05$). In contrast, frequency was significantly related to specific symptomatic gain ($F=5.05$; $p<.01$) and to satisfaction with the treatment received ($F=4.29$; $p<.05$). Once more we find that duration and frequency are associated with distinct aspects of effectiveness.

Final Note

The finding of a substantial relationship between treatment conditions and Effectiveness Scores supports the hypothesis that the experience of a sustained therapeutic presence has an incremental impact on the patient's experience of clinical improvement. This is supported further by the observations of patients in treatment beyond seven months. At that point, a stable treatment frame had been established, and added session frequency appeared to augment effectiveness. In addition, there is a linear progression in patients' description of their therapist's helpfulness up to thirty-two months of treatment. This last observation introduces the facilitating role of the treatment relationship in perceived effectiveness—a topic we turn to next.

**THE TREATMENT RELATIONSHIP:
PROMISE AND CHALLENGE**

The effect of objective treatment conditions has been our organizing variable as we traced the impact of frequency and duration on the patient's perception of effectiveness. Our findings support the notion that, in general, more intensity yields greater gain. However, we would now like to look at the situation from a psychoanalytic perspective. Treatment conditions and the act of attending sessions are in a sense physical facts. But they also create a psychological reality; they create the possibility for the experience of an object relationship. As analysts we hold that an object relationship, if it is to be therapeutic, has to be internalized.

A variety of otherwise divergent analytic perspectives share the view that the patient's affective involvement in treatment facilitates effectiveness. Such involvement is mediated through specific forms of investment in the relationship with the therapist, whether this is conceptualized in terms of transference, the real relationship, or points in between. Clinical phenomena bearing on such issues as therapeutic alliance, treatment relationship, and the patient's experience of the therapist have been identified as crucial conditions favoring a positive treatment response (see, e.g., Orlinsky and Howard 1986). More recently, Luborsky (1996) listed the therapeutic alliance and its correlates as a principal factor in successful outcome. Here we hope to confirm the idea, prevalent in the literature, that the experienced treatment relationship is important in facilitating a positive clinical response. We will take the additional step of studying the quality of the treatment relationship, as a facilitating condition, and its influence on treatment outcome regardless of frequency and duration—that is, as an independent source of variance.

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Empirical Observations

The Positive Relationship Index (PRI), the Negative Relationship Index (NRI), and the Optimal Relationship Index (ORI) are our principal relationship indices. Each of these indices revealed substantial correlations with overall effectiveness: PRI Index ($r=.56$; $p<.001$); NRI ($r=.26$; $p<.01$); ORI ($r=.47$; $p<.001$). As the PRI is the most robust of these correlations, it is used as our primary indicator of the therapeutic relationship. Thus, we found the patient's experience of a positive relationship with the therapist to be significantly correlated with

effectiveness, indicating that patients who most experience their therapist as reassuring, supportive, and insightful are also those most likely to report positive outcomes.

More crucial for our purposes is to determine whether the PRI contributes to outcome independently of our two other predictor variables, duration and frequency. For this purpose we used multiple regression analysis to predict effectiveness.

We constructed a model to predict effectiveness from duration, frequency, and the quality of the therapeutic relationship. Two variables, frequency and PRI, were found to be highly significant predictors of effectiveness ($F=23.11$; $p<.0001$), and to account for over a third of the variance in effectiveness ($R^2=.36$). In our model, both frequency and PRI were statistically significant; duration was not. The data also indicate that frequency and the therapeutic relationship are independent sources of variance in effectiveness, a finding that further supports the idea that frequency and duration (and its correlate, the treatment relationship) are related to qualitatively different aspects of therapeutic outcome.

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A Matter of Interpretation

The findings reported above point to the strong connection between duration of treatment and the quality of the treatment relationship as it shapes outcome. Further, session frequency may now be seen as an independent source of therapeutic gain, and the cumulative impact of frequency and positive therapeutic relationship becomes a powerful predictor of treatment outcome.

It has been our belief that increased therapeutic exposure (frequency and duration) contributes to the experience of greater affective intensity in treatment, and that such intensity facilitates a perception of the therapist as optimally responsive to the patient. Further, we believe these conditions to be particularly important because of their role in facilitating a process of internalization that in turn supports the development of a relatively enduring internal relationship with the supportive and growth-enhancing aspects of the therapist.

However, several alternative arguments should be considered. First, it could be argued that instead of the positive treatment relationship functioning as a vehicle of therapeutic change in its own right, it merely indicates positive feelings that may have facilitated a patient's compliance with other treatment conditions that themselves function as

agents of change. For example, one could argue that specific therapeutic interventions make the difference once patients are induced to stay in treatment by positive feelings for the therapist. While different from our view—that psychic change takes place through a process of internalization—this view would be consistent with Freud’s early view of the role of the unobjectionable positive transference (1912), which brings about the successful result in psychoanalysis, largely by providing the incentive for the patient to work analytically toward the achievement of insight. Others have widened this idea, with concepts such as the “working alliance” (Greenson 1967) and “analytic trust” (Ellman 1991), to include, as aspects of the optimal positive relationship, conditions that the patient might need simply for the analytic relationship to be tolerable. Once these conditions are met, it is the various interventions aimed at insight or integration or other such goals that are ultimately mutative. In our view, this is one possible interpretation of the data, and while it shifts the emphasis somewhat as regards the function of the therapeutic relationship, it does not dispute the importance of an optimal treatment relation as a condition of therapeutic change.

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A second argument against our interpretation of the data is more problematic, namely, that what we have observed is merely the effect of “cognitive dissonance” (Festinger 1957). Simply put, it could be asserted that the idea that one has changed, the belief that one’s therapist is benevolent and supportive, and the awareness that one has spent considerable time and expense in therapy are cognitively consistent with one another. To avoid an experience of internal dissonance, patients who have spent much time in treatment will tend to construct for themselves ideas about the relative benefits of therapy and the good qualities of their therapist. These perceptions then serve to justify actions the patient has taken, rather than reflect anything more meaningful about what has actually transpired in treatment or how it has helped. Clearly, this is an argument that undercuts the very rationale of this study, namely, that patients’ subjective perception about their treatment is a useful indicator of its effectiveness.

In our view, the complexity of our data may well challenge the cognitive dissonance argument. When patients evaluate their treatment as effective, we believe, changes have indeed taken place in their life, changes that can be attributed to what was offered during the treatment. This is not an easy thing to show. Yet several aspects of our study might constitute a response to the cognitive dissonance hypothesis:

namely, the complex interactions between frequency, duration, and, as we will show, patients' clinical syndrome and perceived outcome.

The notion of cognitive dissonance assumes a singular motivation for the perception of improvement: the need for consistency between actions and attitudes. In challenging this view, we look for conditions of differential response; i.e., we look to see whether the treatment conditions of frequency and duration are related to differential patterns of treatment response. Indeed, we are now ready to consider revising our earlier statement, that more input or effort yields more results, because our analysis indicates that frequency and duration serve different functions. Along these lines we now ask two additional questions:

1. Is it not true that selective and differential responsiveness due to patient characteristics challenges the cognitive dissonance hypothesis? If patients with different clinical constellations respond more to one treatment condition than to another, then surely something other than dissonance avoidance must be taking place.

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2. If there are differential observations of effectiveness anchored outside the clinical situation and elaborated in specific detail, would not the thesis of cognitive dissonance then be qualified? Thus, under conditions of posttermination recall, if a patient can specify positive and negative events in his or her life and relate these to particular aspects of the treatment, would this not also challenge the dissonance hypothesis? Indeed such a finding might prove relevant to our hypothesis of an internalization process at work in effective psychotherapy. Preliminary observations on these two questions are sketched out below.

EFFECTIVENESS, TREATMENT CONDITIONS, AND CLINICAL SYNDROME: AN EXPLORATORY STUDY

We now turn to an exploration of the selective impact of treatment conditions on effectiveness when the patient sample is divided according to clinical syndrome. Having established that duration and frequency are significantly related to the perceived effectiveness of treatment outcome, our attention naturally turns to whether this is true across clinical groups.³

³Because of the size of our current sample (n=99), this analysis is merely preliminary and exploratory; rigorous testing of our hypothesis of variable treatment effects according to clinical syndrome requires a discriminant function analysis. Such an analysis awaits a larger sample size in order to reach a significant distribution of subjects into groups.

Identifying Clinical Conditions

As noted earlier, five factors were created from patients' responses to Question 1 of the Effectiveness Questionnaire: (1) eating disorders (including weight loss and anorexia and bulimia); (2) anxiety (including general anxiety, panic attacks, and phobias); (3) depression (including depression, frequent low moods, and grief); (4) family disorganization (including alcohol and drug problems, marital or sexual problems, and problems with children or other family members); and (5) stress (including job problems and stress-related problems).

TABLE 6: RELATIONSHIP BETWEEN FREQUENCY, DURATION, AND EFFECTIVENESS BY CLINICAL SYNDROME

EFFECT BY FACTOR	FREQUENCY	DURATION
Overall	r = .29***	r = .28***
1. Eating Disorders	r = .51*	r = .09
2. Anxiety	r = .57**	r = .14
3. Depression	r = .25	r = .22
4. Family Disorganization	r = .17	r = .44*
5. Stress	r = .07	r = .49**

*=p<.05; **=p<.01; ***=p<.005

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Evaluating the Selective Role of the Clinical Syndrome

To reexamine the impact of frequency and duration on distinct clinical constellations, the correlation between effectiveness, frequency, and duration was computed for each of the five factor groups. As indicated by Table 6, correlations between treatment conditions and effectiveness begin to suggest certain trends when clinical groups are considered separately.

Significance is reached only for patients in the anxiety factor group (r=.57; p<.006) and those in the eating disorder factor group (r=.51; p<.03) when correlated with increasing number of sessions. That is, as intensity of treatment increases, individuals who are in these groups experience more effective treatment outcomes. Specifically, we can say that when patients describe themselves as primarily anxious or concerned about eating disorders, higher frequency of sessions is associated with greater treatment effectiveness; whereas among patients having comparable syndromes who receive lower session frequency, the same positive treatment response is not found.

Similarly, duration was found to be selectively correlated with effectiveness, depending on the clinical group. Here significant correlations

are found between duration and effectiveness for patients in the family disorganization group ($r=.44$; $p<.04$) and the stress group ($r=.49$; $p<.01$). That is, patients in these two groups who receive longer treatment duration (regardless of session frequency) perceive their therapy as more effective. Thus, increased exposure to psychoanalytic psychotherapy over time increases perception of treatment effectiveness in these groups.

In summary, four of the five clinical groups appear to show a selective response to the two parameters of treatment condition (i.e., duration and frequency). These preliminary observations are consistent with the notion that when the clinical syndrome is one of acute disturbance, frequency (i.e., higher intensity of contact) is more salient; and that when the clinical syndrome is more chronic, increased time spent in treatment seems more influential.

These findings confront us with an additional surprising observation: no significant relationship between either frequency or duration and effectiveness was found when subjects in the depression group are considered separately. Yet depression, as an individual complaint, was the most prevalent symptom. This most puzzling outcome of our research effort provoked further inquiry.

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Grief Depression and Anxious Depression

These findings led to a closer examination of the depression factor. To be included in the depression group, patients had to have checked depression, grief, and low mood on the symptom checklist. This group included only sixteen patients. Yet sixty of the total ninety-nine respondents had checked depression as a major reason for coming to treatment. Thus, the depression group did not include forty-four patients who nonetheless were troubled by depression. Inspection of these forty-four indicated that they had checked both low mood and depression (accompanied by other symptoms, notably anxiety), but not grief. On the basis of our data, then, it made both empirical and clinical sense to recognize a second group of depressed patients, which we have called the Anxious Depression Cluster. Thus, we identified two depression syndromes: *depression with Grief* ($n=16$) and *depression with anxiety* ($n=22$).

With these two groups identified, the relationship of each to duration and frequency could be studied. But as patients in the two groups differ in the symptoms checked, it is also likely that they differ in the

way they respond to treatment or how they recognize change in their symptomatology. Until this point, outcome had been measured by the ES. Now we moved to measure outcome in a somewhat different manner. We compare one component of the ES, Specific Improvement, where patients indicate the extent to which they were helped with the specific symptom that brought them to treatment, and the new outcome variable, Adaptive Life Gains, where patients assess the extent to which concrete aspects of their life have been changed. Now the issue of the differential impact of duration and frequency on the perceived effectiveness of the treatment of those with depressive affect could be studied anew.

The results are presented in Table 7. This table presents a pattern of correlations: by clinical group (anxious depressed / Depression with grief), by clinical condition (frequency/duration), and quality of clinical outcome (Focal Symptomatic Gains / Adaptive Life Gains).

TABLE 7: ANXIOUS DEPRESSION AND GRIEF DEPRESSION: CORRELATIONS BETWEEN TREATMENT CONDITIONS, SYMPTOMATIC IMPROVEMENT, AND ADAPTIVE LIFE GAINS

ANXIOUS DEPRESSION		
	FREQUENCY	DURATION
Focal Symptomatic Gains	.39*	.35
Adaptive Life Gains	-.32	-.52**
GRIEF/DEPRESSION		
	FREQUENCY	DURATION
Focal Symptomatic Gains	.13	.08
Adaptive Life Gains	-.23	-.51*

*=p<.05; **=p<.01; ***=p<.005

When perceived change is measured by Focal Symptomatic Gains, the two groups differed, with the anxious depressed group tending to show a positive response to both duration and frequency, and the grief depression group not. In other words, when asked to assess the effectiveness of their treatment in bringing about changes in the particular symptom of depression, the anxious depressed group measured themselves as having received more help than did the grief with depression group. However, when outcome was assessed by Adaptive Life Gains, patients in both groups showed a response to duration but not to frequency. In the grief depression group, for the first time, we saw that

duration of treatment is strongly related to perceived effectiveness of treatment, now measured by changes in their life situation.

We seem to be dealing with two constellations of depression. One group, the anxious depressed, can name and recognize changes in their symptomatology (i.e., can symbolize their distress) and can benefit from increased treatment exposure. The other, the depression with grief group, though unable to recognize symptomatic change, does acknowledge changes in their lives brought about by treatment over an extended period of time (duration).

The effect of psychoactive medication was studied for its effects on both depression groups and on the sample as a whole. Through the use of partial correlation, we determined that for all cases the previously reported findings on the impact of duration and frequency on clinical syndrome were not altered when the role of psychopharmacological treatment was partialled out.

PERSPECTIVES ON CLINICAL VALIDITY

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We now wish to provide clinical validity to what up to now have been statistically reliable findings. Through qualitative interviews conducted after termination, we hope to illustrate how the patients experienced their treatment, and its impact on the quality of their life and on their current state of emotional health. To this end we shall briefly describe our method of "recall validation."

This method was guided by two additional objectives. The first is to give clinical validity to the concept of effectiveness (Seligman 1995,1996), the idea that a perceived alteration within the patient's life situation has indeed taken place. The second is more exploratory; we wish to discover some of the mediating conditions that account for the perceived treatment effects. The focus is on the internalization of the events of therapy, on the therapist as a person, and on the therapeutic process. In general, we hold that this is a method of retrospective reconstruction of therapy that provides a fruitful database for the identification of mediating mechanisms.

The centerpiece of recall validation is an audio-recorded interview of therapy remembered. The interview includes an associative narrative, patient description of the affective quality of the treatment relationship, salient events during treatment, dreams recalled, and an assessment of current life situation. This hourlong interview is supplemented by

selected objective indices of internalization, therapeutic alliance, reflective functioning, attachment, and major symptom clusters.

This endeavor to develop an archive of therapy remembered is the next phase of our research. So far eight patients have participated in the recall study. They represent a range of EQ scores and afford us an opportunity to obtain an account of just how therapy is represented after termination. In order to give the reader an impression of the qualities of the therapy experienced, we present selected material and clinical observations from two patients participating in this phase of the study.

Two Pathways toward Internalization: Ms. A and Ms. B

Ms. A came to treatment with symptoms of depression and low mood, and concerns over her weight and job situation. During the treatment, which lasted approximately two years, Ms. A came two and three times a week. She had an EQ score of 255 (in the High Effectiveness range).

When she began treatment, Ms. A felt depressed and suicidal and said that she needed “extensive therapy” to make changes in her life. Her organization of the world had a decidedly sadomasochistic quality: “I got shit every day. I was a hard-core punk kid with a chip on my shoulder.” The severity of her superego can be inferred from her statement that “prior to therapy everything was always my fault. I always blamed myself.” Ms. A had a very strong emotional connection to her therapist, whom she saw as warm, kindly, strong, and nonjudgmental. “She took criticism really well. She didn’t flinch. I could say anything and be anything and I felt she would accept me. I feel better about myself. It was scary to feel so dependent on this stranger. She was like a lifeline.”

The paradoxical statement expressed by Ms. A, that she does not think about her therapist but at the same time her therapist is not someone she does not think about reflects the internalizations that had been proffered in treatment. From a psychoanalytic perspective the paradox is transparent: I do not think about my therapist on a conscious level because she is available to me on an unconscious level. Ms. A’s capacity to feel good, happy, and productive about her life—her self-representation—is directly related to this object representation that is with her always and is experienced as an understanding inner voice that has helped her have “different expectations. I have a right to

expect people to treat me well.” Throughout the interview Ms. A talked about how her therapist opened a whole new world for her. Ms. A was more able to see things from the perspective of another and had an increased capacity to view self- and object representations from multiple perspectives. In structural terms this represents an advance in the ego and a shift in experienced reality. The changes in Ms. A’s life have been profound. “I feel happy. I’m not depressed anymore. Now I can tolerate being alone.”

Ms. B came to treatment with symptoms of depression, sexual concerns and job problems. She came once a week for less than two years and noted improvements in Adaptive Life Gains (concrete aspects of her life) but did not recognize changes in her depression. She did say that friends said she was less depressed. Ms. B’s EQ score of 202.5 is an average score.

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Ms. B began treatment because she felt depressed and said she wanted to be able to put her emotions into words. Ms. B did not talk about her therapist very much, and when she did it was in terms of a distance she experienced between them. Words did not feel like they had “healing” power. She felt tense and uncomfortable and told her therapist that she should have toy blocks. Clearly words could not be used to convey this woman’s emotional state, nor could they, when used by the therapist, be used by Ms. B as sources of communication about the nature of self- and object representations. Ms. B spoke about her therapist in physically descriptive terms—the color of her hair and clothes, her tone of voice, body weight, how she looked sitting in the chair, the color of her shoes, and how attractive she was. In short, Ms. B’s organization of the world was skewed toward the world of perception and appearances. She could not free herself from the preoedipal world of perception and move into the more mature world of conception. Why then did she stay in therapy for nearly two years? We believe it was because the therapeutic situation provided a much-needed structure. It was not the intensity of the relationship but its continuity—the sense of coming and going, the temporal quality of the relationship.

Ms. B told us that there was something indefinable about the therapeutic relationship that was helpful. She sometimes left sessions feeling more alive, more connected to her body, and better able to put her feelings into words. Her friends said she was less depressed. While she agreed, and thought it must be related to her treatment, she could not say how talking with her therapist actually helped. But Ms. B felt better.

These two cases illustrate not only different pathways of clinical change, but also distinct mediating conditions. Supported by our earlier quantitative findings, the retrospective reconstructions presented above allow us to pursue the qualitative dimension of change.

CONCLUDING COMMENTS

Psychoanalysis as a mode of treatment finds itself today in a constant state of challenge. In the public domain we encounter a continuous barrage of attacks from the media, the pharmacological industry, insurance companies, academics, and, most notably, managed care. Many of these criticisms focus not so much on the effectiveness of treatment as on its *cost* effectiveness, since psychoanalysis demands time and intensity of contact. Yet the notion of sustained exposure, the intensive interchange in a two-person encounter, is an essential ingredient that lies at the heart of all the psychoanalytic psychotherapies—regardless of particular theoretical persuasion.

Our empirical observations, viewed in the context of new and cumulative knowledge, provide a direct response to these criticisms. Admittedly, there are many sources of therapeutic gain other than those defined by sheer exposure to treatment. But these quantitative considerations, time and frequency, have come under ever sharper scrutiny. Early systematic clinical studies have already pointed in that direction. Now, metaanalytic studies have shown an optimal dose effect up to twelve months, much beyond that acknowledged most often by managed care. Further, our present data reveal a positive incremental effect up to thirty-two months of treatment. As to session frequency, studies in England and Scandinavia have indicated that increased session frequency exerts a persistent and even long-term impact on patients' mental health. Our observations confirm that this is so and move beyond these studies, demonstrating that increased session frequency has a specifiable and differential impact on perceived effectiveness of psychotherapy. With increased duration over the first three years, and with increased sessions per week, there were notable gains in patients' perception of their psychological well-being.

Finally, there is the persuasive criterion of effectiveness as a guide to treatment outcome. It involves the patient as consumer, judging that his or her life situation has been altered in a positive direction. This

criterion has to be viewed within the burgeoning literature of empirical psychoanalytic research. The method of retrospective reconstruction may serve to elucidate the clinical conditions that mediate outcome. In the study of recorded analyses we are increasingly in a position to identify the events in sessions that define an optimal psychoanalytic process. But it is the study of effectiveness that enables us to determine that quality of life has been enhanced and, further, that duration and frequency contribute to this end. Our empirical findings, together with those in the evolving literature, establish this as a clinical fact.

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Norbert Freedman et al.

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697 West End Avenue
Apartment 10G
New York, NY 10025
Fax: 212-662-9006

