

PSYCHOANALYSIS—WITH WHOM, FOR WHAT, AND HOW? COMPARISONS WITH PSYCHOTHERAPY

If psychoanalytic treatment is to survive in the era of evidence-based medicine and managed care systems, empirical evidence is needed to demonstrate its unique nature and effectiveness. To address this need, comprehensive analyses were conducted of data from the Menninger Psychotherapy Research Project (Wallerstein 1986). These analyses addressed three questions: (1) What are the differences in outcome between psychoanalysis (PSA) and supportive-expressive psychotherapy (SEP)? (2) With what types of patient, and in what ways, are these two psychodynamic treatments differentially effective? (3) Are these differences in outcome the consequence of possibly different mechanisms of therapeutic action? PSA was found to contribute significantly to the development of adaptive interpersonal capacities and to the reduction of maladaptive interpersonal tendencies, especially with more ruminative, self-reflective, introjective patients, possibly by extending their associative capacities. SEP, by contrast, was effective only in reducing maladaptive interpersonal tendencies and only with dependent, unreflective, more affectively labile anaclitic patients, possibly by containing or limiting their associative capacities.

The advent of managed care and the changed climate for long-term intensive psychological therapies, including a declining interest in psychoanalysis, have raised once again the importance of articulating

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the differences between psychoanalysis (PSA) and psychotherapy and of evaluating their relative effectiveness. An extensive literature has considered the differentiation between PSA and psychotherapy from both operational and theoretical perspectives. While it is easiest to differentiate the two modalities in operational terms (e.g., number of sessions per week, use of the couch, etc.), these distinctions are superficial and relatively unproductive. Rather, this differentiation is best made in process terms, based on what is occurring within the therapeutic dyad and in the treatment process. It is important to note, however, that from a process perspective it is possible that some patient-therapist dyads, though meeting the operational definition of psychotherapy (face-to-face contact and fewer sessions per week), might in fact be involved in a psychoanalytic process, while other dyads, who might meet the operational definition of PSA (use of the couch and sessions three to five times weekly), may not have established one. Thus, it is important to define as precisely as possible the concepts *psychoanalytic work* and *psychoanalytic process*. But considerable difficulty has been encountered in arriving at consensus definitions of these concepts (Vaughan and Roose 1995; Vaughan et al. 1997). Moreover, even if reasonably acceptable definitions could be established, another major problem would be developing methods for systematically assessing the degree to which a particular treatment has met these criteria.

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An alternative to this more conceptual, or theoretical, approach to differentiating PSA from psychotherapy is to address these issues empirically by evaluating aspects of therapeutic outcome and process in studies that compare psychoanalysis with different forms of psychotherapy and to then use these observed differences to identify essential differences between the modalities. We have attempted to address these issues in further analyses of data from the Menninger Psychotherapy Research Project (MPRP). Our purpose here is to integrate and extend the findings from our various analyses of the MPRP data set (e.g., Blatt 1992; Blatt and Shahar 2004; Shahar and Blatt 2004) to identify and articulate some of the differences between PSA and psychotherapy. This type of systematic empirical investigation of the efficacy and effectiveness of psychodynamic treatment is essential if psychoanalysis

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is to survive as an intellectual discipline (Bornstein 2001) and if it is to establish and maintain a credibility with mental health professionals, with patients, and with the managed care systems whose concern for cost containment force them to be very skeptical of long-term intensive interventions.

The now classic MPRP (see Wallerstein 1986) was one of the earliest systematic attempts to compare psychoanalysis with psychotherapy. Carefully designed and sophisticated both methodologically and clinically, the project compared five-times-weekly PSA with two- and three-times-weekly supportive or expressive psychotherapy. Whereas the MPRP distinguished these two forms of psychoanalytic psychotherapy, we have in our analyses grouped patients receiving either of these treatments under the heading supportive-expressive psychotherapy (SEP) and have compared this combined group with the group of patients who were in psychoanalysis (PSA). The MPRP is one of a very few studies that have attempted to systematically compare these modalities—two psychodynamically informed, long-term intensive treatments that differ primarily in the emphasis they place on the role of interpretation and insight in the treatment process. Though the MPRP was not a randomized clinical trial (patients were provided the treatment clinical staff thought would be most effective with them), the study was well conceptualized and carefully implemented, and included extensive clinical ratings and psychological assessments (including the Rorschach) at intake, termination, and follow-up. The various qualitative and quantitative analyses of the clinical and empirical data in the MPRP have resulted in over seventy publications, including five books, that have made important contributions to our understanding of various aspects of psychopathology and the therapeutic process (Rosen 2003). But one of the major disappointments with the MPRP was its failure to find significant empirical differences between PSA and SEP (Wallerstein 1986). As Wallerstein (1989) noted, “psychotherapy accomplished more stable and enduring results than expected, . . . [whereas] psychoanalysis . . . was more limited . . . than had been anticipated or predicted” (p. 205).

Wallerstein (1986) described PSA in the MPRP as operating “essentially through the establishment of a full-fledged regressive transference neurosis, and its ultimate resolution comes about centrally through interpretation leading to insight and mastery” (p. 54; see also Gill 1984, 1988). According to Wallerstein, SEP in the MPRP is “similar to psychoanalysis in mechanism but differs sharply in degree.

It is limited in focus to agreed-upon sectors of psychic distress and personality malfunction . . . operating through means that do not evoke a full transference regression, all leading to less extensive (more ‘intermediate’) results . . . ” (p. 54). SEP in the MPRP also included emotional support, reassurance, advice, and sometimes active suggestions and directions.

Sandell and colleagues (Blomberg, Lazar, and Sandell 2001; Blomberg and Sandell in press; Sandell et al. 2000), in a systematic empirical attempt to differentiate psychoanalysis and long-term psychodynamic psychotherapy, acknowledge many similarities but also report important differences between the two forms of treatment, including differences in outcome and in the clinician’s therapeutic attitudes and techniques. They note that it is important to think of psychoanalytic psychotherapy not as a diluted form of psychoanalysis, but as a unique treatment in its own right. They call for further systematic studies addressing the differences between the two modalities, not only to deal with the increasingly extensive research on empirically validated short-term therapies, but also to provide a substantive basis on which the psychoanalytic community can clarify the distinction between these forms of treatment (see Kernberg 1999), thereby possibly arriving at a fuller understanding of the mutative factors in the therapeutic process.

The MPRP (see, e.g., Luborsky et al. 1958; Sargent 1956a,b; Wallerstein and Robbins 1956) was designed to evaluate the interaction among aspects of patient, therapy, therapist, and evolving life circumstances and how they affected the therapeutic process and contributed to therapeutic outcome (Wallerstein, personal communication). Consistent with this approach, Blatt (1992) introduced the distinction between anaclitic and introjective forms of psychopathology (Blatt and Shichman 1983) into subsequent analyses of data from the MPRP (see also Blatt and Shahar 2004; Shahar and Blatt 2004). These subsequent analyses of the MPRP data have demonstrated significant differences between these two treatment modalities by introducing two major innovations into the data analyses: (1) the differentiation between two primary types of patient and (2) the introduction of relatively new methods for evaluating the Rorschach protocols that had been obtained in the MPRP at admission and at the termination of treatment. The design of the MPRP, the characteristics of the patients, and details of the two treatment conditions have been extensively described in a number of publications, including the book *Forty-*

two Lives in Treatment (Wallerstein 1986). Our analyses of data from the MPRP are based on thirty-three of the forty-two patients for whom Rorschach protocols were available both pre- and posttreatment.

RESEARCH METHOD

Differentiation between Anaclitic and Introjective Patients

Several prominent research methodologists (e.g., Cronbach 1953) have noted that some of the difficulty in identifying significant differences among different types of psychological interventions may be a function of the assumption of a “homogeneity” of patients (Kiesler 1966) whereby no differentiations are made among patients, all of whom are regarded as equivalent at the beginning of treatment (Blatt and Felsen 1993). This failure to differentiate limits a study’s potential to address more complex questions like whether certain treatments are more effective with certain kinds of patient (see Roth and Fonagy 1996), possibly resulting in different kinds of change (Blatt, Shahar, and Zuroff 2002).

Consistent with the call by Cronbach and others (e.g., Beutler 1976, 1979; Colby 1964; Kiesler 1966) to introduce patient differences into psychotherapy research, Blatt (1992) introduced the distinction between anaclitic and introjective patients into the comparison of PSA and SEP in the MPRP and found significant treatment differences as a function of patients’ pretreatment personality structure. Based on a fundamental polarity between relatedness and self-definition (see, e.g., Bakan 1966; Freud 1930; Loewald 1962; Wiggins 1991), Blatt and colleagues (Blatt 1990a, 1991, 1995b; Blatt and Blass 1990, 1996; Blatt and Shichman 1983) conceptualized personality development as involving two primary lines of psychological development—interpersonal relatedness and self-definition (or identity)—and, based on these two major psychological dimensions, were able to distinguish two primary personality styles as well as two fundamental configurations of psychopathology—anaclitic and introjective.

The differentiation of relatedness and self-definition as two fundamental psychological dimensions has enabled investigators from different theoretical orientations (e.g., Arieti and Bemporad 1978, 1980; Beck 1983; Blatt 1974, 1998, 2004; Blatt, D’Afflitti, and Quinlan 1976; Bowlby 1988a,b) to identify two types of depression (Blatt and Maroudas 1992)—an anaclitic depression centered on feelings of

loneliness, abandonment, and neglect and an introjective depression focused on issues of self-worth and feelings of failure and guilt (see, e.g., Blatt 1974, 1998; Blatt, D’Afflitti, and Quinlan 1976; Blatt et al. 1982). Extensive empirical investigation (see Blatt 2004; Blatt and Zuroff 1992; Luyten 2002) indicates consistent differences in the life experiences (both current and early) of these two types of depressed individuals (Blatt and Homann 1992), as well as major differences in their basic character style and the clinical expression of their depression.

The differentiation between individuals preoccupied with issues of relatedness and with issues of self-definition has also enabled investigators to identify an empirically derived structure for integrating the diversity of personality disorders described in Axis II of DSM-IV. Systematic empirical investigation of outpatients (Morse, Robins, and Gittes-Fox 2002; Ouimette et al. 1994) and of inpatients (Levy et al. 1995) found that the various personality disorders can be organized into two primary configurations—one organized around issues of relatedness and the other around issues of self-definition. Ouimette et al. and Morse, Robins, and Gittes-Fox with outpatients, and Levy et al. with inpatients, found that dependent, histrionic, and borderline personality disorders¹ (anaclitic patients) had significantly greater preoccupation with issues of relatedness than with issues of self-definition. Conversely, individuals with paranoid, schizoid, schizotypic, antisocial, narcissistic, avoidant, obsessive-compulsive, and self-defeating personality disorders (introjective patients) had significantly greater preoccupation with issues of self-definition than with issues of relatedness (Blatt and Levy 1998).

Thus, the fundamental polarity of relatedness and self-definition has facilitated the differentiation of two primary configurations of psychopathology—anaclitic and introjective—based on differences between an excessive preoccupation with issues of relatedness and an excessive focus on issues of self-definition (Blatt 1990a, 1995b; Blatt and Shichman 1983). Anaclitic psychopathology involves exaggerated preoccupations with establishing and maintaining satisfying intimate

¹Ouimette and colleagues found that BPD patients had elevated concerns on issues of both relatedness and self-definition. Blatt and Auerbach (1988), in a clinical-theoretical contribution, differentiated between highly dependent borderline patients who conform to the BPD diagnosis as described in DSM, and a more overideational, introjective type of borderline patient with obsessive-compulsive and paranoid features. Blatt and Auerbach suggest that the more dependent borderline patient, who is vulnerable to profound feelings of abandonment, would have greater concerns about issues of relatedness, while the more overideational obsessive-paranoid borderline patient would have greater concerns about issues of self-definition.

relationships—with feeling loved and being able to love. Anaclitic patients are desperately concerned about trust, closeness, and the dependability of others, as well as with their capacity to receive and give love and affection. The development of the self is disrupted by these intense conflicts about feeling deprived of care, affection, and love. This excessive preoccupation with establishing and maintaining satisfying interpersonal relatedness can occur at several developmental levels, from a lack of differentiation between self and other, through intense dependent attachment, to difficulties in more mature, reciprocal types of relationship. Anaclitic disorders, ranging developmentally from more to less disturbed, include nonparanoid schizophrenia, borderline personality disorder, infantile (or dependent) personality disorder, anaclitic depression, and hysterical personality disorders. Patients with these disorders use primarily avoidant defenses (e.g., withdrawal, denial, repression) to cope with psychological conflict and stress and to avoid intense erotic longings and competitive strivings, feelings that might threaten their already tenuous interpersonal relations.

Introjective psychopathology involves an excessive preoccupation with issues of self at varying developmental levels. These issues range from a basic sense of separation and differentiation from others, through concerns about autonomy and control of one's mind and body, to more internalized issues of self-worth, identity, and integrity. The development of interpersonal relations is interfered with by exaggerated struggles to establish and maintain a viable sense of self. Introjective patients are more ideational, and issues of anger and aggression, directed toward the self or others, are usually central to their difficulties. Introjective disorders, ranging developmentally from more to less severely disturbed, include paranoid schizophrenia, the overrideational borderline, paranoia, obsessive-compulsive personality disorder, introjective (guilt-ridden) depression, and phallic narcissism. Patients with introjective disorders use primarily counteractive defenses (e.g., projection, rationalization, negativism, isolation, intellectualization, doing and undoing, reaction formation, and overcompensation) such that the underlying impulse and conflict are partially expressed, but in disguised form. The basic issue for introjective patients is to achieve separation, control, independence, and self-definition, and to be acknowledged, respected, and admired. Conflicts within the introjective configuration usually involve profound feelings of inadequacy, inferiority, worthlessness, guilt, and difficulty managing affect, especially anger

and aggression, toward others and the self (Blatt 1974, 1990a, 1991, 1995a; Blatt and Shichman 1983).

The differentiation between these two broad configurations of psychopathology can be made reliably from clinical case records (see, e.g., Blatt 1992; Blatt and Ford 1994). In contrast to the atheoretical DSM diagnostic scheme, based primarily on differences in manifest symptoms, the anaclitic/introjective (or relational/self-definitional) distinction derives from dynamic considerations, including differences in instinctual focus (libidinal vs. aggressive), types of defensive organization (avoidant vs. counteractive), and predominant character style (e.g., emphasis on an object vs. a self-orientation and on affects vs. cognition). Thus, various forms of psychopathology are no longer considered discrete diseases but rather are regarded as interrelated disturbances that are the consequence of disruptions of normal psychological development. Continuity is maintained in these theoretical formulations among normal psychological development, variations in normal character or personality organization, and different forms of psychological disturbance. Even further, continuity is maintained within clusters of various disorders so that pathways of potential regression and progression, as well as the processes of therapeutic change, can be understood more fully.

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In our further analyses of the data from the MPRP, two independent judges distinguished anaclitic and introjective patients based on an evaluation of the clinical case records prepared at the beginning of treatment. These two senior clinicians agreed on the differentiation of twenty-six of the thirty-three patients included in this study as either anaclitic or introjective. The anaclitic/introjective differentiation of the remaining seven was made by a third senior clinician. Fifteen of the thirty-three outpatients (two female and seven male anaclitic; three female and three male introjective) had been seen in psychoanalysis. At intake, seven of these patients were diagnosed as neurotic and eight as having a personality disorder. Their mean age was thirty years. Eighteen of the thirty-three patients (six female and six male anaclitic; three female and three male introjective) had been seen in SEP. At intake, seven of these patients were diagnosed as neurotic, nine as having a personality disorder, and two as latent psychotic. Their mean age was 32.67 years.

New Methods for Evaluating Rorschach Protocols

Therapeutic outcome in our analyses of the MPRP data was assessed both by using ratings made by clinicians in the MPRP with the Health–Sickness Rating Scale, or HSRS (Luborsky 1975), and with more recently developed methods for systematically evaluating aspects of the Rorschach test protocols that had been gathered in the MPRP at admission and discharge. We approached these Rorschach protocols with the assumption that psychological tests, if evaluated with scoring systems derived from fundamental psychoanalytic and developmental concepts, can provide a methodology for the independent evaluation of patients' psychological development in the treatment process (Blatt and Auerbach 2003). We used several relatively new methods to evaluate aspects of object representation in the Rorschach protocols (Blatt 1990b, 1999; Leichtman 1996a,b) that had been obtained in the MPRP at admission and termination. In addition to the demonstrated reliability and validity of these new Rorschach scoring procedures in several cross-sectional studies of patients with different diagnoses (see, e.g., Blatt et al. 1976a,b; Urist 1977), these psychological assessment procedures had also been used in the study of therapeutic change in the long-term psychoanalytically oriented inpatient treatment of seriously disturbed treatment-resistant patients in the Riggs-Yale Project (RYP; see, e.g., Blatt and Ford 1994; Blatt et al. 1988). Thus, the assessment of therapeutic change in these further analyses of data from the MPRP parallel the measures of therapeutic change that had been used in an earlier study of therapeutic change in the long-term psychoanalytically oriented intensive inpatient treatment of seriously disturbed treatment-resistant patients at the Austen Riggs Center.

A series of psychological test variables derived from the Rorschach were used in the RYP to assess therapeutic change: composite thought disorder, degree of reality testing (F+%), the quality of adaptive and maladaptive object representation (OR+ and OR-), and the Mutuality of Autonomy (MOA) scale. Extensive cross-sectional research had earlier demonstrated acceptable levels of interrater reliability, as well as the construct validity of these variables in distinguishing among different types of psychopathology (for summaries of these measures, see Blatt 1992; Blatt and Ford 1994). These same test variables were used in our analyses of data from the MPRP. It is important to note, however, that the participants in the MPRP were outpatients, in contrast to the seriously disturbed treatment-resistant inpatients in the RYP. Thus, we did

not expect significant treatment effects in the MPRP to occur on the measures included in the RYP to assess more psychotic levels of functioning: thought disorder, level of reality testing (F+%), and the developmental level of maladaptive, inaccurately perceived object representation (OR-; Blatt et al. 1976a). Rather, significant treatment effects were expected in the MPRP on the measures designed primarily to assess functioning in the neurotic and borderline range: the developmental level of adaptive, accurately perceived object representations (OR+) and the Mutuality of Autonomy (MOA) Scale. Thus, we expected the assessment of object representation on the Rorschach with the recently developed scales, the Concept of the Human Object and the Mutuality of Autonomy scales, to be particularly relevant to evaluating the therapeutic effects of PSA and SEP in the treatment of the outpatients in the MPRP.

Concept of the Object on the Rorschach (COR). Based on concepts derived from developmental psychology (see, e.g., Werner 1948), Blatt et al. (1976a,b) developed a system for assessing the concept of the human figure on the Rorschach. The system calls for scoring responses with humanoid features according to developmental principles of *differentiation* (i.e., types of human figures perceived: quasi-human part properties, human part properties, quasi-human full figures, and full human figures), *articulation* (i.e., number and type of perceptual and functional features attributed to figures), and *integration*, including the degree of internality in the motivation of action attributed to the figures (unmotivated, reactive, and intentional action), the degree of integration of the object and its action (fused, incongruent, non-specific, and congruent action), the content of the action (malevolent, benevolent), and the nature of any interaction (active-passive, active-reactive, and active-active interactions). In each of these six categories (differentiation, articulation, motivation of action, integration of the object and its action, content of the action, and nature of interaction), responses are scored along a developmental continuum. This developmental analysis is made for those responses with any human or humanoid features that are accurately perceived (F+) or inaccurately perceived (F-). Scores in each of the six categories are standardized, and a weighted sum (developmental index, DI) and an average developmental score (developmental mean, DM) over the six categories is obtained for F+ and for F- responses separately. The composite weighted sum (developmental index, DI) and the developmental

average (developmental mean, DM) of the differentiation, articulation, and integration of accurately perceived human forms (OR+) assess the capacity for investing in appropriate interpersonal relationships; the composite weighted sum (DI) and the developmental average (DM) of differentiated, articulated, and integrated inaccurately perceived human forms (OR-) assess the degree of investment in inappropriate, unrealistic, possibly autistic fantasies rather than in realistic relationships. Prior research indicates that these variables can be scored reliably (see, e.g., Blatt et al. 1988; Blatt and Ford 1994; Ritzler et al. 1980), and that the OR+ variables develop longitudinally with age from early adolescence to adulthood (Blatt et al. 1976b) and that the OR+ and OR- variables are significantly related to independent estimates of psychopathology (see, e.g., Blatt et al. 1976b; Blatt, Schimek, and Brenneis 1980; Lerner and St. Peter 1985; Ritzler et al. 1980).

Mutuality of Autonomy (MOA). Another measure for assessing aspects of object representation on the Rorschach is the Mutuality of Autonomy Scale, or MOA (Urist 1977; Urist and Shill 1982). The MOA assesses the thematic content of interactions by rating all human, animal, and inanimate relationships (stated or implied) in a Rorschach protocol along a seven-point continuum ranging from mutually empathic, benevolent relatedness (scale score = 1) to themes of malevolent engulfment and destruction (scale score = 7). Scale points 1 and 2, the most adaptive scores in the scale, refer respectively to themes of reciprocal acknowledgment and constructive parallel interactions. A score of 1, for example, is given to a response to Card II of “two people having a heated political argument.” An example of a score of 2 is “two animals climbing a mountain” on Card VIII. Scale points 3 and 4 indicate an emerging loss of autonomy in interaction in which the “other” exists solely either to be leaned on (a score of 3) or to mirror oneself (a score of 4). An example of a score of 3 is a response to Card I of “two men leaning on a mannikin.” A score of 4 is given to the response “a tiger looking at its reflection in the water” to Card VIII. Scale points 5, 6, and 7 reflect an increasing malevolence and loss of control over one’s separateness. A score of 5 is given to responses characterized by themes of coercion, hurtful influence, or threat, such as “a witch casting a spell on someone” given to the top large detail of Card IX. A score of 6 indicates violent assault and destruction of one figure by another—for example, “a bat impaled on a tree” to Card I. Finally, a score of 7 represents a larger-than-life destructiveness imposed usually by inanimate,

calamitous force as depicted, for example, in the response to Card X, "a tornado hurtling its debris everywhere." Judges can make these distinctions at a high level of reliability.

The average (mean) MOA score is assumed to express the individual's usual quality of interpersonal relatedness. Each subject's single most pathological and single most adaptive MOA scores reflect the individual's range or repertoire of interpersonal interaction.² MOA scores have been shown to correlate significantly with measures of interpersonal and social functioning in clinical and nonclinical groups (see, e.g., Blatt et al. 1988; Harder et al. 1984; Ryan, Avery, and Grolnick 1985; Spear and Sugarman 1984; Tuber 1983; Urist 1977). Urist (1977) reported significant positive correlations of the MOA scale with independent ratings by ward staff of interpersonal relationships, as well as with aspects of autobiographical descriptions of interpersonal experiences in adult inpatients. Urist also found that the tendency for individuals to give at least one response at the more integrated end of the MOA scale correlated significantly with ratings of constructive interpersonal behavior on the ward, whereas the tendency to give at least one response at the more disrupted end of the scale correlated significantly with ratings of disrupted relationships in autobiographical narratives. Using comprehensive case records that included developmental and family history reports, notes on clinical progress, and nursing staff notes to assess the quality of interpersonal relationships of sixty adolescent patients, Urist and Shill (1982) found that ratings of these clinical case records correlated significantly with the mean MOA score. More disrupted MOA scores were consistently associated with reports of poorer interpersonal functioning on the clinical units and in the past history. Harder et al. (1984) found that the MOA scale correlated significantly with ratings of the severity of psychopathology derived from both complex symptom checklists and independent diagnostic assessment according to DSM-III. The mean MOA score differentiated

²The MOA mean is most highly correlated with the level of the single most malevolent (maladaptive) adaptive response ($r = .82$) but only marginally with the level of the most benevolent (adaptive) score ($r = .40$). These findings suggest that the level of the single most benevolent score probably reflects the individual's capacity to give at least one socially conventional response, whereas the level of the single most malevolent response reflects the potential range and depth of an individual's psychopathology. Other than the high correlation between MOA mean and the level of the single most malevolent MOA score, the correlations among the various outcome measures (COR and MOA) at time 1 and time 2 in this study are modest to low, indicating little overlap among these measures.

among schizophrenic, affective, and nonpsychotic conditions. More severe disorders were associated with a more disrupted mean MOA score. Spear and Sugarman (1984), using a modified version of the MOA, found significant differences among infantile borderline patients, overrideational borderline patients, and schizophrenics. In summary, MOA ratings correlate significantly with independent assessments of interpersonal behavior from clinical case records (Harder et al. 1984; Spear and Sugarman 1984; Urist and Shill 1982), ward staff ratings of social interactions (Urist 1977), psychiatric symptoms in adults and children (Harder et al. 1984; Tuber 1983; Tuber and Coates 1989), and ratings of interpersonal behavior in a nonclinical context (Ryan, Avery, and Grolnick 1985). In addition, more disrupted interactions on the Rorschach were significantly associated with more severe clinical symptoms and psychological test indicators of severe psychopathology, including measures of thought disorder (Blatt, Tuber, and Auerbach 1990).

These two conceptual schemes for evaluating interpersonal imagery in Rorschach responses (the COR and the MOA) were scored in the present study by two independent judges who previously had established acceptable levels of interrater reliability (Intraclass Correlation [ICC] > .70) in scoring the various dimensions of these two schemes. Judges were uninformed about any aspects of the patient, including age, sex, diagnosis, and the treatment group to which the patient was assigned. Judges were also uninformed about which two Rorschach protocols were from the same patient and about whether a particular Rorschach protocol was obtained before the start of treatment or at termination. Even further, the scoring of the COR and the MOA on the Rorschach was done by different judges.

Thus, we explored the difference in therapeutic response of analytic and introjective patients in PSA and SEP by evaluating change in their Rorschach protocols from pretreatment (Time 1) to the termination of therapy (Time 2) on five variables derived from the Rorschach—two from the COR, the developmental index (DI) and the developmental mean (DM), and three from the MOA (the MOA mean and the levels of the single most malevolent and the single most benevolent MOA responses). Regarding the two OR+ scores derived from the COR (DM and DI), it is important to note that the scores on the DM can range only from 1 to 4, while the scores on the DI (the weighted sum of all the responses with humanoid features, corrected for overall number of

Rorschach responses) have a much broader range and therefore are likely to be a more differentiated measure. Likewise, among the three MOA scores, the MOA mean is based on a wide range of responses and therefore is likely to be a more stable measure than the levels of the single most benevolent and single most malevolent responses.

We conducted a principal components factor analysis on these five scores derived from the Rorschach and found that the DI and DM of OR+ responses and the level of the MOA single most benevolent score formed a common factor we labeled “Adaptive Representations,” while the MOA mean and the level of the most malevolent MOA response formed a second factor that we called “Maladaptive Representations.”

Because the patients in the MPRP were not randomly assigned to the two treatment groups, but instead were provided the treatment the clinical staff thought would be most effective with them, it is important to note that no significant differences were found at the beginning of treatment between the patients in PSA and SEP in their initial scores at Time 1 on the five outcome measures (Blatt 1992).

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Statistical Analyses

Our prior statistical analyses of data from the MPRP (Blatt 1992) were conducted using Analysis of Covariance (ANCOVA), a procedure that assesses residualized change scores in which Time 2 levels of the outcome variables were regressed on Time 1 levels. Although these earlier analyses of the MPRP data using ANCOVA (Blatt 1992) yielded important findings, including several significant treatment differences and Patient-by-Treatment interactions, in the course of our extensive reanalyses, we discovered that this statistical procedure (ANCOVA) actually underestimated the effects that can be detected in these data.

Because psychoanalytic treatment usually involves lengthy and intensive treatment, as well as extensive information gathered on each patient, the number of patients that can be studied is usually restricted. This reduced sample size presents marked limitations for research because it reduces the statistical power of the analyses. This is problematic generally, but it becomes particularly so when we attempt to statistically evaluate interaction effects. Indeed, as reported below, the observed power underlying our findings is very small, presenting a serious obstacle to detecting statistically significant Patient-by-Treatment interactions.

In light of these considerations, in the present study we elected to use repeated-measures Analysis of Variance (ANOVA), instead of ANCOVA, in our further exploration of the MPRP data. In contrast to ANCOVA, which corrects for baseline levels of the variable by residualizing the outcome levels from baseline levels, repeated-measures ANOVA assesses the simple differences, or change scores, between Time 1 (baseline) and Time 2 (termination). In the process of estimating the baseline regression coefficient, ANCOVA loses an additional degree of freedom, a loss that does not occur in repeated-measures ANOVA. Though ANCOVA is generally the preferred data-analytic strategy (Cronbach and Furby 1970), the loss of an additional degree of freedom in ANCOVA places serious limitations on analyses of data from small samples. Consequently, repeated-measures ANOVA appears to be a more sensitive procedure for detecting Patient-by-Treatment interactions in studies with small sample sizes and the resultant loss of statistical power, as in the present study (Rogosa 1988; Rogosa and Willett 1983).³

OVERVIEW OF RESULTS

The findings of our study will be presented below in three sections: (1) differences in therapeutic outcome; (2) impact of patient pretreatment characteristics on therapeutic change; (3) possible mechanisms of therapeutic change.

Table 1 presents the means for all the outcome variables at baseline and termination in psychoanalysis (PSA) and supportive-expressive psychotherapy (SEP) for anaclitic and introjective patients. Table 2 presents *F* values and statistical significance levels of the repeated-measures ANOVAs conducted with five outcome variables, as well as the number of Rorschach responses, for the data analyses presented below. Each section of data analysis is introduced by an italicized subhead and is followed by a summary section presenting a narrative exposition of the statistical findings.

³We are grateful to David C. Zuroff for consultation on these statistical matters.

Table 1: Means of outcome variables at baseline and termination in psychoanalysis (PSA) and supportive-expressive psychotherapy (SEP) among anaclitic and introjective patients

	Anaclitics PSA (N = 9)		Anaclitics SEP (N = 12)		Introjectives PSA (N = 6)		Introjectives SEP (N = 6)	
	T1	T2	T1	T2	T1	T2	T1	T2
HSRS	47.88	58.66	44.66	50.91	55.00	68.66	46.33	60.91
MOA Mean	2.37	3.20	2.62	2.28	2.70	2.51	2.43	3.16
MOA Mal	3.55	4.88	3.91	3.33	4.66	3.83	4.00	5.50
MOA Ben	1.66	1.33	1.83	1.50	1.50	1.00	1.16	1.66
OR+ Index	-.50	.08	-2.22	-1.62	1.05	1.85	5.21	.78
OR+ Mean	1.44	.33	-.56	-2.69	1.10	1.08	2.75	-1.19
# Responses	47.11	52.00	36.75	33.25	58.50	60.33	50.83	37.83

T1 = baseline; T2 = termination; PSA = psychoanalysis; SEP = supportive-expressive psychotherapy; HSRS = Health-Sickness Rating Scale; MOA Mean = average score of the Rorschach Mutuality of Autonomy Scale (MOA); MOA Mal = most malevolent response of the MOA; MOA Ben = most benevolent response on the MOA; OR+ Index = weighted sum of accurately perceived responses of the Concept of the Object on the Rorschach Scale; OR+ Mean = developmental mean of accurately perceived responses of the Concept on the Object on the Rorschach Scale.

Omitted from this table are the mean scores for the psychological test variables that had been included in the Riggs-Yale Project (RYP) to assess more psychotic levels of functioning (degree of reality testing [F+%], thought disorder, and the two object representation measures for inaccurately perceived responses [OR-]). No significant main effects or interactions were obtained with these variables in the present study.

RESULTS: DIFFERENCES IN THERAPEUTIC OUTCOME

Development of Adaptive Interpersonal Schemas

Three measures were used to evaluate the level of adaptive interpersonal schemas: (1) the level of the most benevolent response assessed on the MOA (a reverse 7-point scale on which the score of 1 indicates a representation of reciprocal and constructive [benevolent] interaction), and (2–3) the level of accurately perceived object representations (OR+) as measured by (a) the developmental index (DI, or weighted sum [WS]), and (b) the developmental mean (DM) on the Concept of the Object Scale for the Rorschach (COR).

Table 2: F values and statistical significance levels of repeated-measures ANOVAs conducted on six Rorschach variables

Effect	MOA Most Adaptive	OR+ DI (WS)	OR+ DM	MOA MEAN	MOA Most Maladaptive	# Responses
Patient	2.38 ^{ns}	4.02 ^b	1.21 ^{ns}	.08 ^{ns}	1.33 ^{ns}	1.19 ^{ns}
Treatment	1.06 ^{ns}	.00 ^{ns}	1.43 ^{ns}	.06 ^{ns}	.00 ^{ns}	2.84 ^{ns}
Time	1.78 ^{ns}	.62 ^{ns}	9.57 ^c	3.74 ^{ns}	1.04 ^{ns}	.69 ^{ns}
Patient x Treatment	.00 ^{ns}	.93 ^{ns}	.86 ^{ns}	.90 ^{ns}	1.20 ^{ns}	.00 ^{ns}
Patient x Time	1.78 ^{ns}	2.74 ^{ns}	.09 ^{ns}	.01 ^{ns}	.00 ^{ns}	1.14 ^{ns}
Treatment x Time	4.02 ^b	3.25 ^a	4.49 ^c	.21 ^{ns}	.09 ^{ns}	3.93 ^b
Pt. x Treatmt x Time	4.02 ^b	3.01 ^a	1.54 ^{ns}	15.26 ^d	9.42 ^c	.30 ^{ns}

1. Patient = anaclitics vs. introjectives
2. Treatment = PSA vs. SEP
3. Time = baseline vs. termination
4. Numbers = F values derived from the repeated-measures ANOVAs
5. Degrees of freedom for all tests: *DF* = 29
6. ^a *p* < .10; ^b *p* < .05; ^c *p* < .01; ^d *p* < .001; ^{ns} nonsignificant

Level of the most benevolent interaction on the MOA. A 2 x 2 x [2] (Treatment-by-Patient-by-Time) repeated-measures ANOVA conducted on the MOA adaptive response yielded two statistically significant effects: (1) a Treatment-by-Time interaction ($F[1,29] = 4.02, p = .05$; Effect size [Partial Eta Squared] = .14; Observed Power = .52), and (2) a three-way Treatment-by-Patient-by-Time interaction ($F[1,29] = 4.02, p = .05$; Effect size [Partial Eta Squared] = .12; Observed Power = .49).

Probing the significant two-way interaction, we found that patients in PSA improved significantly in terms of the most adaptive MOA response from baseline to termination (Dependent-sample $t[14] = 2.44, p = .02$). By contrast, no improvement was found in SEP (Dependent-sample $t[17] = .29, p = .77$).

A statistically significant three-way interaction, however, qualifies this treatment effect by suggesting that this improvement occurred primarily in one type of patient (i.e., anaclitic or introjective) but not the other. Probing this three-way interaction, we found that the Treatment-by-Time interaction was statistically significant among introjective patients ($F[1,10] = 6.00, p = .03$), but not among anaclitic patients

($F[1,19] = 0, p = 1.00$) (Dependent-sample $t[5] = -1.46, p = .20$). Whereas anaclitics tended to improve in both PSA and SEP, only PSA resulted in a near-significant level of improvement among introjectives (Dependent-sample $t[5] = 2.23, p = .07$). By contrast, SEP led to a non-significant trend reflecting a decline in the level of benevolence in introjective patients (Dependent-sample $t[5] = 1.46, p = .20$).

Narrative summary. As illustrated in Figure 1, PSA led to improvement (i.e., increase in the level of benevolence in interactions on the Rorschach) in both anaclitics and introjectives. By contrast, SEP led to similar improvement in anaclitics, but to a deterioration (a reduction of benevolence) in introjectives. Thus, while PSA is effective with both types of patient, SEP is effective only with anaclitics and appears, in fact, to impede therapeutic progress in introjectives.

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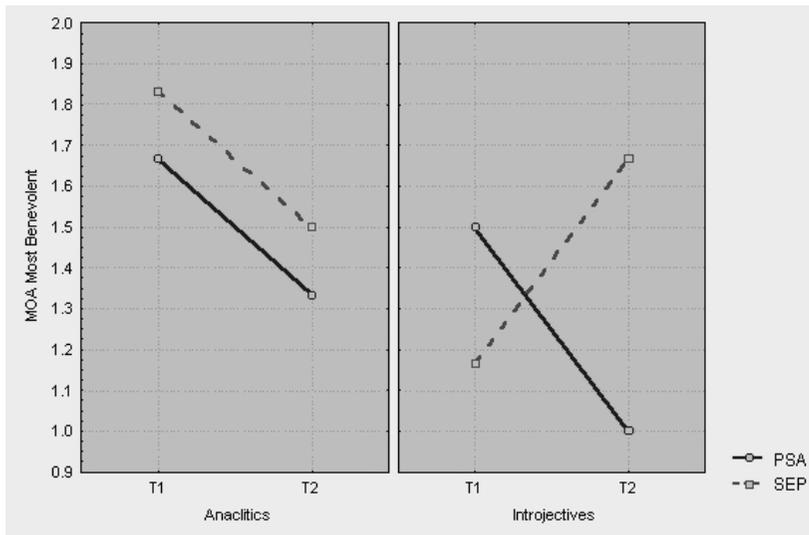


FIGURE 1: Means of MOA Most Benevolent (adaptive) score at baseline (T1) and termination (T2) among anaclitic and introjective patients in psychoanalysis (PSA) and supportive-expressive psychotherapy (SEP). (Note: the MOA is a reverse scale, the most benevolent score receiving a rating of 1.)

Developmental index (DI) of accurately perceived human responses (OR+). A 2 x 2 x [2] (Treatment-by-Patient-by-Time) repeated-measures ANOVA conducted on OR+ DI yielded three statistically significant, or trend, effects: (1) a significant main effect for Patient ($F[1,29] = 4.02, p = .05$, Effect size [Partial Eta Squared] = .14; Observed Power = .57),

indicating that introjective patients had greater improvement than anaclitic patients on the OR+ DI ($M = 2.22$ vs. $M = -1.09$, respectively); (2) a trend toward a statistically significant, two-way Treatment-by-Time interaction ($F[1,29] = 3.25$, $p = .08$; Effect size [Partial Eta Squared] = .10; Observed Power = .41); and (3) a trend toward a statistically significant three-way interaction ($F[1,29] = 3.01$, $p = .09$; Effect size [Partial Eta Squared] = .09; Observed Power = .39).

Probing the two-way interaction, we found that patients tended to have greater improvement in PSA than in SEP. (Both patterns were nonsignificant [PSA $t[14] = -.59$, $p = .55$; SEP $t[17] = 1.16$, $p = .25$]). As with the findings with the most benevolent MOA response discussed above, however, this Treatment-by-Time interaction is qualified by patient characteristics. Namely, the treatments appear to differ significantly with only one of the two types of patient. Probing this possibility, we found that the treatments clearly did not differ ($F[1,19] = .00$, $p = .94$) among anaclitic patients, as both PSA and SEP led to nonsignificant improvement. Among introjective patients, however, we found a trend toward a differential treatment effect ($F[1,10] = 2.79$, $p = .12$). This pattern, presented in Figure 2, is noteworthy, as it is similar to the pattern presented in Figure 1 that is derived from the analyses of the level of the most benevolent MOA response. Thus, the results presented in Figures 1 and 2 indicate that PSA and SEP were equally effective in contributing to indications of increased adaptive capacities in anaclitic patients. By contrast, introjective patients had nonsignificant (Dependent-sample $t[5] = -.34$, $p = .72$) improvement in PSA, but a trend toward diminished adaptive capacities in SEP (Dependent-sample $t[5] = 2.11$, $p = .08$), resulting in a trend toward a differential treatment effect ($p = .12$).

Narrative summary. Figure 2 presents changes in adaptive interpersonal schemas in anaclitic and introjective patients in PSA and SEP as measured by the developmental index (weighted sum) of adaptive (accurately perceived) representations of human figures (OR+) with the Concept of the Object Scale. Figure 2 illustrates a statistically significant treatment effect with the developmental index of OR+ responses that is primarily a function of increases in these adaptive representations in PSA in both anaclitic and introjective patients. Similar to the results obtained with the level of the most benevolent MOA response (as illustrated in Figure 1), PSA led to an increase in adaptive representations in both types of patient.

These data analyses also indicate that the effects of SEP were again more complex and suggestive of a Patient-by-Treatment interaction. SEP again, as in the analyses based on the level of the most benevolent MOA response, presented in Figure 1, led to a substantial decline in adaptive responses in introjective patients, while anaclitic patients in SEP had an increase in these adaptive capacities.

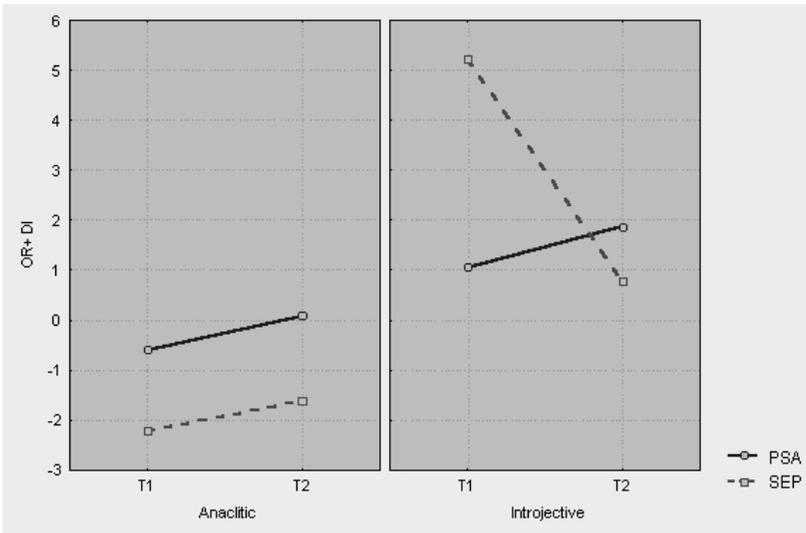


FIGURE 2: Means of the COR developmental index (DI or weighted sum [WS]) at baseline (T1) and termination (T2) of accurately perceived responses (OR+) among anaclitic and introjective patients in psychoanalysis (PSA) and supportive-expressive psychotherapy (SEP).

Developmental mean (DM) of accurately perceived human responses (OR+). A 2 x 2 x [2] (Treatment-by-Patient-by-Time) repeated-measures ANOVA conducted on the OR+ developmental mean yielded two statistically significant effects: (1) a significant main effect of Time ($F[1,29] = 9.57, p = .004$; Effect size [Partial Eta Squared] = .24; Observed Power = .84) indicative of a decline in adaptive representations across the two treatments over time ($M[T1] = .80$ vs. $M[T2] = .90$) and (2) a statistically significant two-way interaction between Treatment and Time ($F[1,29] = 4.49, p = .04$; Effect size [Partial Eta Squared] = .13; Observed Power = .53). The three-way interaction was nonsignificant ($F[1,29] = 1.54, p = .22$). Because the pattern of the three-way interaction embeds the statistically significant two-way Treatment-by-Time interaction, it is presented in Figure 3.

As shown in Figure 3, the two-way interaction between Treatment and Time appears to reflect the fact that, while no change occurred in PSA (Dependent-sample $t[14] = 1.43, p = .17$), a significant decline in adaptive capacities (as measured by OR+ DM) occurred in SEP (Dependent-sample $t[17] = 2.91, p = .009$). As shown in Figure 3, this decline occurred in both anaclitic and introjective patients.

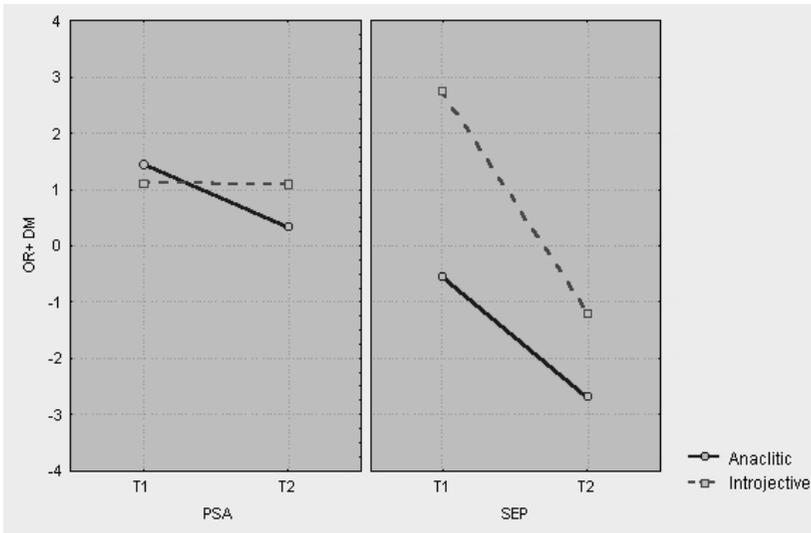


FIGURE 3: Means of the COR developmental mean (DM) of the accurately perceived responses (OR+) at baseline (T1) and termination (T2) among anaclitic and introjective patients in psychoanalysis (PSA) and supportive-expressive psychotherapy (SEP).

Narrative summary. Figure 3 presents the results using the developmental mean of accurately perceived responses (OR+) on the Rorschach as the outcome measure for evaluating changes in adaptive interpersonal schemas. Again these two treatments had significantly different effects on the development of adaptive, accurately perceived object representations (OR+) on the Rorschach. While no statistically significant changes were noted in the developmental mean of these adaptive representations (OR+) in anaclitic and introjective patients in PSA, both anaclitic and introjective patients had a substantial decline in adaptive interpersonal representations as measured by the OR+ developmental mean in SEP.

Summary of the development of adaptive interpersonal schemas. Consistent with the earlier analyses of the MPRP data using ANCOVA

(Blatt 1992), the results with repeated-measures ANOVA indicate a pattern suggestive of the superiority of PSA over SEP. Namely, PSA was more effective than SEP in increasing adaptive interpersonal schemas (i.e., with the MOA most adaptive response and the OR+ DI) and in preventing a decline in the developmental level of these adaptive schemas (as measured with the OR+ DM).

It is important to note, however, that with respect to two of the three adaptive outcome measures, the superiority of PSA over SEP was qualified by the type of patient seen in either treatment. Thus, the overall advantage of PSA over SEP in increasing adaptive responses (the level of the most benevolent MOA response, the OR+ DI) is accounted for by the fact that PSA, but not SEP, produced an improvement with introjective patients. Indeed, introjective patients in SEP had a non-significant decline in adaptive capacities rather than an improvement.

Reduction of Maladaptive Interpersonal Schemas

Mean (average) MOA score and the level of the single most malevolent MOA score both assess the extent of maladaptive interpersonal representation. The high score of 7 on the MOA indicates a highly destructive unilateral representation in which a powerful calamitous force destroys a vulnerable and passive victim.

Average level of MOA responses. A 2 X 2 X [2] repeated-measures ANOVA involving Treatment, Patient, and Time on the MOA mean yielded a statistically significant three-way interaction ($F[1,29] = 15.26, p = .000$; Effect size [Partial Eta Squared] = .34; Observed Power = .96). The pattern of this interaction is presented in Figure 4.

Probing this three-way interaction, we found that the treatments differed significantly among anaclitic patients ($F[1,19] = 14.07, p = .001$) and tended to differ among introjective patients ($F[1,10] = 4.07, p = .07$). As shown in Figure 4, the pattern underlying these treatment effects was inverse among anaclitic patients, as compared to introjective patients. Namely, among anaclitic patients, PSA yielded a significant increase in maladaptive representations (Dependent-sample $t[8] = -5.59, p = .000$), whereas SEP brought about a trend toward improvement (Dependent-sample $t[11] = 1.40, p = .18$). Among introjectives, PSA yielded a nonsignificant pattern consistent with improvement (Dependent-sample $t[5] = .56, p = .59$), whereas SEP resulted in a near-significant increase in maladaptive representations (Dependent-sample $t[5] = -2.29, p = .06$).

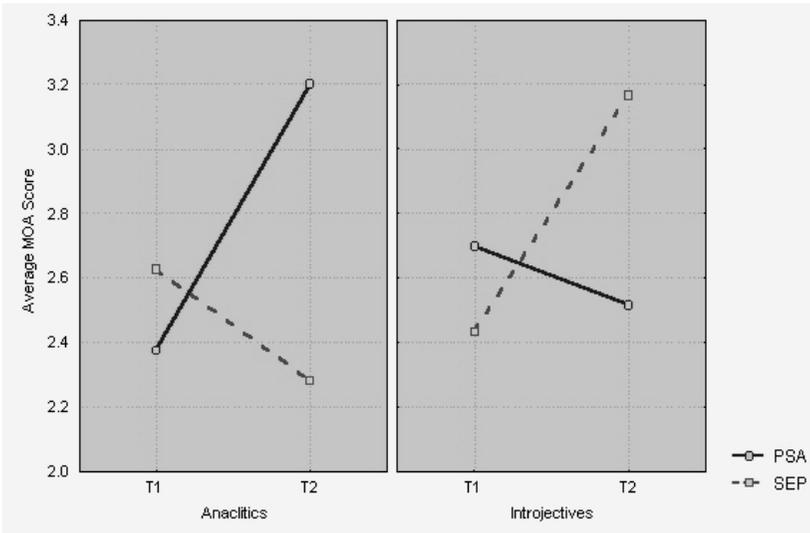


FIGURE 4: Means of the MOA average score at baseline (T1) and termination (T2) among anaclitic and introjective patients in psychoanalysis (PSA) and supportive-expressive psychotherapy (SEP).

Level of most malevolent interaction on the MOA. A 2 X 2 X [2] repeated-measures ANOVA involving Treatment, Patient, and Time on the single most malevolent response on the MOA also yielded a statistically significant three-way interaction ($F[1,29] = 9.42, p = .004$; Effect size [Partial Eta Squared] = .24; Observed Power = .84). The pattern of this interaction is presented in Figure 5.

Significant treatment effects were found among anaclitic patients ($F[1,19] = 4.54, p = .04$) and among introjective patients ($F[1,10] = 6.20, p = .03$). Among anaclitic patients, PSA yielded a significant decline in functioning (Dependent-sample $t[8] = -2.52, p = .03$), whereas SEP yielded a nonsignificant increase in functioning (Dependent-sample $t[11] = .87, p = .40$). Among introjective patients, PSA yielded a nonsignificant trend toward improvement (Dependent-sample $t[5] = 1.53, p = .18$), whereas SEP yielded a trend toward increased malevolence (Dependent-sample $t[5] = -1.96, p = .10$).

Narrative summary. In contrast to the significant treatment effects indicating the superiority of PSA in facilitating the development of adaptive interpersonal capacities discussed earlier, the data analyses reported above reveal a significant Patient-by-Treatment interaction in the reduction of maladaptive tendencies, as measured by the average

MOA score and by the level of single most malevolent response on the MOA. As illustrated in Figures 4 and 5, PSA was significantly more effective than SEP in reducing the level of maladaptive imagery with introjective patient; with anaclitic patients, however, PSA interfered with the reduction of such imagery. SEP, by contrast, was significantly more effective than PSA in reducing these maladaptive tendencies with anaclitic patients and interfered with their reduction in introjective patients. These findings using repeated-measures ANOVA are consistent with earlier analyses of these data using ANCOVA (Blatt 1992).

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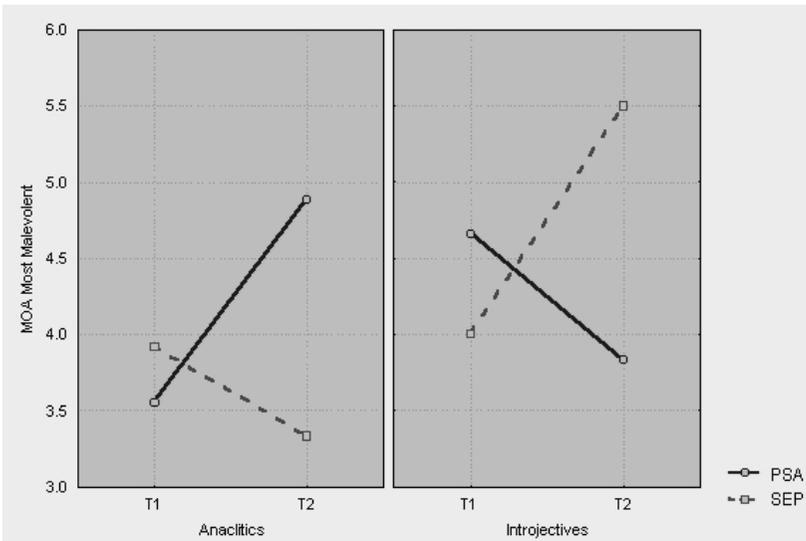


FIGURE 5: Means of the MOA Most Malevolent (maladaptive) score at baseline (T1) and termination (T2) among anaclitic and introjective patients in psychoanalysis (PSA) and supportive-expressive psychotherapy (SEP).

Similar to the analyses with the measures of adaptive outcome, results obtained with measures of maladaptive interpersonal schemas consistently indicated a Patient-by-Treatment interaction. The pattern of results obtained with the maladaptive interpersonal schemas is more clear-cut than that obtained with adaptive interpersonal schemas, in that it suggests a reverse process among the two types of patient. Among anaclitic patients, SEP appears to reduce maladaptive schemas and PSA to increase them. Among introjective patients the inverse appears to occur: PSA reduces maladaptive schemas, whereas SEP increases them.

Stability of the Patient-by-Treatment Interaction

Because it is most unusual to find significant Patient-by-Treatment interactions in psychotherapy research, particularly with the reduced sample size and low statistical power of the MPRP, we (Blatt and Shahar 2004) sought to assess the stability of this interaction. We tested the stability of these Patient-by-Treatment interactions with the MOA mean score because the MOA mean is a more stable measure than the level of the single most malevolent response. Not only is this Patient-by-Treatment interaction statistically significant for the entire sample of thirty-three patients, as well as for the subsample of twenty-six patients with whom the anaclitic/introjective distinction was clear (see Figure 6), but aspects of this interaction are significant for the seven patients on whom the two judges differed in their evaluation of whether the patient was predominantly anaclitic or introjective and for whom this differentiation was made by a third, independent judge. These findings are illustrated in Figures 6–8.

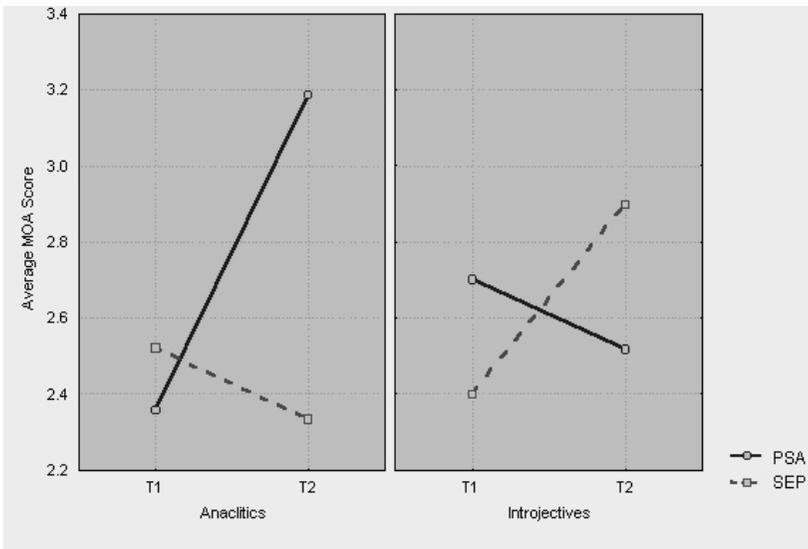


FIGURE 6: Means of the MOA average score at baseline (T1) and termination (T2) among nonambiguous ($N = 26$) anaclitic and introjective patients in psychoanalysis (PSA) and supportive-expressive psychotherapy (SEP).

Figure 6 presents this significant interaction with the MOA mean for the twenty-six patients on whom the two primary judges agreed

about the anaclitic/introjective distinction, and Figures 7 and 8 present aspects of this interaction for the seven patients on whom the two primary judges disagreed and for whom this distinction was decided by the third, independent judge (Blatt and Shahar 2004).

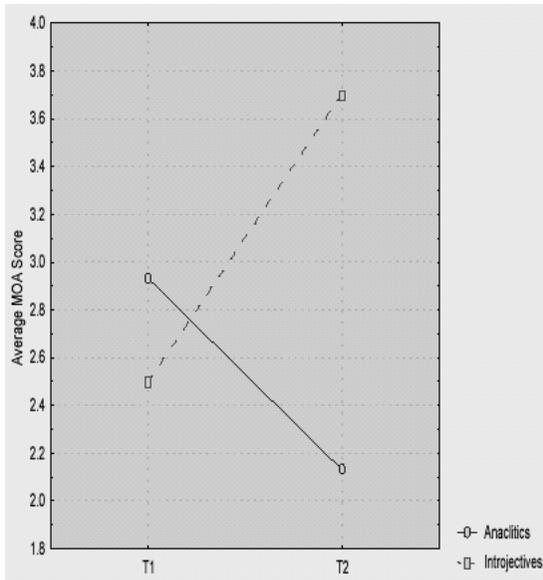


FIGURE 7: Means of the MOA average score at baseline (T1) and termination (T2) among less clearly defined anaclitic ($N = 3$) and introjective ($N = 2$) patients in supportive-expressive psychotherapy (SEP).

Five of the seven patients with a less certain anaclitic/introjective distinction (three anaclitic and two introjective) were in SEP, and two (both anaclitic) were in PSA. A repeated-measures ANOVA with Patient (anaclitic vs. introjective) as a between-subject predictor and Time (baseline vs. termination) as a repeated-measures outcome yielded a statistically significant interaction ($F[1,3] = 8.78, p = .05$). The pattern of this interaction is presented in Figure 7.

As shown in Figure 7, the three “ambiguous” anaclitic patients in SEP showed improvement. Although a Dependent-sample t test did not yield a statistically significant effect ($t[2] = 1.62, p = .24$), this is clearly due to the meager sample size. By contrast, the two “ambiguous” introjective patients in SEP showed a pattern consistent with a deterioration, although this very small sample size yielded only a statistical trend (Dependent-sample $t[1] = -4.00, p = .15$).

Figure 8 presents the results with the two “ambiguous” anaclitic patients seen in PSA. These two patients showed a clear trend toward deterioration, although the meager sample size prevented this pattern from reaching statistical significance (Dependent-sample $t[1] = -2.66$, $p = .22$).

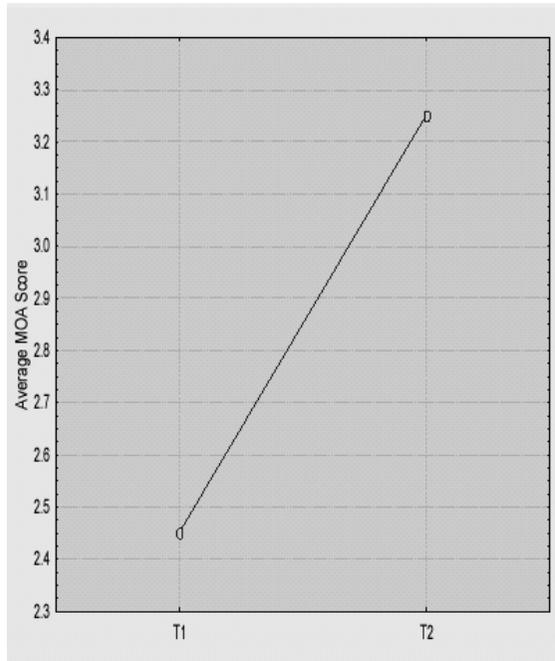


FIGURE 8: Means of the MOA average score at baseline (T1) and termination (T2) for two less clearly defined anaclitic patients in psychoanalysis (PSA).

Summary of Differences in Therapeutic Outcome

In summary, PSA was more effective than SEP in facilitating both the reduction of maladaptive malevolent representations in introjective patients and the development of more adaptive, benevolent representations with both anaclitic and introjective patients, but especially with the latter; indeed, introjective patients had a decline in functioning in SEP. SEP was more effective than PSA in reducing maladaptive representations with anaclitic patients, whereas PSA was more effective in reducing them in introjective patients. These results consistently indicate that PSA is unique in its facilitation of the development of adaptive capacities, and that both forms of treatment (PSA and SEP) are

effective in reducing maladaptive tendencies with some patients and ineffective with others, depending on their personality organization (anaclitic or introjective).

RESULTS: IMPACT OF PATIENT PRETREATMENT CHARACTERISTICS ON THERAPEUTIC CHANGE

In addition to the statistically significant treatment differences and the significant Patient-by-Treatment interactions discussed above, we found that patients' pretreatment characteristics had a significant impact on therapeutic outcome. These analyses were inspired by relatively recent findings in our further analyses of data from the NIMH-sponsored Treatment of Depression Collaborative Research Program (TDCRP), a carefully designed randomized clinical trial that compared three manual-directed brief outpatient treatments for depression: cognitive-behavioral therapy (CBT), interpersonal therapy (IPT), and imipramine with clinical management (IMI-CM) with a double-blind placebo with clinical management (PLA-CM). While IPT and IMI-CM were superior to PLA-CM in reducing symptoms of depression at termination ($p < .05$), no significant differences were found in symptom reduction among the three active treatment conditions (CBT, IPT, and IMI) at termination (Elkin 1994; Elkin et al. 1985) or at follow-up (Blatt et al. 2000). In contrast, our analyses of the TDCRP data, based on our introduction of patients' pretreatment characteristics into the data analyses, revealed a host of significant findings indicating that patients' personality characteristics have a significant effect on treatment outcome and on aspects of the therapeutic process (Blatt et al. 1995, 1996, 1998; Blatt, Shahar, and Zuroff 2001; Shahar et al. 2003, in press; Zuroff et al. 2000). Specifically, these analyses indicate that patients' pretreatment levels of perfectionism or self-criticism (i.e., an introjective personality organization) predicted poorer therapeutic outcome at termination and follow-up in all three of these brief treatments for depression, primarily because this personality characteristic interfered with the development of interpersonal relationships both within, and external to, the treatment process (for a review, see Blatt, Shahar, and Zuroff 2001, 2002). Based on these results of our analyses of data from the NIMH-sponsored TDCRP, we decided to explore the effects of patients' pretreatment personality organization on therapeutic out-

come in PSA and SEP in the MPRP. Using general linear modeling (GLM) analysis, a robust and flexible data-analytic procedure that enables the examination of interactive effects involving dichotomous and continuous variables, we explored the quality of pretreatment personality characteristics on change in overall clinical functioning as the measures of treatment outcome in the MPRP.

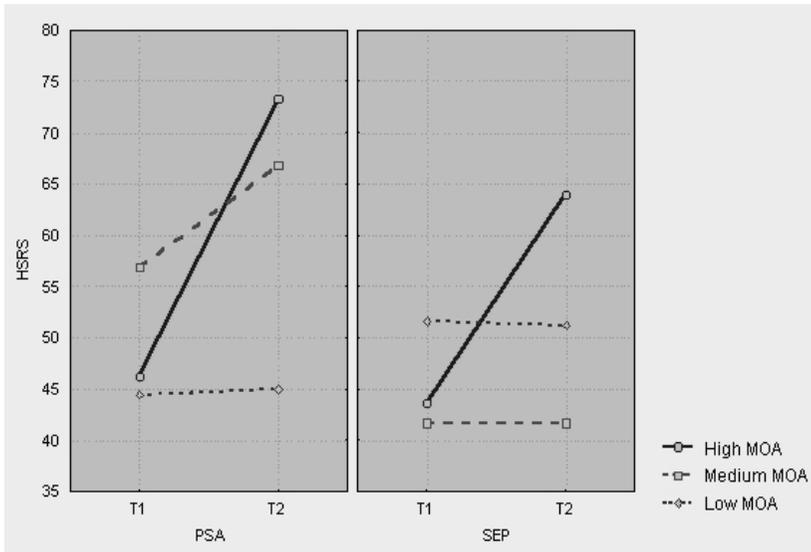


FIGURE 9: Means on the Health-Sickness Rating Scale (HSRS) at baseline (T1) and termination (T2) among patients with high, medium, and low MOA mean scores at baseline (T1) in psychoanalysis (PSA) and supportive-expressive psychotherapy (SEP).

Given our findings of the importance of changes in object representations as measures of therapeutic outcome in PSA and SEP in the MPRP, we decided to explore the effects of pretreatment levels of object representation, particularly the MOA mean, on therapeutic outcome in PSA and SEP (Shahar and Blatt 2004). Using general linear modeling (GLM) analysis, we found that more mature pretreatment levels of interpersonal schemas (as measured by MOA mean) significantly predicted improvement from intake to termination in clinical functioning in the MPRP as assessed by the Health-Sickness Rating Scale (HSRS; $\beta = -.55, p < .001$) and that this effect was significant in both PSA ($\beta = -.74, p < .0001$) and in SEP ($\beta = -.52, p < .05$). The pretreatment level of the average MOA score had an impact on the

change in level of clinical functioning (HSRS) even when controlling for baseline levels of HSRS and for the anaclitic/introjective distinction. Patients with more mature and adaptive interpersonal schemas prior to treatment made more extensive therapeutic gains. Further GLM analyses revealed a statistically significant treatment interaction ($\beta = -.31, p < .05$), indicating that PSA was superior to SEP in contributing to improved clinical functioning (as measured by clinical ratings on the HSRS) among patients who initially had both medium and lower MOA levels (more adaptive and mature interpersonal schemas). As illustrated in Figure 9, no significant differences were found between PSA and SEP, however, in producing clinical change in patients with less mature or less adaptive (more malevolent) interpersonal schemas (higher MOA mean). Thus, patients with more mature interpersonal schemas made more extensive therapeutic gains in both PSA and SEP, and these gains were greater in PSA than in SEP.

RESULTS: POSSIBLE MECHANISMS OF THERAPEUTIC CHANGE

The significant differences in the impact of PSA and SEP on patients' development of adaptive interpersonal capacities, and the differential interaction of these two modalities with anaclitic and introjective patients in reducing maladaptive interpersonal tendencies, suggest the possibility that PSA and SEP may involve different mechanisms of therapeutic change. We attempted to identify possible mechanisms of therapeutic change by testing the hypothesis that SEP is more effective in reducing maladaptive interpersonal tendencies with affectively labile, emotionally overwhelmed anaclitic patients because SEP provides a supportive and containing context, and that this containing context would be indicated by a significant *reduction* in associative activity during the treatment process. PSA, by contrast, is more effective in decreasing maladaptive interpersonal tendencies, as well as in facilitating the development of adaptive interpersonal capacities, primarily with the more distant and isolated introjective patients, who are more distant and well-defended, because the explorations and interpretations in PSA more fully engage them. We assumed that the uncovering process of exploration and interpretation in PSA would result in a significant *increase* in associative activity during treatment.

To explore this hypothesis about possible mechanisms of therapeutic change in PSA and SEP in the MPRP, we evaluated the effects of these two treatment conditions on associational activity by comparing their impact on the change in the total number of responses that patients gave to the Rorschach from intake to termination. Specifically, a $2 \times 2 \times 2$ [2] repeated-measures ANOVA (i.e., Treatment-by-Patient-by-Time) on the number of Rorschach responses yielded a statistically significant two-way interaction involving Treatment and Time ($F[1,29] = 3.93, p = .05$). The pattern of this interaction is presented in Figure 10, which shows the number of Rorschach responses among anaclitic and introjective patients in PSA and SEP at baseline and at termination. As shown in Figure 10, the number of Rorschach responses increased in PSA and decreased in SEP in both anaclitic and introjective patients. Because of the small sample size and low power (Effect size [Partial Eta Squared] = .11; Observed Power = .48), these trends were nonsignificant (Dependent-sample $t[14] = -.98, p = .34$; Dependent-sample $t[17] = 1.64, p = .11$; for PSA and SEP, respectively).

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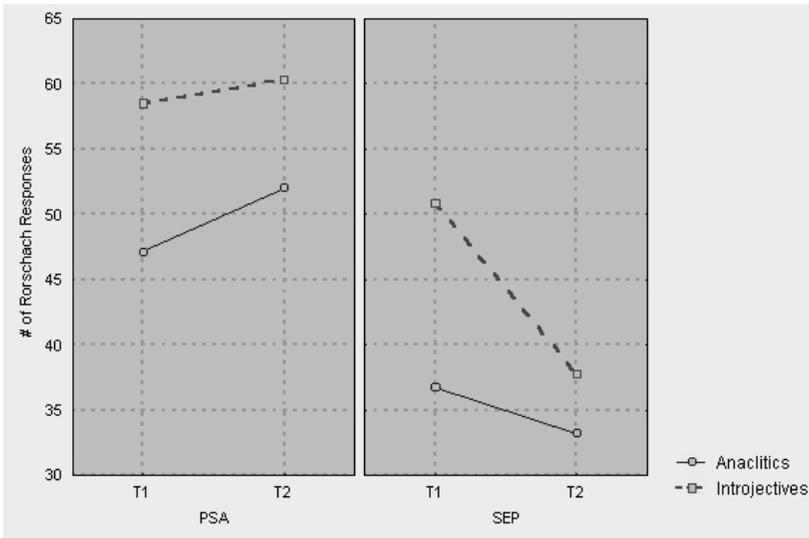


FIGURE 10: Means of number of Rorschach responses at baseline (T1) and termination (T2) among anaclitic and introjective patients in psychoanalysis (PSA) and supportive-expressive psychotherapy (SEP).

DISCUSSION

Initially we will summarize the findings about the differential effects of psychoanalysis (PSA) and supportive-expressive psychotherapy (SEP) and then consider the implications of these findings for understanding the nature of the therapeutic process and the mechanisms of therapeutic change. In this investigation we differentiated psychoanalysis (PSA) and psychotherapy (SEP) by identifying differences in their therapeutic effects with anaclitic and introjective patients. We also attempted to identify possible mechanisms through which these therapeutic effects might have occurred. It is important to emphasize that our findings of systematic differences between PSA and SEP were obtained despite the severe limitations imposed on the MPRP, as it is often in other studies of long-term intensive treatment, by a restricted sample size and the consequent loss of statistical power. Studies of long-term intensive psychodynamic treatments often have a restrictive sample size because of the extensive observations made on relatively fewer patients in these more extended treatments. Also, many of these studies of psychodynamic treatments, like the MPRP, include patients with a broad range of psychopathology and thus are dealing with a more difficult patient sample than many studies of pharmacological and brief manual-directed treatments that study atypical “purified” patients who have a focal symptom without complicating comorbid pathologies (see, e.g., Blatt, Shahar, and Zuroff 2002; Doidge 1997; Shahar 2003), thereby avoiding including in their study more seriously disturbed, comorbid, more treatment-resistant patients (Blatt and Levy 1998; Shahar and Blatt 2004; Wallerstein 1986).

Differential Effects of PSA and SEP

In considering the differences between PSA and SEP, it is important to be mindful that, by design, the weekly frequency of treatment sessions was significantly different in the two treatment conditions (on average, SEP = 2.72 and PSA = 4.67 sessions per week; $F = 41.26$, $p < .001$), but that the total number of treatment sessions was not significantly different in the two treatment groups (on average, SEP = 453.16 and PSA = 733.73 sessions; $F = 2.17$, ns). Thus, SEP and PSA were both long-term intensive treatments (Blatt 1992).

Consistent with a retrospective evaluation by Waldinger and Gunderson (1984) that indicated that borderline patients who had been

in psychoanalysis “had better object relations and sense of self than borderline patients who had been in psychotherapy” (p. 195), we found that PSA was significantly more effective than SEP in facilitating the development of adaptive and benevolent interpersonal schemas in both anaclitic and introjective patients, and that SEP actually resulted in a decline of these more adaptive representations among introjective patients. In addition, we found that both PSA and SEP were effective in reducing the intensity of maladaptive malevolent interpersonal schemas, but with different types of patients. PSA was significantly more effective than SEP in reducing the intensity of malevolent, destructive representations in introjective patients, while SEP was significantly more effective than PSA in reducing the intensity of these malevolent representations in anaclitic patients. Elements of this statistically significant Patient-by-Treatment interaction were found even in those few patients for whom the two primary clinical judges disagreed in classifying the patients as either anaclitic or introjective and the decision had to be made by a third judge.

Introjective patients in the MPRP also tended ($p < .10$) to have greater therapeutic gains than anaclitic patients in general clinical functioning as rated by the MPRP clinicians using the HSRS (Blatt 1992), especially when these patients were in PSA. Thus, our findings suggest that PSA is particularly effective with introjective patients, whereas SEP is relatively ineffective with them, or even detrimental (see Figures 1 and 2). This greater therapeutic response of introjective patients in PSA in the MPRP is consistent with reports by Blatt et al. (1988) and Blatt and Ford (1994) that indicate more extensive therapeutic gains in introjective patients in their evaluation of long-term, psychodynamically oriented intensive treatment of seriously disturbed treatment-resistant inpatients at the Austen Riggs Center. These findings of positive outcome in long-term psychodynamic treatment with both inpatients in the RYP and outpatients in the MPRP are consistent with the findings of Fonagy et al. (1996) and with the conclusions by Gabbard et al. (1994) about the constructive response of introjective patients to long-term insight-oriented psychodynamic treatment. Thus, findings from several studies indicate that such treatment is effective, especially with introjective patients. Several of these studies also indicate the importance of assessing aspects of interpersonal relations, like the quality of object relationships or the representations of interpersonal interactions, as measures of therapeutic change.

The constructive response of introjective patients to long-term psychodynamic treatment stand in stark contrast to findings in our analyses (Blatt et al. 1995, 1996) of data from the study of brief treatment for depression (sixteen weeks once a week) in the NIMH-sponsored Treatment of Depression Collaborative Research Program (TDCRP), which compared the differential effects of two forms of manual-directed brief psychotherapy for depression (cognitive-behavioral therapy [CBT] and interpersonal therapy [IPT]) with medication (imipramine, IMI) and a double-blind placebo. Differences in symptom reduction among the three active treatments (CBT, IPT, and IMI) in this study, both at termination and at follow-up, were minimal (see, e.g., Elkin et al. 1989). In further analyses of data from the TDCRP, however, we (see Blatt et al. 1995, 1996) found that introjective (highly self-critical or perfectionistic) patients did particularly poorly in all three treatments. Thus, introjective patients appear not to benefit extensively in brief treatment in the TDCRP or from long-term SEP in the MPRP, but appear to be particularly responsive to classic PSA and to other long-term, psychodynamically oriented intensive treatments.

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In addition, our analyses of data from the MPRP indicated that patients who had more constructive interpersonal schemas prior to treatment made significantly greater therapeutic gains in both PSA and SEP, but especially in PSA. These findings are consistent with a series of studies by Piper and colleagues (Piper and Duncan 1999, Piper et al. 1998, 2003), who demonstrated that outpatients with good object relations, as assessed in an unstructured interview, benefited more from brief, psychoanalytically oriented expressive psychotherapy than from brief supportive treatment. These findings from the MPRP are also consistent with the conclusions of Gabbard et al. (1994) that interpretive therapeutic approaches are most effective with patients who have greater ego strength.

Taken together, these findings provide strong confirmation of Cronbach's formulations (1953) that pretreatment characteristics of patients are important dimensions that influence therapeutic response (Blatt and Felsen 1993). This mounting evidence of the crucial role of patients' pretreatment characteristics reflects a major shift in psychotherapy research, in which data analyses are now going beyond the comparison of two forms of treatment for the reduction of a particular focal symptom (e.g., depression or anxiety) and are beginning to address more complex questions, such as what types of treatment are more effective,

in what kinds of ways, with different types of patients (Blatt, Shahar, and Zuroff 2002).

Nature of the Therapeutic Process

It seems consistent with clinical experience that more dependent, interpersonally oriented (anaclitic) patients in the MPRP were more constructively responsive to a therapeutic context with greater interpersonal interaction in face-to-face psychotherapy, while the more ideational patients, who emphasize separation, autonomy, control, and independence (introjective patients), found the context of psychoanalysis more conducive to therapeutic progress. It is important to stress, however, that these differences between PSA and SEP in our analyses of the MPRP data reflect differences between these two forms of psychological intervention as practiced by the clinicians who participated in this research at the particular facility at the time this study was conducted. As was noted in our initial report of these further analyses of data from the MPRP (Blatt 1992), caution needs to be exercised about generalizing from these findings about the particular therapeutic effects of SEP and PSA in the MPRP to contemporary clinical practice in other clinical settings. Despite this limitation, however, the results do suggest that we must be mindful that the usual therapeutic context contains at least two major mutative dimensions—a supportive therapeutic relationship and the possibility for insight and self-understanding (see, e.g., Blatt and Behrends 1987; Fonagy et al. 2002). Though these two dimensions are intertwined in the therapeutic process—interpretations are effective primarily in the context of a constructive therapeutic relationship and the therapeutic relationship, in turn, is enhanced by accurate, well-timed, tactfully stated interpretations—some patients seem to respond to the quality of the therapeutic relationship, while others seem responsive to interpretations and the gaining of insight and self-understanding. While most patients undoubtedly gain from both of these therapeutic dimensions, the differential response of anaclitic and introjective outpatients to PSA and SEP in the MPRP, along with the recent findings of Fertuck et al. (2004) about the differential role of referential activity in the treatment of seriously disturbed treatment-resistant anaclitic and introjective inpatients in the Riggs-Yale Project, suggest that psychological treatments may comprise the two fundamental mechanisms, interpersonal and interpretive (Blatt and Behrends 1987; Fonagy et al. 2002),

and that different types of patient may be differentially responsive to these two mechanisms.

While in a broad and general sense psychotherapy highlights the interpersonal or relational dimension and psychoanalysis emphasizes more the interpretive dimension, both dimensions exist in most psychotherapeutic approaches. Depending on the clinician's therapeutic style, these two dimensions appear in a relative balance in every psychotherapeutic endeavor. While different types of patient appear differentially responsive to these two dimensions, these results do not necessarily indicate that therapists should alter their therapeutic style to accommodate the characterological emphasis of particular patients (Blatt 1992). The findings do suggest, however, that therapists need to be alert to the fact that different patients, particularly in the early phases of treatment, may be differentially responsive to one or the other of these two dimensions and that these dimensions have important implications for understanding transference and countertransference dynamics.

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Blatt and Behrends (1987) discussed the interpersonal and interpretive dimensions of the treatment process—how effective treatment involves a successive series of attachments and separations. Attachment is experienced in the quality of the therapeutic relationship and separation is experienced, at least partly, in interpretations. Blatt and Behrends (1987) noted that psychological development, both generally (Behrends and Blatt 1985) and in the therapeutic context, involves a series of attachments (“gratifying involvements”) and a series of separations (“experienced incompatibilities”) in which meaningful aspects of the therapeutic relationship, at different developmental levels, are internalized and become part of the individual's functional repertoire, such that the individual no longer has to rely on the therapist to provide that function. The experience of a series of attachments and separations, of “gratifying involvement” and “experienced incompatibilities,” at different developmental levels, facilitates the development and internalization of increasingly mature levels of psychological structures or schemas (representations) of self and significant others (Blatt 1991, 1995b; Blatt and Blass 1990, 1996). This emphasis on attachment and separation in the treatment process is congruent with recent research on the impact of different attachment styles of patient and therapist on the treatment process, which we will discuss shortly.

Different types of patient appear to be more responsive, at least initially, to one of these dimensions than to the other. The therapist's empathic and supportive interventions facilitate the early phases of the treatment process, especially with anaclitic patients. Anaclitic patients are usually more responsive to aspects of the interpersonal or relational dimensions of the treatment process—the dependability and support of the therapeutic relationship—and express their therapeutic gains primarily in changes of their interpersonal relations (Blatt and Ford 1994). Introjective patients, by contrast, are more responsive to the interpretive aspects of the treatment process and the insights gained in treatment than to the relational aspects of the treatment process, and express their therapeutic progress primarily in changes in their manifest symptoms and cognitive functioning (Blatt and Ford 1994). The interpretive aspects are more congruent with the intellectualized cognitive style of introjective patients, who are initially more comfortable with an objective, detached, and task-oriented therapeutic relationship. More personal feelings about the therapist can provoke concerns about losing control and power, possibly even precipitating feelings of distrust and suspicion. Though introjective patients have the self-reflective capacities that would allow them to benefit from intensive therapy, the therapeutic process has to be more extended for them to begin to feel safe and secure with the therapist and to establish a meaningful therapeutic alliance based on feelings of trust and mutuality (Blatt 1992, 2004).

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When anaclitic patients feel secure in the therapeutic relationship and are no longer threatened by apprehensions of abandonment and loneliness, they can begin to consider issues of self-definition and assert a sense of agency. Thus, for example, they no longer simply seek to be loved but can now begin to consider the type of person with whom they wish to share feelings of love and intimacy. Likewise, as introjective, self-critical patients begin to feel secure in their self-definition and are no longer threatened by interpersonal closeness, they can begin to allow themselves to get close to others and to trust them. Thus, as anaclitic and introjective patients make therapeutic progress and resolve to some degree their vulnerabilities—the former to loss and abandonment, the latter to impaired feelings of self-definition and self-worth—themes from the opposite developmental line, of relatedness or self-definition, begin to emerge in the treatment. In the later stages of the treatment process with both anaclitic and introjective patients, a

normal, dialectical interaction between the development of relatedness and of self-definition begins to emerge in the treatment. Thus, the therapeutic process enables both anaclitic and introjective individuals to reactivate “a previously disrupted developmental process” (Blatt and Shichman 1983, p. 249) whereby an integrated and coordinated development of both self-definition and interpersonal relatedness evolves, each in its own right, even as it synergistically contributes to overall development (see also Blatt and Blass 1990, 1996). The therapeutic process should facilitate access to this normal dialectical developmental process, leading ultimately to the integration of more mature levels in both the relatedness and the self-definitional developmental lines. The reactivation of this normal process, one that has its own developmental trajectory, can enhance the therapeutic process and lead eventually to the development of more differentiated and integrated levels of interpersonal relatedness (e.g., the capacity for intimacy) and self-definition (e.g., identity and integrity).

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While these formulations need to be evaluated systematically in detailed clinical and empirical observations of therapeutic change throughout the treatment process, it is important to note that these considerations are beginning to address dimensions that are central to the therapeutic process as we attempt to identify possible mechanisms of therapeutic change.

Mechanisms of Therapeutic Change

The results of our further analyses of data from the MPRP also suggest that PSA and SEP appear to involve different therapeutic mechanisms. For both anaclitic and introjective patients, SEP leads to a significant reduction of Rorschach responses, whereas PSA leads to their increase. Thus, SEP may be more effective with anaclitic patients because it provides a supportive therapeutic context that contains the associative activities and maladaptive interpersonal schemas of these more affectively labile, emotionally overwhelmed, and vulnerable patients. PSA, by contrast, facilitates the development of adaptive interpersonal schemas and the decrease of maladaptive ones in introjective patients because the explorations and interpretations of the modality may more effectively engage these more distant, well-defended, and interpersonally isolated individuals.

The increase in associational activity in PSA, its decrease in SEP, and their possible roles in the treatment processes studied by the MPRP

are consistent with clinical observations and expectations, as well as with recent findings by Fertuck et al. that therapeutic progress in seriously disturbed treatment-resistant anaclitic inpatients in the Riggs-Yale Project was significantly associated with a reduction in referential activity, while progress in introjective patients was significantly associated with its increase. Fertuck et al. assessed changes in patients' capacity for referential activity (Bucci 1984)—the degree to which connections are established between nonverbal systems and a communicative verbal code so that emotional experiences are translated into language capable of provoking corresponding experiences in a listener—using computer analyses of linguistic dimensions in narratives given to a standard set of TAT cards at intake and much later in the treatment process. In the intensive, psychoanalytically oriented inpatient treatment of seriously disturbed treatment-resistant patients in the RYP (dynamically oriented psychotherapy at least four times weekly), therapeutic progress in introjective patients was significantly associated with an increase in referential activity, while progress in anaclitic patients was significantly associated with its decrease.

These findings by Fertuck et al., consistent with the results of our analyses of data from the MPRP, suggest that anaclitic patients do better in a treatment process that inhibits associational activity, whereas introjective patients do better in a treatment that facilitates it. The findings of a significant difference between PSA and SEP in changes in associational activity in the MPRP, as measured by the number of responses to the Rorschach, suggest that each modality has a unique effect on associative activity that may be part of the mechanism through which each results in constructive therapeutic change with a different type of patient.

Recent research by Fonagy et al. (2002) indicates that reflective functioning (RF), or mentalization, is an important dimension of therapeutic progress. RF assesses the degree to which an individual has developed a theory of mind—an understanding of mental states, both one's own and those of others. Using the Adult Attachment Interview (AAI), Fonagy and his colleagues evaluated individuals' capacity for RF and demonstrated how the development of this capacity is significantly related to therapeutic progress. Levy (2002) recently reported that RF increases significantly during outpatient psychotherapy. According to Fonagy et al., the two primary dimensions of the therapeutic process, interpersonal and interpretive, both contribute to the regeneration

of mentalized connections for fundamental affective experiences. Meanings are connected to affective experiences in the treatment process through the development of “second-order representations” derived from “interpersonal interpretive mechanisms” (p. 16). Fonagy and colleagues view the establishment of linkages between affect and cognition in therapy as essential for the development of an agentic sense of self and the capacity to establish close relationships. They assume that the development of mentalization, or RF, is critical to therapeutic progress with all patients. But, as Fonagy et al. note, therapeutic progress stems from both interpersonal and interpretive mechanisms, and our findings in the MPRP and the RYP suggest that some patients may be more responsive to the former and others to the latter. As suggested by Blatt and Felsen (1993), as well as by Blatt, Shahar, and Zuroff (2001), and as indicated by the results of our analyses of data from the MPRP, the RYP, and the Treatment for Depression Collaborative Research Project (TDCRP), patients may be differentially responsive to different aspects of the treatment process.

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Referential thinking (see Fertuck et al. 2004), associative activity (Rorschach responses), and mentalization, or reflective functioning, appear to have a more important role in the treatment of introjective patients with a primarily ideational orientation, who seem to be more responsive to interpretive dimensions, than in the treatment of affectively labile anaclitic patients, who appear more responsive to the interpersonal, supportive, and containing dimensions of the therapeutic process. The findings in the MPRP that SEP serves to contain and limit associative activity is consistent with a report by Eames and Roth (2000) that patients with a preoccupied attachment style (anaclitic patients) respond to the support and structure of psychotherapy, strive to establish a close therapeutic relationship, and appear to benefit most from a therapeutic strategy that helps them contain and modulate their overwhelming feelings. Patients with an avoidant attachment style (introjective patients), by contrast, appear to benefit most from a therapeutic strategy that facilitates their emotional engagement (see Hardy et al. 1999).

Though a number of studies have found that changes in cognitive activity are an important aspect of therapeutic change, research groups have different conceptions of this cognitive activity and its assessment. Blatt, Shahar, and Fertuck (2003), for instance, found no significant relationship between changes in referential activity in narratives told to

the TAT and changes in the number of Rorschach responses during the treatment of seriously disturbed treatment-resistant inpatients in the RYP. Thus, future research needs to examine the conceptual assumptions and measurement procedures in these various approaches to the study of the cognitive processes considered important in the process of therapeutic change, especially with avoidant introjective patients. Research is also needed to examine further the effects of different treatment processes on cognitive activity and how different measures of this cognitive activity—RF, referential activity (Bucci 1984), and associative activity on the Rorschach—are interrelated and how they contribute to therapeutic change in different types of treatment with different types of patients.

Congruence of Patient and Therapist

The powerful influence of the patient's pretreatment personality characteristics on treatment outcome in both long-term treatment in the MPRP and the RYP and in short-term treatment in the TDCRP suggests that it might be valuable to also consider the impact of the therapist's personality on treatment outcome. Though no studies have yet attempted to differentiate anaclitic and introjective therapists and address the impact of these personality styles of the therapist on treatment outcome with different types of patients, these issues of the match between patient and therapist have begun to be addressed in research on the role of attachment styles in the therapeutic process.

The treatment differences we found with anaclitic and introjective patients in the MPRP (Blatt 1992) and in the RYP (Blatt and Ford 1994) are relevant to the research on the therapeutic response of patients with different attachment patterns because several studies have demonstrated that the anaclitic/introjective distinction is closely linked to patterns of insecure attachment. Several reports (e.g., Blatt and Homann 1992; Blatt and Levy 2003; Levy and Blatt 1999; Reis and Grenyer 2002; Zuroff and Fitzpatrick 1995) have noted significant links between introjective personality organization and avoidant insecure attachment and between anaclitic personality organization and preoccupied insecure attachment. In addition, several investigations (e.g., Alexander 1993; Alexander and Anderson 1994; Brennan and Shaver 1998; Levy and Clarkin 2001; Meyer et al. 2001; Rosenstein and Horowitz 1996) have found that resistant (preoccupied) attachment is related to anaclitic disorders (i.e., dependent, histrionic, and borderline personality

disorders), while dismissive attachment is related to introjective disorders (i.e., narcissistic, antisocial, and paranoid personality disorders).

Several recent studies indicate that securely attached patients have greater therapeutic gains in both brief and long-term treatment than do insecurely attached patients (Eames and Roth 2000; Fonagy et al. 1996; Kanninen, Salo, and Punamäki 2000; Mallinckrodt, Gantt, and Coble 1995; Meyer et al. 2001; Mosheim et al. 2000). But consistent with the findings that introjective patients do better in PSA than in SEP in the MPRP (Blatt 1992), several of these studies (e.g., Eames and Roth 2000; Fonagy et al. 1996; Mallinckrodt, Gantt, and Coble 1995; Meyer et al. 2001) found that patients with a dismissive-avoidant attachment style (introjective patients) respond best to psychodynamically oriented interpretive therapy. Emotionally detached, isolated, avoidant, and wary (Mallinckrodt, Gantt, and Coble 1995) introjective patients, who tend to recall more family conflicts and who view relationships with others, including the therapist, “as potentially hostile or rejecting” (Meyer and Pilkonis 2002, p. 375), found the exploratory emphasis in psychoanalysis liberating and conducive to therapeutic change (Hardy et al. 1999). Meyer and Pilkonis (2002), in an extensive review of the literature on attachment style and psychotherapy, concluded that dismissively attached, avoidant (introjective) patients “may benefit . . . from strategies that facilitate emotional involvement” (p. 378) and “require more concentrated . . . interventions, helping them overcome their characteristic detachment” (p. 373). Consistent with our findings in the MPRP and in the RYP (Blatt and Ford 1994), Meyer and Pilkonis noted that once dismissively (or avoidantly) attached patients “connect emotionally with a therapist . . . improvement might be all the more dramatic” (p. 373).

The significant Patient-by-Treatment interactions that we have identified in the MPRP are also consistent with reports that patients with preoccupied insecure attachment (anaclitic patients) who “yearn for intimacy and fear abandonment might strive . . . to establish a close, supportive relationship with a therapist” (Meyer and Pilkonis 2002, p. 374). Mallinckrodt, Gantt, and Coble (1995, p. 311) have discussed how patients with a preoccupied insecure attachment yearn “to be at one” with a therapist and in a frantic effort to avoid rejection “may try to submissively please and appease their therapist without engaging in . . . [or] identifying and openly discussing difficult personal problems” (Meyer and Pilkonis 2002, p. 375). The structure and supportive con-

text of psychotherapy appear to contain the fears and apprehensions (Hardy et al. 1999) of affectively labile, insecure preoccupied (anaclitic) patients, who often feel emotionally overwhelmed (Eames and Roth 2000). Therapists are often more supportive in an effort to contain the apprehensions of these patients.

Hardy et al. (1998, 1999) found that therapists adjust their interventions in response to different attachment characteristics. Therapists respond to insecure preoccupied attachment with reflection, containment, and support, and to dismissive attachment with interpretation meant to facilitate the engagement of introjective patients who are emotionally detached and who defensively deny problems or establish a superficial relationship and remain reluctant to relate to the therapist “on a more genuine, personal level” (Meyer and Pilkonis 2002, p. 374). Hardy et al. (1998) also found that therapists adopt more affective, relationship-oriented interventions with patients with a preoccupied attachment style but use more cognitive interventions with patients with an unresolved or dismissive attachment style. As noted by Gabbard et al. (1994) in discussing the treatment of borderline patients, “introjective patients . . . appear to be more responsive to insight and interpretation, while anaclitic patients . . . are more responsive to the interpersonal dimensions of the psychotherapeutic process” (p. 67).

Securely attached patients form an effective therapeutic alliance, but insecurely attached patients (both preoccupied and dismissive) experience difficulties in the treatment process (Eames and Roth 2000). Patients with preoccupied and dismissive insecure attachment styles have different patterns of involvement over the course of treatment. Kanninen, Salo, and Punamäki (2000), as well as Satterfield and Lyddon (1998) and Eames and Roth (2000), found that patients with preoccupied attachment had low levels of therapeutic alliance at the beginning of treatment but a very strong alliance as they approach termination. Anxiety about the dependability of the relationship seems to initially impede the development of a therapeutic alliance for preoccupied, anaclitic individuals, but their strong desire for intimacy appears to facilitate the development of a better alliance in the latter phases of the treatment process. Meyer and Pilkonis (2002, pp. 374–375), in a summary of this research, note that patients with preoccupied attachment are particularly sensitive “to changing interventions over the course of therapy. In the middle stages of treatment, when therapists challenge and confront problematic patterns . . . [these preoccupied] patients tended

to infer rejection and . . . notice problems in the therapeutic relationship. . . . Toward the end of therapy, however, as gains are consolidated and the tone becomes much more supportive, they came to view the therapeutic alliance in unrealistically positive terms. In contrast, patients with dismissive attachment may superficially rate the alliance as strong in early and middle phases of therapy. By the end . . . they remain detached and fail to establish genuine emotional connectedness . . . ” (for an elaboration of the difficulties of dismissively attached, introjective patients in the latter half of brief outpatient treatment for depression, see Blatt et al. 1996; Zuroff et al. 2000).

Several recent studies have extended this type of research by evaluating the attachment styles of therapists and their impact on the therapeutic process. Rubino et al. (2000) found that therapists with an anxious (preoccupied) insecure attachment tended to respond with less empathy, especially to patients who were securely attached or who had an insecure dismissive attachment. Rubino et al. speculated that “more anxious therapists may interpret ruptures as an indication of their patients’ intention to leave therapy, and their own sensitivity towards abandonment might diminish their ability to be empathic” (p. 416).

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Securely attached case managers tended to challenge the patient’s interpersonal style, while insecurely attached case managers were more likely to complement it (Dozier, Cue, and Barnett 1994; Tyrell et al. 1999). Patients with attachment styles different from their clinician showed better therapeutic outcome and stronger therapeutic alliance (Dozier, Cue, and Barnett 1994; Tyrell et al. 1999). Patients had the best therapeutic outcome when treated by securely attached clinicians or by a complementary combination of insecure attachment styles between clinician and patient. Preoccupied patients fared best with dismissing clinicians; vice versa, dismissive patients fared best with preoccupied clinicians (Dozier, Cue, and Barnett 1994; Tyrell et al. 1999). Consistent with earlier empirical research on patient-therapist match (e.g., Beutler et al. 1991), dissimilarity in the interpersonal styles of patient and therapist was found to facilitate the treatment process because patients benefit from interventions that run counter to their own problematic interpersonal style. Affectively labile patients seem to require supportive, emotion-containing interventions, whereas emotionally detached patients seem to benefit from interventions that facilitate affective expression (see Hardy et al. 1999; Stiles, Honos-Webb, and Surko 1998). The study of the match of attachment styles (and of anaclitic-introjec-

tive personality styles) of patient and therapist and its impact on therapeutic process and outcome provides a potential research methodology for systematically studying an important phenomenon that has been elucidated extensively in the psychoanalytic literature by Kantrowitz (1986, 1992, 1993, 1995; Kantrowitz et al. 1989) in a series of provocative and informative case illustrations of the positive and negative consequences of different types of patient-therapist match.

Summary

Findings from our further analyses of data from the MPRP indicate that psychoanalysis and supportive-expressive psychotherapy result in different kinds of therapeutic change and that the nature of some of these changes varies in consequence of patients' pretreatment personality features. The findings also indicate that introjective patients do better in PSA and that anaclitic patients do better in SEP. Anaclitic patients, who usually have a preoccupied insecure attachment style, make significantly greater progress in treatment if they are engaged in less referential activity (Fertuck et al. 2004) and if the therapist is supportive (Hardy et al. 1999) and aware of the intense desires of these patients to remain in treatment (Eames and Roth 2000; Kanninen, Salo, and Punamäki 2000). Affectively labile, emotionally overwhelmed anaclitic patients do better in SEP because it contains their affective lability, possibly by reducing their associative activity. Introjective patients, who usually have an avoidant or dismissive attachment style, make significantly greater progress in treatment if they are engaged in more referential activity (Fertuck et al. 2004) and if they are in long-term psychoanalytically oriented intensive treatment (Blatt and Ford 1994; Fonagy et al. 1996) that helps them overcome their interpersonal and emotional detachment (Eames and Roth 2000; Mallinckrodt, Gantt, and Coble 1995; Meyer et al. 2001) through interpretations (Hardy et al. 1999). Emotionally and interpersonally detached introjective patients do better in PSA than in psychotherapy, because PSA liberates their associative processes.

Our findings, along with the findings about patient-treatment interactions from an attachment perspective, provide considerable support for the call by Cronbach, many years ago, to include patient variables in studies of psychotherapy process and outcome. Our findings indicate that the anaclitic/introjective distinction is an effective way of doing this. They indicate also the importance of studying interpersonal

schemas, representations of self and significant others, in evaluations of the therapeutic process and suggest that the Concept of Object on the Rorschach (COR) and the Mutuality of Autonomy scale (MOA) are effective means for addressing change in the quality of mental representations in the treatment process. In addition, the findings based on different types of attachment styles indicate the importance of including qualities of the therapist, as well as of the patient, in studies of the complex and subtle interpersonal processes we call psychoanalysis and psychotherapy. The findings reported and reviewed in this paper suggest that we may be ready to address more complex questions in treatment research—e.g., what kind of treatment is best for what kind of patient (Roth and Fonagy 1996) and with what kind of therapist, and leading to what kind of therapeutic change. Our findings indicate that psychoanalysis and supportive-expressive psychotherapy are therapeutic interventions that involve different mechanisms of change and that are differentially effective, sometimes in different ways, with different types of patients.

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