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VARIETIES OF LONG-TERM OUTCOME AMONG PATIENTS IN PSYCHOANALYSIS AND LONG-TERM PSYCHOTHERAPY

A REVIEW OF FINDINGS IN THE STOCKHOLM OUTCOME OF PSYCHOANALYSIS AND PSYCHOTHERAPY PROJECT (STOPPP)[1]

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This paper reports the main findings of a large-scale study of subsidised psychoanalysis and long-term psychotherapy. More than 400 people in various phases, before, during and after subsidised psychoanalysis or long-term psychodynamic psychotherapy, were followed up for a period of three years with personal interviews, questionnaires and official statistics. Our analyses revealed progressive improvement the longer patients were in treatment—impressively strong among patients in psychoanalysis—on self-rating measures of symptom distress and morale. Improvement, however, was equally weak in both groups on a self-rating measure of social relations. Dosage factors (treatment duration and session frequency in combination) partly accounted for the outcome differences between those referred to psychoanalysis and those referred to long-term psychotherapy. Attitudes and ideals among therapists and analysts concerning the goals and means of psychotherapy were also associated with patient outcome, although in rather complex ways. A significant part of the outcome differences between patients in psychoanalysis and in psychotherapy could be explained by the adoption, in a large group of therapists, of orthodox psychoanalytic attitudes that seemed to be counterproductive in the practice of psychotherapy but not in psychoanalysis. It is suggested that this effect may be a negative transfer of the psychoanalytic stance into psychotherapeutic practice and that this may be especially pronounced when the attitudes are not backed up by psychoanalytic training.

Internationally, psychoanalysis is presently under heavy attack, one of the prime arguments being that psychoanalysis has failed to document beneficial effects in any adequate way. It has to be conceded that, with few exceptions, psychoanalysts have been strangely uninterested in demonstrating the value of their practice in any systematic way that is likely to satisfy the traditionally scientistic community. Furthermore, the quality of the few systematic studies that have indeed been undertaken (as reviewed by Bachrach et al., 1991; Doidge, 1997; Kantrowitz, 1997) has been poor, generally. 'In fact, there is no study of psychoanalysis as a treatment that cannot be dismissed because of seriously contaminated or compromised data', Fisher and Greenberg (1996, p. 201) conclude in their otherwise positive review of research on psychoanalysis.

That there is a dearth of well-controlled studies, not only of psychoanalysis but of long-term psychotherapy in general, is evident in the

[1] This paper has been selected to appear for discussion on the *Journal*'s World Wide Web pages and Bulletin Board (see http://www.ijpa.org).

review by Grawe et al., 1994. Some calculations of our own show that, out of the 796 studies reviewed, not more than 1% were concerned with therapies two years or longer, and that not more than 9% were concerned with allegedly psychoanalytically orientated therapies. In fact, there was not more than one single study listed as being concerned with individual, psychoanalytically orientated therapies with, mostly, non-psychotic patients, of a duration over two years and at least equally long follow-up—and that was the Menninger Project (Wallerstein, 1986).

There are of course several reasons for this state of affairs. The main reason, probably, is that the so-called gold standard of clinical outcome research (prospective, double-blind, randomised, manualised etc. treatment design) is practically impossible to realise in research on outcomes of psychoanalysis. This is not only a result of the fact that psychoanalysis could hardly be manualised without ceasing to be psychoanalytic, or that psychoanalysts in general could never be expected to accept being manualised, in the first place. It is also a matter of the fact that such degrees of control over treatment assignment as required by randomisation are inevitably impossible for such long durations as are typical of psychoanalysis. Patients actively seek their therapies, interrupt those they are not satisfied with and seek other, new ones. So, as other writers have argued (Mumford et al., 1984; Seligmann, 1995), self-selection is part and parcel of psychotherapy and psychoanalysis, not only in starting a treatment but as well in choosing to *stay* in it.

Finally—which really makes independent evaluation impossible in the first place—the unusually strong confidentiality of the psychoanalytic setting will tend to make patients unidentifiable and unreachable for third parties of any kind. So one has to choose other strategies in planning research on the clinical values of psychoanalysis. The Stockholm Outcome of Psychoanalysis and Psychotherapy Project (STOPPP) was designed to cope with these difficulties as well as possible, in the context of a programme of the national health insurance authorities to subsidise psychoanalyses and long-term psychotherapies with private practitioners in Stockholm County. What that programme offered was a fairly large number of identified analysands/patients and identified analysts/therapists in fairly long treatments. The methodological challenge was to find a way to use information from this group so that we could draw some relatively secure conclusions about the treatment outcomes and the factors that may have influenced them. The idea adopted was to collect information on both patients on the waiting list and patients in treatment and to do this on three occasions over a three-year period. We will refer to this as a three-wave panel design. By splitting the panel into subgroups depending on the patients' positions in the treatment process in each panel wave, we could establish information about patients at all stages of the process—waiting, at various periods in treatment, and up to three years after they had finished.

METHOD

The patient sample consisted initially of 756 people (out of a total of about 1500 potentially available) being subsidised for, at the longest, three years in psychoanalysis or psychotherapy or being on the respective waiting-lists for such subsidisation. Our intention was to sample patients in various phases of treatment, before, during and after therapy. Specifically, 202 were in subsidised 'psychoanalysis' or 'psychotherapy' and 554 were still on the waiting list for either kind of treatment. The two kinds of treatment were assigned by referral from analysts or licensed therapists after assessment of the patient's need of, and suitability for, either kind of treatment. Thus, treatment assignment was not randomised.

Outcome was assessed in terms of symptoms, social relations, morale or existential attitudes, general health, health care utilisation, working capacity etc., by qualitative interviews, self-report inventories, questionnaires

and official records. The project included several data collections.

The referrals were used for pre-treatment assessment, with the purpose of describing the psychotherapy and the psychoanalysis populations demographically, socially and psychiatrically. Specifically, all patients were diagnosed and rated, on the basis of the information in the referrals, on the DSM-IV, axis I (psychiatric syndromes), axis II (personality disorders) and axis V (Global Assessment of Functioning; GAF, for current and lowest [after the age of 18 years] levels of functioning). Also, a rating of vocational impairment was collected. Except for the axis II diagnoses, reliabilities were satisfactory.

Data on absenteeism, health care utilisation etc. among all 756 patients, 1988–96, were collected from the national health insurance and health care authorities.

A postal questionnaire (the Well-being Questionnaire—WbQ) was distributed annually 1994–96, (the first year to all 756 patients, each of the following years to all respondents from the previous year) obtaining data on: (1) demographic, familial and socio-economic conditions, (2) current psychotherapeutic treatment, (3) previous treatment for psychological problems, including psychotherapy, (4) sickness and health care utilisation during the past twelve months, (5) current and previous psychological problems, (6) working (or studying) conditions during the past twelve months. Also the WbQ includes several standardised self-rating scales, all of them with high or very high reliabilities: (7) The Social Adjustment Scale (SAS; Weissman & Bothwell, 1976) is a well-established instrument used to measure quality and quantity of social contacts in various contexts (the extent to which the patient has had, and enjoyed, contacts with children, spouse or partner, extended family, friends, colleagues at work etc., during the past two weeks). Scores on the SAS have been shown, in unpublished studies of our own, to be associated with quality of primary object representations. (8) The Symptom CheckList-90 (SCL-90; Derogatis et al., 1974) is one of the most frequently used instruments in psychotherapy research to measure current symptom distress (the extent to which the patient has been troubled with each of 90 different signs of somatic and psychic distress during the last seven days). (9) The Sense of Coherence Scale (SOCS; Antonovsky, 1987) is a self-rating scale measuring what is, essentially, morale, vitality and optimism (to what extent the patient has the experience of living and living conditions as generally meaningful, comprehensible, manageable and stimulating).

For norming purposes, the WbQ was also administered in two non-clinical groups: (1) a community random sample of people, 20–69 years of age, in Stockholm County and (2) a student sample. The two samples, which were pooled when it was later discovered that their means on the self-rating scales were almost identical, comprised 650 people altogether.

Informal, or qualitative, interviews were performed in a sub-sample of 60 patients, on two occasions with twelve months' interval, 1994–95. (Unfortunately, scarcity of financial resources prevented us from doing, as we had planned, a third round of interviews.) The sample was composed such that 20 of the patients had terminated psychoanalyses, 20 had terminated psychotherapy, and 20 had not been in treatment at all since the time of referral. The interviews were tape-recorded. Besides being available for qualitative analyses not yet finished, the taped interviews were rated on the Change after Psychotherapy scales (CHAP; Sandell, 1987a, b), with high reliabilities. The CHAP is designed to support ratings of 'the patient's experience of having changed' in the following four aspects: symptoms, adaptive capacity, self-insight and basic conflicts, the last of which is offered as a rating of structural change. These ratings are then adjusted with respect to ratings of the influence of extra-therapeutic change factors.

A postal questionnaire (Therapeutic Identity; ThId) was distributed in 1996 to all 316 therapists who had at least one patient (the range was 1–11 patients) in the initial sample. The ThId has about 150 questions and/or

items, divided into six sections, (1) basic education and professional training; (2) professional experience; (3) personal/training therapy/ies; (4) theoretical orientation; (5) therapeutic ideals and technical approach; (6) ideas about the nature of psychotherapy and of the human mind.

Partly for standardisation, norming and validation purposes, the same questionnaire was also distributed in a random sample of 350 licensed therapists throughout Sweden.

Complete data for all three waves of the administration of the WbQ were obtained from 450 people, thus yielding an accumulated response rate of 60%. (Three reminders were distributed each year.) After having to exclude 20 people because of incomplete or inconsistent data and 12 people who never started their treatments, there remained a group of 331 people whose treatment (or, in cases when the person had been in more than one round of treatment, whose *main* treatment, longest in terms of number of sessions) was long-term psychodynamic psychotherapy, and a group of 74 people whose main treatment was psychoanalysis. In addition, there was a small group of 13 patients in various kinds of low-dose therapies, viz. brief, low-frequency, group or family therapies, which we shall exclude in the following account. Psychoanalysis was defined as treatment three to five times a week (M = 3.57; SD = 0.7) with a member of one of the psychoanalytic societies in Sweden (one within the IPA and one within the IFPS, at the time), and psychotherapy as one to three sessions a week (M = 1.48, SD = 0.52) with a psychotherapist licensed by the National Board for Health and Welfare. On average, the analyses had a total of 642 sessions (SD = 324) over about four and a half years (M = 54 months; SD = 23) and the therapies 233 sessions (SD = 151) over nearly four years (M = 46 months; SD = 24).

The ThId, after four reminders, was returned in a usable form by 209 of the 316 therapists, yielding a return rate of 66% after four reminders.

Results

Some of our findings have been reported in written form in Swedish, and we have presented findings on several national and international conferences. Detailed reports in English are in preparation. A list of publications is available through the first author.

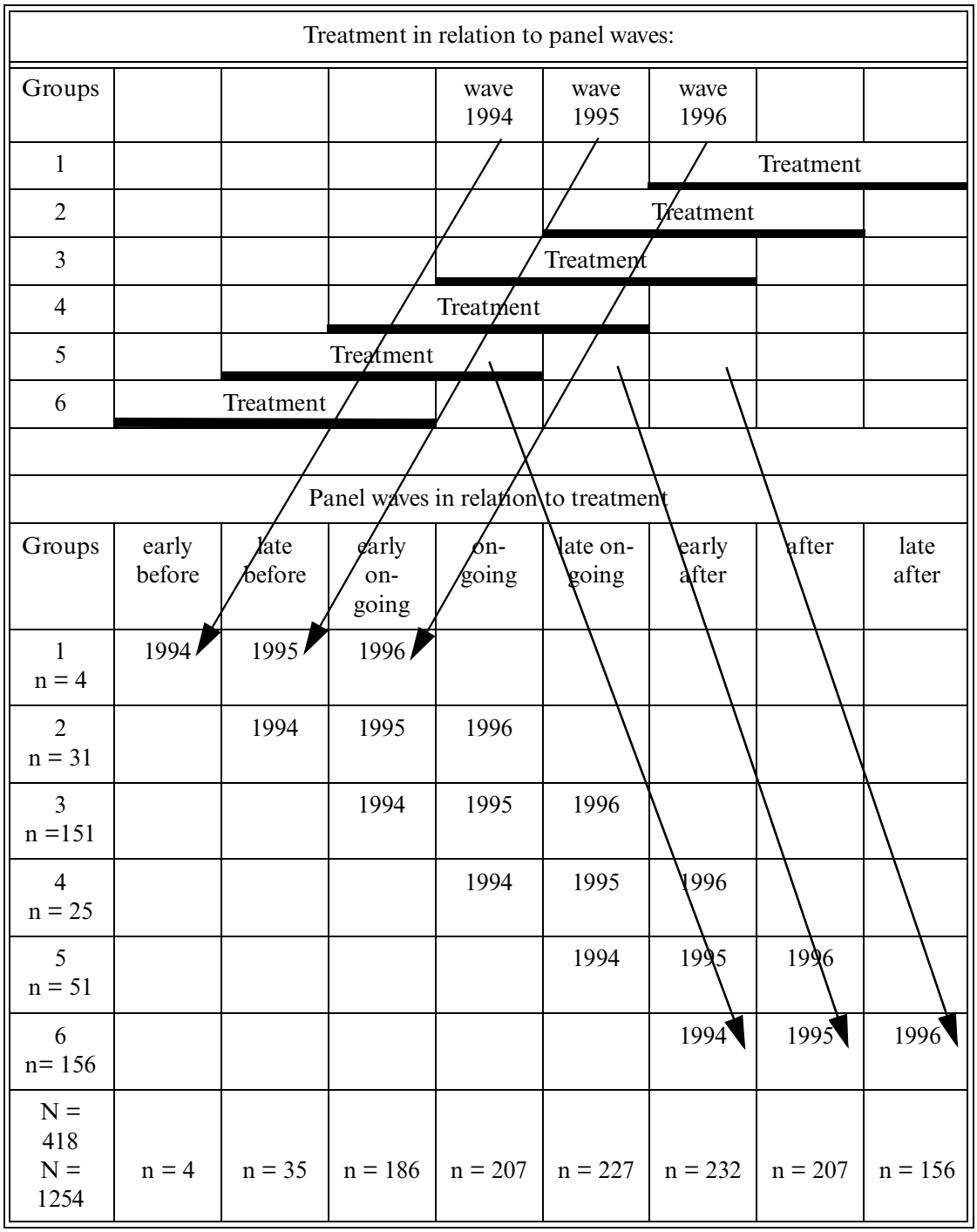
The psychoanalysis population

On the basis of a random sample of 200 of the 756 referrals, we were able to analyse the differences between patients who had been referred to psychoanalysis and patients who had been referred to long-term psychotherapy, generally described as 'psychodynamic' or 'psychoanalytic(ally orientated)'. The analysands appeared as a very qualified group, educationally and vocationally, although psychiatrically quite vulnerable and distressed, with long histories of suffering and long histories of psychiatric care. They were indeed a different population from patients in long-term psychodynamic psychotherapy. Demographically, analysands were older, on average; more frequently they were men; they were—or had been—married, had children, and had university degrees. Psychiatrically, there were no diagnostic differences or differences in severity or level of disturbance, but psychotherapy patients tended to have utilised, before the present treatment, institutionalised psychiatry (in-patient or out-patient clinics, emergency rooms etc.) to a larger extent, whereas analysands tended to have rather turned to psychotherapy for help. Experiences with psychopharmaceutics were equally frequent (around 60% in both groups).

Psychotherapy or psychoanalysis is not a once-in-a-lifetime experience. Shopping, i.e. trial treatments, repeated interruptions and retakes are quite frequent. The probability of *prior* psychotherapeutic treatment (of any kind) is equal among analysands and therapy patients, but the probability of *further* such treatment is about twice as high *after* the termination of psychotherapy as *after* the termination of psychoanalysis.

Table 1:

Unfolding the three-wave panel: groups of cases at different stages of treatment, in relation to waves of administration of the Well-being Questionnaire (WbQ) (upper panel) and in analysis design (lower panel)



Long-term outcomes

As a brief description of how we analysed our panel data, each respondent was categorised, each panel year, with respect to his or her position in the treatment process: pre-treatment, ongoing treatment or post-treatment. As this was repeated for several years, we could trace all transitions between these three positions and also distinguish, in a crude way, between 'sub-positions' before, during and after treatment. For example, a person who had not yet started her treatment the first year but was in treatment during the second and third years, was in a relatively later pre-treatment stage in the first year than one who was not in treatment until the third year, and in an earlier treatment stage in the second year than a person who had been in treatment already during the first year. Thus, by repeating this for all people all years, we were able to establish a *relative* time scale with eight steps, each defined by the relations 'earlier than' or 'later than' each other and each with its own group of patients at the same *relative* stage in their treatment process. We have thus 'unfolded' a three-wave panel into an eight-step time scale and have therefore chosen to call our design an 'unfolded panel' design. We have attempted to describe the unfolding of the panel pictorially in Table 1. Although the time scale is only relative, not in real time, one may consider the stages as of roughly one year's duration each.

By distinguishing, also, between patients with psychoanalysis and patients with psychotherapy as their main treatments, we thus have, for each treatment, two groups *before* treatment, who were later to commence treatment, one at an earlier time than the other, and, for each treatment, a group that is rather early *in* treatment, one rather late and one in-between and, finally, three groups *after* each kind of treatment, each being later than the one before. Because our timing of the panel waves was independent of where any of the patients was in his or her treatment process, we consider this grouping on the time scale a *functional equivalent* to randomisation (Chambless & Hollon, 1998). In support of this, when we tested for progressive differences across the time stages on more than fifty possibly confounding variables (patients' and therapists' demographics, patients' psychiatric state and history, therapists' experience, training and orientation etc.), we did not find a single variable that differed systematically between the groups on the time scale. Therefore, we have concluded that possible outcome differences across time in all probability are due to the passage of time in treatment and not to any confounding variables.

When we plotted the mean of each group along the time scale on each of the self-rating scales, we could derive so-called growth curves (or decay curves, as the case may be) for each of the treatment groups. (In deriving these curves the very first group on the time scale was excluded because of its small size, so the time scale and the curves shown span only seven positions or stages.) When self-ratings of symptom distress (the mean scores across all 90 items on the Symptom CheckList-90) are concerned, the decay curves in Figure 1 show that the analysands and the psychotherapy patients started off at roughly the same level before treatment, followed each other during treatment and began to diverge as treatment ended and continued to do so as follow-up continued. A measure of standardised effect size (*d*), according to conventions in psychotherapy research, when we compare the first and the last points on the curves, is *very* large, around 1.55, for the psychoanalysis group and close to 0.6 in the psychotherapy group, which is considered a moderate to large effect. If we adjust straight lines to the two curves, their slopes—which indicate the respective average rates of change in the groups—are significantly different, whereas their intercepts—the points at which the groups started before treatment, so-to-speak—do not differ.

As assignment to treatments was not random, and the psychoanalysis and psychotherapy groups did differ on several variables, we cannot exclude the possibility that outcome differences between the two treatment groups were

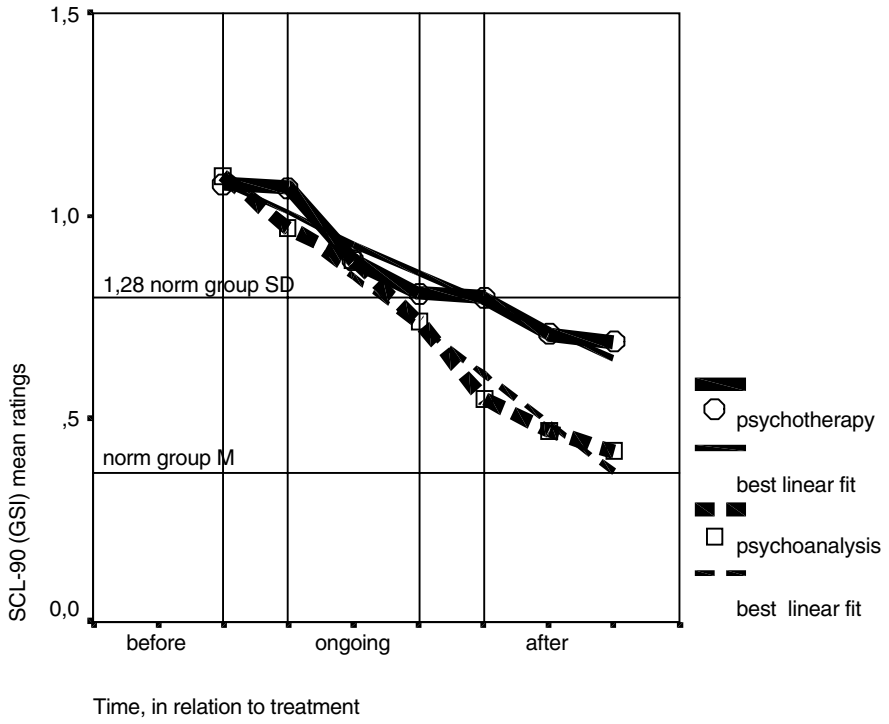


Figure 1: SCL-90 (GSI—General Symptom Index): Decay curves and best linear fit for patients in psychotherapy and psychoanalysis, in relation to the norm group mean and the 'caseness' criterion (norm group $SD = 1.28$).

in fact due to different patient characteristics. However, when initial patient differences in terms of a large number of demographic and psychiatric variables were controlled for by statistical means, the outcome differences between the groups remained essentially the same.

In Figure 1, the upper horizontal line indicates the value that divided the 10% worst-scoring people in the combined norm group from the 90% best-scoring people. This is an arbitrary but rather demanding demarcation between what we have defined as a clinical and a non-clinical range of scores on the SCL-90. In psychotherapy research, this division is ordinarily defined in a more lenient way, between the 5% worst-scoring and the 95% best-scoring people in a so-called normal sample, which of course leaves a wider range for what should be considered non-clinical. In support of our decision, the originator of the SCL-90 has chosen the same value as we have for what he calls 'the caseness criterion' (Derogatis & Lazarus, 1994): that is the value which empirically best predicts whether a person is diagnosed as 'a case', psychiatrically speaking, or not. By comparing the decay curves with this horizontal line in Figure 1, one may see that the mean levels in the psychotherapy and the psychoanalysis groups before treatment were quite far into the region of the 10% worst-scoring people in the combined norm group. Thus, to begin with, both groups were quite distressed.

In the Figure, the lower horizontal line is the mean level of the norm group. Although it may be debatable, let us assume that this level of distress of the average person in a random non-

clinical sample is the limit of what should be possible to achieve in any kind of treatment, *on average*. Obviously, the psychoanalysis group came fairly close to that limit about three years after termination, whereas the psychotherapy group was still far from it.

For the Sense of Coherence Scale, as a measure of morale and vitality, Figure 2 was constructed in the same way as Figure 1 was constructed for the SCL-90. Again, the mean score across all items was analysed, initially. Scores on the SOCS are defined such that increased scores should be considered as increased well-being; therefore growth curves on the SOCS correspond to decay curves on the SCL-90. Thus, after a small decrease the first year in both treatments, the SOCS developed in the same general way as the SCL-90, that is, in the direction of increased well-being and with a gradual differentiation between treatments after termination, again to the favour of psychoanalysis. It may be noted that the mean initial level of neither group on the SOCS was as low in relation to the norm group as it was on the SCL-90. In terms of effect size *d*, the development on the SOCS was not as positive as on the SCL-90, but still a large effect (1.18) in the psychoanalysis group, whereas there was only a small effect (0.34) in the psychotherapy group. The slope of the psychoanalysis group was almost double that of the psychotherapy group. As with the SCL-90, when variations in patient characteristics were statistically controlled for, the group differences remained unaffected.

Analyses of change ratings on the CHAP scales, on the basis of tape recordings of the qualitative follow-up interviews, corroborated these findings. Although rated change was generally largest for symptoms and adaptive capacity, especially pronounced differences

Figure 2: SOCS: Growth curves and best linear fit for patients in psychotherapy and psychoanalysis, in relation to the norm group mean and 'caseness' criterion (norm group *SD* = - 1.28).

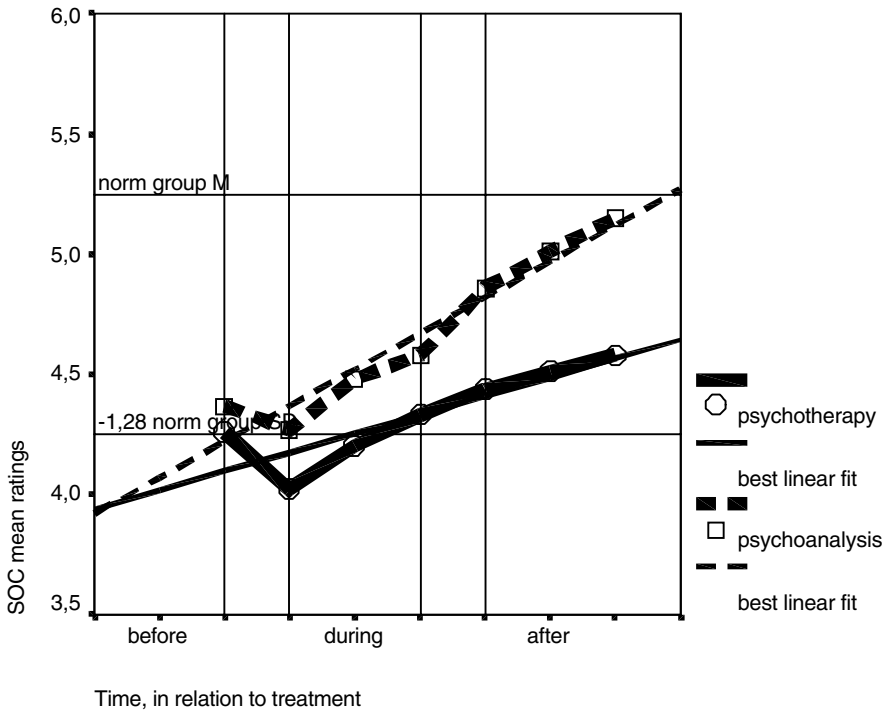


Figure 3: SAS: Decay curves and best linear fit for patients in psychotherapy and psychoanalysis, in relation to the norm group mean and caseness criterion (norm group *SD* = 1.28).

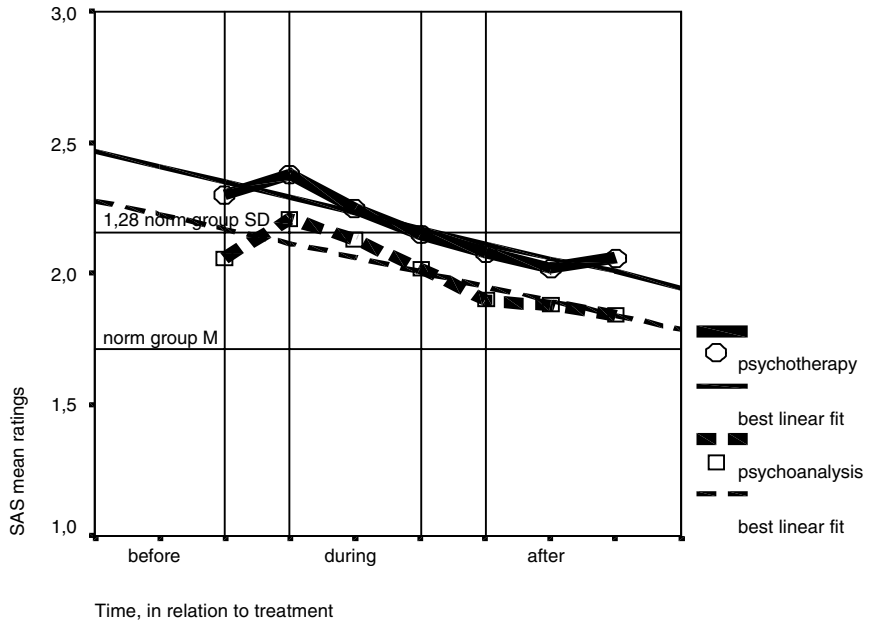
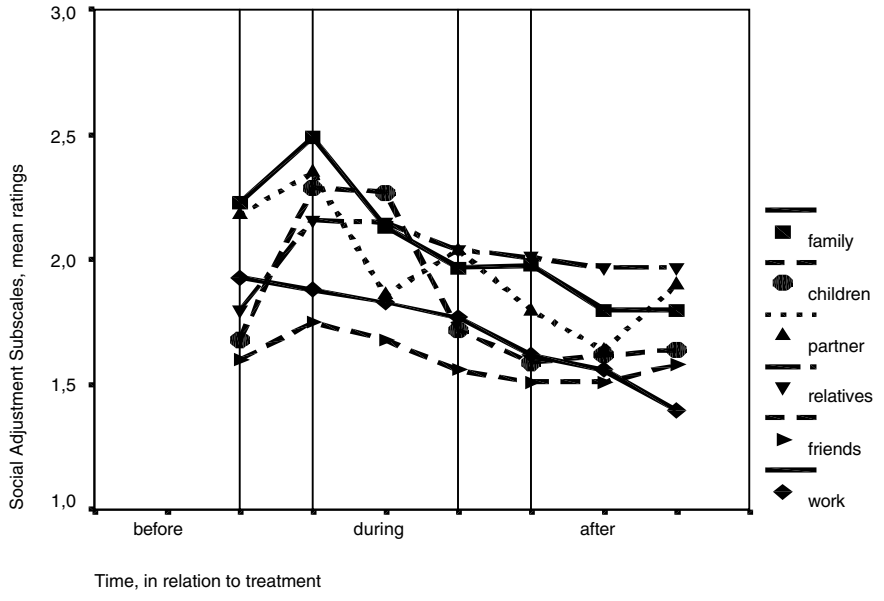


Figure 4: SAS—Decay curves for patients in psychoanalysis on the SAS subscales.



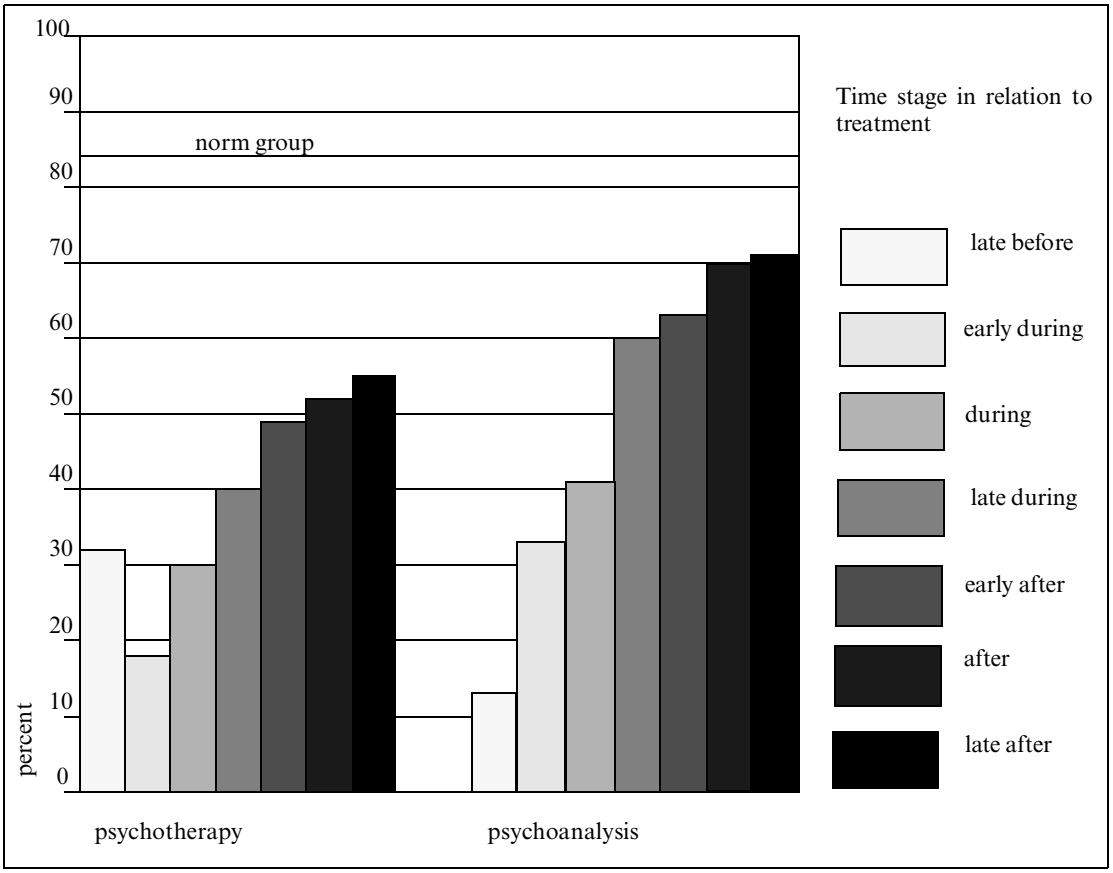


Figure 5: Proportions of patients with clinically significant scores in different phases of the treatment process.

between analysands and psychotherapy patients were found for ratings of basic conflict resolution, which is interpreted as structural change, in the psychoanalytic vernacular.

The Social Adjustment Scale, as a measure of the quantity and quality of social relations, is scored such that decreased scores indicate more frequent and generally smoother social contacts. When self-ratings on the SAS (again using the mean scores across all items) were plotted in the same manner as the SCL-90 and the SOCS scores, a very different pattern emerged, as in Figure 3. The mean improvement was almost exactly equal in the two groups and only small to moderate in size, effects sizes $d = 0.45$ and 0.44, respectively. Interestingly, the analysands started from a somewhat lower (which is better) level and maintained this differential throughout. As with the SOCS, there was an initial deterioration in both groups. Although there are large differences between the subscales (Figure 4), there was, unfortunately, little recovery across time, let alone gains, on most of them.

The initial differences on the SAS to the favour of analysands could not be explained by differences in patient characteristics. The hypothesis that these initial between-groups differences in social relations in their turn might explain the superior development of the analysands on the SCL-90 and the SOCS was also tested but found no support.

In order to summarise the findings on the self-rating scales, we defined a clinical case as a case where the scores on *all three* scales fell in the range of the 10% worst scores in the norm group, and a non-clinical case conversely. This

is an extension of the 10/90 division applied to each of the scales separately and, unless the scales are perfectly correlated (which they were not), this is obviously an even more exacting criterion. As may be seen in Figure 5, there was an increase from 12% of such non-clinical cases before treatment to over 70% about three years after termination in the psychoanalysis group, whereas the psychotherapy group had a more modest increase, from 33% to 55% non-clinical cases within the same time span.

Differences between psychoanalysis and psychotherapy

But, the reader is now likely to ask, what do we really mean when calling a treatment psychoanalysis or psychotherapy in this project? As has already been mentioned, the treatments were defined partly in terms of session frequency, with psychoanalysis three to five times a week and psychotherapy one to three times a week. It has also been mentioned that mean durations differed between treatments by, roughly, half a more year in psychoanalysis, and that there was a dose difference of roughly 400 more sessions in psychoanalysis, at an average.

Initially, the treatments were also defined in terms of the analysts' or therapists' training and consequent licensing. When we compared the psychoanalysis cases with the psychotherapy cases on the basis of other provider characteristics, some interesting differences were found. In summary, the findings indicated that the psychoanalyses tended to be conducted by more experienced people, in a general sense, than the psychotherapies. Thus, in comparison with the psychotherapies, the psychoanalyses were more often provided by a person who was a few years older, had longer experience doing psychotherapy *after* licensing or graduation, had longer experience of doing psychotherapy in private practice—but had a few years less experience of doing psychotherapy in in-patient psychiatric care. Besides more frequent psychoanalytic training, as a matter of course, the psychoanalysis providers also more frequently had formal training as supervisors and had more frequently been active offering supervision during the last year. There were no significant differences in gender, length of experience doing psychotherapy *before* licensing or graduation, length of experience doing psychotherapy in out-patient psychiatric care, case-load, taking supervision during the last year, frequency of auxiliary psychotherapeutic training (after licensing), or frequency of university training unrelated to psychotherapy.

The therapists, using the self-rating scales of the ThId questionnaire, also described their own views on the curative factors in psychotherapy, on their own style or doing psychotherapy, and on the nature of psychotherapy and the nature of man. In sum, the profile of the psychotherapy providers across the factor scales (which had been standardised on the national sample) was significantly more similar to a group of behavioural and cognitive therapists in the standardisation sample than were the psychoanalysis providers. Thus, they put greater value on curative factors like Adjustment (e.g. *giving the patient concrete goals*; *helping the patient adjust to prevailing social conditions*; *helping the patient avoid anxiety-provoking situations*) and *kindness* (e.g. *being warm and kind to the patient*; *the patient feeling well-liked by the therapist*; *supporting and encouraging the patient*). Further, they described themselves as higher on *self-disclosure* (e.g. 'I always communicate the therapeutic goals to the patient in the beginning of a therapy'; 'I always make the therapeutic goals explicit to myself during a therapy'; 'I admit my own mistakes to the patient') and lower on *neutrality* (e.g. 'I do not answer personal questions from the patient'; 'I keep my personal opinions and circumstances completely outside the therapy'; 'I am more neutral than personal in therapy'). When the therapists' basic assumptions about human nature and the nature of psychotherapy were concerned, there were large variations across the cases within each treatment but no differences between them, whether in terms of their averages or their variances.

Effects of temporal and financial treatment factors on patient outcome

To see to what extent duration and frequency factors could account for the outcome findings, we performed so-called path analyses on the 156 people who had terminated their treatments already in the first panel wave. Path analysis is a statistical technique to test whether one's data are compatible with a model of causal relations that one sets up as a kind of hypothesis for a set of more than two variables. Without going into technical details, we found that increasing session frequency and/or treatment duration had rather complicated effects on outcome. Thus, we could not find any *generally* positive effect on treatment outcome of either one. Statistically speaking, frequency and duration rather interacted in such a way that the effect of increasing frequency depended on the duration, and vice versa. Specifically, increasing frequency had a negative effect in therapies of short duration, and increasing duration had a negative effect in low-frequency therapies. Conversely, there was an increasingly positive effect of increasing frequency the longer the duration or of increasing duration the higher the session frequency. The latter, positive effects were much larger than the former, negative effects. Thus, long durations and high frequencies, *in conjunction*, were associated with the most benign treatment outcomes on the SCL-90. Interestingly enough, these effects became visible and significant only at the third follow-up, that is, about three years after termination. Before that there were no significant effects at all. This is probably a repetition of the previous findings of increasing post-treatment differentiation between psychoanalysis and psychotherapy.

In order to see whether the amount of money spent and the amount of subsidisation made any difference to outcome, we performed another series of path analyses on the same group of terminated patients. Again skipping the technical details, we may conclude that subsidisation had no *direct* influence on self-rated outcomes, and neither had the amount spent by the patient himself or herself. Rather, financial variables, amount subsidised as well as amount of own money spent, exerted their importance by allowing the patient more freely to self-select his or her treatment, typically treatments of higher frequencies and longer durations. The psychoanalytic tenet that patients who themselves pay for their treatment are more motivated to take responsibility for their share of the treatment work (and therefore may have a more favourable prognosis) thus found no support in our data.

Associations of patient outcome with analyst and therapist characteristics

We had a group of 337 cases available with complete data from both patient and analyst/therapist, and in this sample we were able to study the associations between patient outcome and various therapist variables. These associations were mainly tested on symptom change, and only symptom change associations will be reported, as these were more obvious than the associations with any of the other scales that we have studied.

Starting our review with some demographic variables, patients with female therapists had significantly better outcomes than patients with male therapists, irrespective of patient gender and treatment—although the female therapist superiority was not as large among psychoanalysis patients. Also, with the exception of the next youngest group (44–50 years of age), therapists and analysts seemed to do better with increasing age, considering the outcomes among their patients. The age trend was consistent across both therapist/analyst gender and treatments.

Variables relating to different parameters of experience and training showed mixed results. Number of years in private practice, particularly in psychoanalytic practice and particularly *after* licensing, had positive associations with patient outcome. As mentioned above, the analysts tended to be somewhat older and to have been longer in practice, especially in private practice. Nevertheless, when we controlled

for these differences, they could not account for the superiority of psychoanalysis over psychotherapy. It is noteworthy, for example, that psychoanalytic training, in comparison with regular psychotherapeutic training, did not appear to be any asset in practising *psychotherapy*, when we compared treatment providers with and without psychoanalytic training.

Supervisory training and offering supervision experience tended to have positive associations with outcome, whereas length of personal therapy or training analysis and recently received supervision on the part of the therapist/analyst both had clearly negative associations with patient outcome. When length of personal therapy was concerned, more detailed analysis revealed that the negative association was primarily restricted to one particular condition, namely *psychotherapies* that had been provided by therapists who had been in particularly long personal *psychoanalyses*.

The associations between patient outcome and therapist/analyst self-ratings (differences in outcome between above-median-scoring and below-median-scoring cases) were strong on some variables. What seemed to be particularly important in relation to patient outcome was that the therapist valued *kindness* as a curative factor and described his or her manner of doing psychotherapy as high on *supportiveness* (e.g. '*I often put questions to the patient*', '*it is important to convey hope*', '*it is important to order and structure the material*') and *neutrality*. It also seemed to matter that he or she considered psychotherapy basically more a work of art than a craft or science (the factor was called '*art*' and was indicated by items such as *psychotherapy may be described as free creative work* [rather than a craft]; *therapeutic work is governed by personality* [rather than by training]; *psychotherapy may be described as a form or art* [rather than a science]).

Now, if we consider what would be advantageous to outcome on the basis of these associations, we should not expect that psychotherapy would be inferior to psychoanalysis. After all, although lower on therapists' *neutrality*, the psychotherapy cases were indeed higher on therapists' *kindness* (and *supportiveness*, though not with conventional significance). Thus, considering the associations of the self-rating scales with outcome, we should not expect them to be able to account for the outcome superiority of psychoanalysis, and this was borne out by statistical testing.

So we had here a somewhat puzzling situation. However, when we explored the associations between the therapists' self-ratings and patient outcome in psychotherapy and psychoanalysis *separately*, we found two quite different patterns of findings. *Psychotherapy patients* with therapists low on *kindness*, low on *self-disclosure*, low on *supportiveness*, low on *insight*,[2] low on *neutrality* and low on *art* did significantly worse than psychotherapy patients with 'high' therapists. But *analysands* seemed to do as well, no matter what the attitudes of the analyst were. If we assume that attitudes like these reflect the manner in which these treatments were conducted, both seem to have been conducted in different manners, judging from the fact that there were indeed both 'high' and 'low' cases. However, the manner of psychoanalysis did not matter much, whereas the manner of psychotherapy did. To further explore this difference between the conditions of the treatments, we sought to identify different *types* of psychotherapies and psychoanalyses, on the basis of the therapists'/analysts' attitudes.

What we did was to assign all therapists to clusters, on the basis of their self-rating factors (*adjustment*, *kindness*, *supportiveness*, *self-disclosure*, *insight*, *neutrality*, *art*, *irrationality* and *pessimism*).[3] The clustering had been found statistically to discriminate between four groups of therapists in our national standardi-

[2] Insight (e.g. helping the patient to understand that old reactions and relations are repeated in relation to the therapist; helping the patient see the connection between his/her problems and his/her childhood; encouraging the patient to reflect, in the therapy, on earlier painful experiences) was one of the curative factors scales.

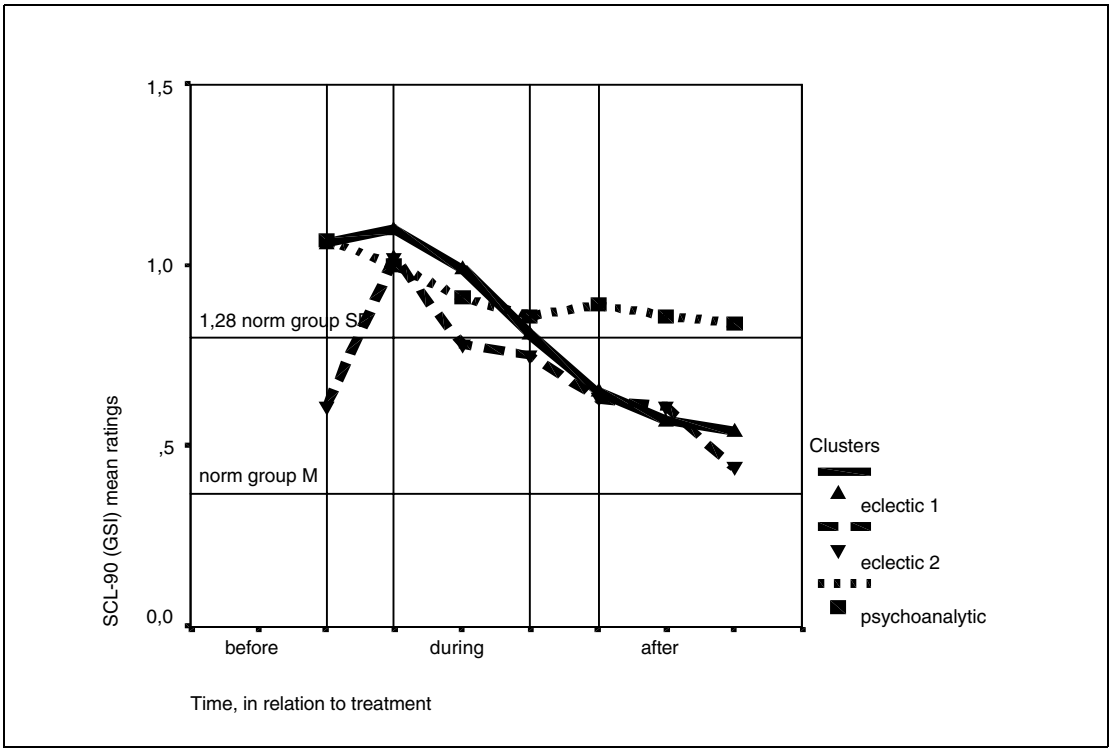


Figure 6: SCL-90 (GSI): Decay curves for patients with therapists with classically psychoanalytic or two varieties of eclectic attitudes.

sation sample, in a way that meaningfully and significantly related to different psychotherapeutic schools and different training sites. Thus, we had found a cluster (12%) where therapists with cognitive or cognitive-behavioural training were over-represented; one (27%) with a rather complementary profile across the self-rating factors, with an over-representation of people with psychoanalytic training (but also people with regular psychotherapeutic training); and two with profiles high on the self-rating scales where the cognitive and cognitive-behavioural therapists were high (adjustment, kindness and supportiveness) and also high on those where the psychoanalytically trained were high (insight and neutrality). They differed radically on self-disclosure, however, one cluster (34%) being high (like the cognitive/cognitive-behavioural cluster) and one (27%) being low (like the psychoanalytic cluster). Different training sites, with local particularities, were over-represented in the two clusters, but we chose to consider both as eclectic in their attitudes, endorsing both behavioural and psychoanalytic ideals.

When the therapists in the outcome sample were assigned to the closest of these standard clusters, we found that there were no therapists

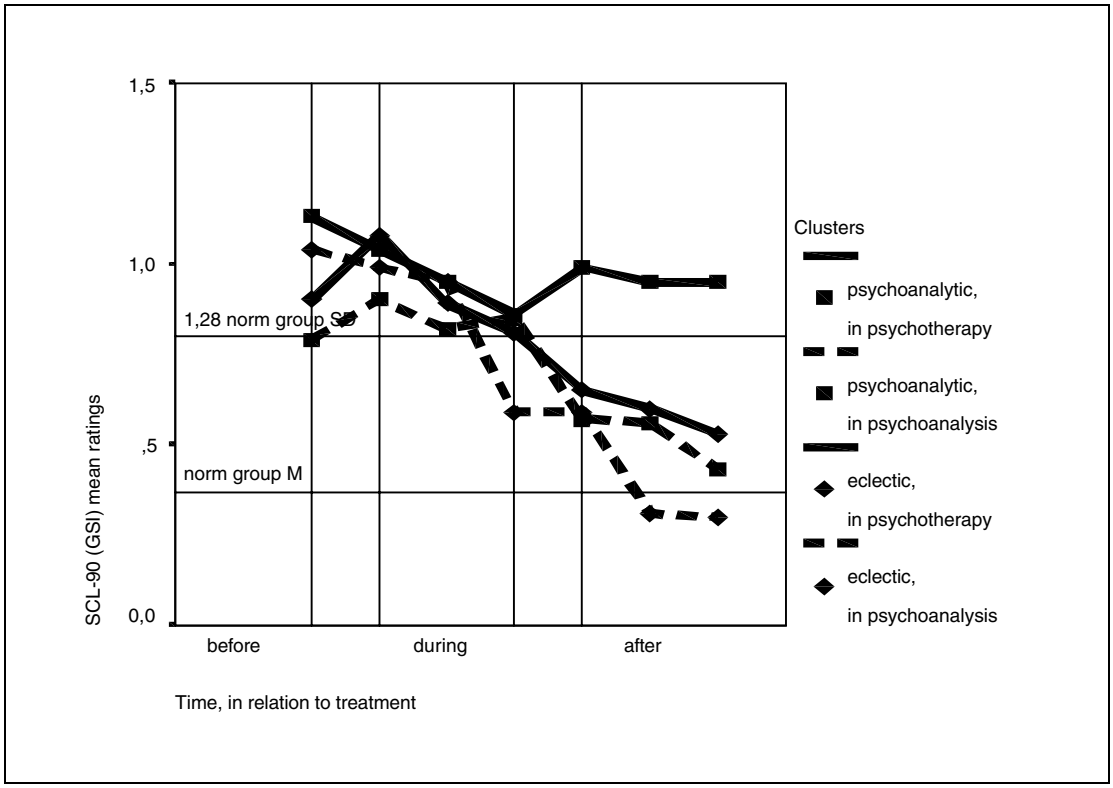
[3] Irrationality was a factor scale accounting for therapists' views on the rationality/irrationality of human nature (human behaviour is governed … by free will/by uncontrollable factors; by nature, man is … rational/irrational; human behaviour is governed … external, objective factors/by internal, subjective factors). Likewise, pessimism was a factor derived to account for the therapists' ideas on some epistemological and ontological issues (the basic principles of human behaviour may be understood … completely/not at all; humans can develop … infinitely/not at all; therapeutic work is governed by the fact … that everything may be understood/that not everything may be understood).

in the cognitive/cognitive-behavioural cluster. Instead, the psychoanalytic cluster was larger (42%), whereas the eclectic clusters were of roughly the same sizes as in the national sample (34% and 24% respectively). This classification might be compared to responses to a global self-rating item, where the same therapists rated the strength of their orientation towards each of five different schools. In 95% of the cases, the therapist rated his or her psychoanalytic orientation as 'fairly strong' or 'strong'.

When these three clusters were compared on the basis of outcomes among their patients, we found that therapists and analysts in the psychoanalytic cluster had significantly inferior patient outcomes in comparison with therapists and analysts in both of the eclectic clusters. This finding, visualised in Figure 6, further increased our puzzlement, particularly as it was replicated both on the SOCS and the SAS. The psychoanalysis cases had better outcomes, yet the cases with therapists in the psychoanalytic cluster had worse.

To explore this puzzle we took our point of departure in the observation that therapist attitudes that seemed to matter in psychotherapy did not in psychoanalysis. So we partitioned each cluster of cases according to treatment. To simplify this complex interaction, we analysed the two eclectic clusters pooled, as we had found their performance quite similar in a split analysis. What we found for the SCL-90 is shown in Figure 7, and the SOCS and the SAS yielded essentially the same pattern of results. Evidently, the significant inferiority of the psychoanalytic cluster of cases was limited to cases in *psychotherapy*, on all three scales. Not shown in the figure, there was a non-significant tendency for the psychoanalysts in this cluster to do better than the psychotherapists with patients in psychotherapy on all three scales. Finally, comparing the psychoanalysts in the

Figure 7: SCL-90 (GSI): Decay curves for patients in psychotherapy or psychoanalysis with therapists with classically psychoanalytic or eclectic attitudes.



psychoanalytic cluster with the psychoanalysts in the eclectic clusters—who, being a minority (29%), might be considered 'atypical analysts'—their achievements in psychoanalysis were not in any way superior.

Absenteeism and health-care utilisation

Turning now from the self-rating scales to our analyses of official records and self-reports on health and sickness, we found significant improvement in the psychotherapy group both during and after treatment, in terms of independence of social welfare, absence from work due to sickness and utilisation of somatic out-patient health care. Considering other parameters of health care utilisation, there were non-significant improvements generally, except in somatic in-patient treatment and psychiatric treatment, out-patient and in-patient. These trends were in accord with the moderate improvement in subjective well-being reported on the self-rating scales and also with self-ratings of general health state.

In the psychoanalysis group, however, despite self-reported gains in the capacity for work on the SAS, for instance, there was a significantly *increased* dependence on social welfare, a significant *increase* in absence from work due to sickness, a significant *increase* in number of visits in somatic treatment, and a significant *increase* in consumption of psychoactive medicine. There were non-significant *increases* on several other parameters, but not on number of weeks in sickness pension, number of weeks in psychiatric hospital treatment and consumption of medicine generally. With a few exceptions, thus, the pattern of change in the psychoanalysis group was negative. Nevertheless, there was a significant *improvement* in self-rated general health state.

DISCUSSION

There are two questions persistently raised in connection with this study. One is whether the decay, or growth, curves really indicate treatment *effects* at all. The other is whether, in that case, they really indicate *treatment differences* at all. We shall deal with the second of these questions at the end of this discussion but respond to the first one immediately. The factors that might account for the development across time in treatment are of course such that would be correlated with time in treatment. As already noted, a large number of such factors have been tested and found not to be correlated with time. Some others, like history and maturation (Cook & Campbell, 1979), are not applicable, simply because the different stages-in-treatment groups are indeed different patients who are tested at the same points of real time. That is also why time alone, allegedly the great healer, is not applicable, either. For the same reason, parenthetically, the effect sizes are not pre-post differences within patients, which are known to be inflated, but between-groups differences.

Regression to the mean is still another factor that has frequently been suggested to account for psychotherapeutic changes across time. This is based on a stereotypical misunderstanding of the mechanism of regression. Without being technically detailed, suffice it to say that regression of extreme individual scores to the group mean will occur in any series of measurements on the same individuals, unless the measurements are perfectly reliable. To the extent that there is a *biased selection* of individuals from the group on the basis of one of the measurements, and this measurement is unreliable, the mean of the next measurement *in this select group* will be closer to the mean of the original group than the mean of the selected individuals was on the first measurement. In this study, insofar as people were selected for treatment (and hence to the study) on the basis of some unreliable measurement (or judgement) *before* the study, their mean on that measurement was unduly inflated (or deflated) in comparison with the mean of their true values and hence higher (or lower) than their mean on the measurements *in* the study. There could not have been any mean change due to regression from the first-wave measurement in

this study to the second wave, however, because the first-wave measurement was not used for any selection. If there were indeed any self-selection among patients, such that high-scoring people on the SCL-90 would have tended to drop out from the first to the second wave, this should rather have produced a selection of low-scoring people in the first wave, with the result that this measurement should have been deflated in comparison with the measurements on the second wave, thus creating an apparent *increase* of symptom distress in the group, contrary to what was observed.

Assuming, thus, that they are indeed treatment effects, several of our findings have come as surprises to us. One is that the symptom distress variable was the most responsive to the treatments. One way to interpret this is that the SCL-90 is more sensitive to change than either the SOCS or the SAS. Whereas this may explain why changes were smaller on the other scales, it may not explain the large changes found on the SCL-90. After all, it is claimed to be a distinctive feature of psychoanalysis and psychoanalytically orientated psychotherapy, in contrast to the behavioural therapies, that they are *not* focused on symptom amelioration but rather on the resolution of internal conflicts, so-called structural change. However, following Freud, it is clear that classical psychoanalytic theory regards symptoms as maladaptive conflict solutions. One of the necessary conditions for a state to be considered a structure is that it is habitual and enduring; therefore, symptoms are indeed themselves structures, in turn signalling maladaptive internal structures of conflict resolutions or adaptations. Classically, one regards the symptom as a substitute formation (thus, a structure) signalling the return of the repressed (Freud, 1894, 1915, 1926). It is this very signalling function that is activated in the form of symptom remission or symptom substitution if treatment fails to change the underlying internal structures. Thus, on the basis of classical psychoanalytic theory, one should regard symptom change as being as close as possible to so-called structural change. Besides, symptom change not only reflects internal structural change but is also an indirect, if not direct, indication of change in internal and external autonomy, that is, the freedom to be able to choose and shape one's way of living without internal inhibitions and self-imposed external restrictions. No doubt, this is a central and specific goal of psychoanalytic treatment. In conclusion, therefore, focusing on symptom change should not at all be alien to the psychoanalytic undertaking.

Another astounding finding was that both treatments produced so generally unimpressive effects on the SAS. After all, again, the structural focus of modern psychoanalysis is on internal object relations rather on inter-systemic conflicts. The SAS is an established instrument, and we have made great efforts to adapt it to modern Swedish users and to improve it psychometrically. Its reliability is high in our study. The suspicion that it merely measures quantitative trivia of social life and has little to do with internal object relations was clearly contradicted by an unpublished study in our project. Positively loaded primary object representations (Blatt et al., 1992) correlated significantly with well-functioning social relations as indicated by SAS scores.

For the time being we can offer no reasonable explanation for the lack of obvious long-term beneficial change on the SAS. Evidently, the scale is sensitive enough to change as such, because change is indeed large—to the negative—on most subscales in the beginning of the treatments, but not in the end of them, or after. This initial deterioration on the SAS is itself an unexpected finding and, as a speculation, one might interpret this as indicating the kind of withdrawal of object libido that Freud (1914) posited as the economic mechanism in secondary narcissism. Phenomenologically, this would be experienced as a decreasing involvement with other people, thus, a redirection of one's interest in others to an increased preoccupation with oneself.

What also came as a surprising result was that there were no apparent differences between the two treatments until after their terminations. Obviously, there is no simple direct

effect of frequency, such as would have been the case if the final outcome were an accumulation of the minute effects of each single session. If so, there should have been a cumulative differentiation starting from the very first session, and psychoanalysis would have had a slope about three times that of psychotherapy from the beginning, corresponding to the ratio of frequencies. That there is a critical differentiation setting in as the treatments are terminated implies a rather more complicated effect of frequency. Again, we can only speculate that something is occurring during the more frequent sessions in psychoanalysis that prepares for an outcome process that has to be *qualitatively* different, qualitatively because there can be no further *quantitative* differences between the treatment regimes once the treatments are terminated. Only further follow-up can determine to what extent the treatment groups will continue to diverge or not. Evidently, both groups are levelling off and may not change much further, although more detailed analysis of the data, wave by wave in our panel, clearly indicated that the psychotherapy group, but not the psychoanalysis group, was close to its asymptote at the final stage of our time scale. If this is correct, the outcome difference between the groups would have continued to increase.

We shall use the qualitative follow-up interviews to enquire further into this important difference between the two treatments. The interviews have so far been analysed in terms of change ratings, only, but the validity of these ratings is hampered by the fact that the raters were not blind with respect to what kind of treatment the patient had been in. Therefore, one cannot dismiss the possibility that the ratings were influenced by the raters' ideas of theoretically expectable or desirable outcomes. This kind of contamination is difficult to avoid in free, informal interviews, without radical editing, and their value in measuring outcome is therefore limited. Their primary value is rather that this richness of qualitative information may be used to illuminate and comment on the quantitative findings. When the specific issue of the between-treatments differentiation is concerned, what will be particularly interesting is of course the patients' accounts of the post-treatment process. For instance, one might expect accounts, in the psychoanalysis group, of a growing self-analytic attitude that may not be as strong in the psychotherapy group. Whatever one's expectations, however, an open mind is the best instrument for discoveries in texts like these.

Still another unexpected finding was the negative trends in terms of absenteeism and health-care utilisation, which are in such stark contrast to the improvement in self-rated symptom-distress in the psychoanalysis group, the improvement in self-rated working capacity on the SAS work subscale, and the improvement in self-rated general health state. Also, these findings are at odds with the results of several German and American studies (Dührssen, 1962; Dührssen & Jorswieck, 1965; Breyer et al., 1997; Gabbard et al., 1997; Keller et al., 1998; Leuzinger-Bohleber, 1999). The data have been checked for errors and corrected, and other data artefacts have been controlled for, and the data now seem to be fairly valid in comparisons between official records and self-reports. Also, extreme cases have been excluded or neutralised. We conclude, therefore, that the findings reflect at least some kind and degree of truth. In a series of path analyses we have found, however, that utilisation of health care and health insurance is essentially unrelated to subjective well-being, according to self-ratings. In contrast, evaluating sickness-type of data in comparison with self-ratings, as on the SCL-90, a recent report from the Swedish Council for Planning and Coordination of Research, concluded that self-ratings were the best predictors of later sickness and mortality on the basis of meta-analyses.

A frequent speculation on presentations of our negative findings on health care and health insurance consumption is that, during psychoanalysis, the harsh superego softens and the analysand is weaned from her or his exaggerated ambitions and learns to take a break when not feeling well. There is indeed some support for such a conjecture. In the first stages of treat-

ment, the average analysand has more *somatic* health care and more sickness pension than the average norm group level but *less* psychiatric health care, *less* consumption of psychoactive medicine, *less* sickness absence from work, and *less* dependence on social security. In these latter respects, during treatment and after, she or he tends to approach the normal level 'from below'. In the psychotherapy group, there is an opposite trend 'from above' towards the norm group mean. Thus, the psychoanalysis group initially appears as a group with substantial reasons for somatic complaints, without, however, taking due consequences of them. Through treatment their utilisation of social security and health care normalise, and their subjective evaluation of their general health state becomes significantly more positive. Our next task will be to try to illuminate and clarify these findings. Besides further analyses of data already collected, we plan to conduct a series of intensive personal interviews with especially interesting cases, such as people who reported increased absenteeism, illness and/or health care utilisation while at the same time rating themselves as in an improved state of well-being. We will especially focus on the role of treatment in moderating this superficially paradoxical relation.

Returning now to the self-rating findings, whereas the associations between outcome and some of the therapist variables may not have come as surprises, others are likely to raise eyebrows. For instance, how might we explain the negative association between outcome and length of therapists' personal therapies and between outcome and therapists' supervision experience? The associations between therapist factors and outcome are open, in principle, to three different kinds of interpretation. One is that there is a treatment effect: that the more experienced therapists do indeed provide superior treatments. Another type of interpretation is that there is rather a selection effect with regard to the patients, that more experienced therapists are better able to select the 'good' patients—or that the 'good' patients, for some reason, tend to select the more experienced therapists. The third type of interpretation is that there is a selection effect with regard to the therapists. The mechanism may be different in different cases. With regard to therapist age, for instance, it is indeed possible that not-so-good therapists gradually leave the profession after their training, which will leave higher percentages of better therapists in increasingly older age groups. Likewise, it may be the particularly good therapists who seek supervisory training. With regard to personal therapy and supervision, it may be that not-so-good therapists try to alleviate their difficulties with more personal therapy, especially psychoanalysis, or more supervision—although this does not help. Various randomising procedures would have helped to test these interpretations, but in a self-selection design like the present the findings are mere associations, providing, at best, an impetus for further investigations.

Originally, the STOPP project was intended to compare psychoanalysis and so-called psychotherapy. So, what are the principal findings? To begin with, it is obvious that the psychotherapy population is different from the psychoanalysis population, not very different but systematically different, demographically, socio-economically, and psychiatrically. These differences cannot explain the different outcomes, however. Partly, these are due to dosage factors, insofar as the psychoanalytic time schedule (long treatment duration and high session frequency) seems generally more effective than the psychotherapeutic one (as long duration but lower frequency).

Further, the psychotherapists are a different population from the psychoanalysts. Again, the differences are not large but systematic and, in general, the psychoanalysts have more of those varieties of experience that are positively associated to outcome but, again, these differences do not account for the outcome differences. More paradoxical are the relations between the therapists' attitudes and the outcomes among the patients. In contrast to experience, it is the psychotherapists who have more of those ideals and values that are positively related to outcome and yet the

psychoanalysts have the more successful patients. Our analyses indicate a solution to this paradox, when we discover that psychotherapy in our project was really provided by two kinds of psychotherapists, different in their ideals and values. If we may assume, for the sake of argument, that the therapists conducted their therapies in accordance with their ideas and ideals, we would suggest that psychotherapy was really carried out in two basically different ways: one according to rather classical psychoanalytic ideas and the other in a more eclectic way, by mixing the psychoanalytic ideas of insight and neutrality with a more sociable attitude, typical of the cognitive/behavioural therapists in our national sample. There is a similar typology among the psychoanalytic cases, but the very critical difference between the treatments is that, whereas this does not seem to matter as much, it does indeed make a difference in psychotherapy. Our tentative conclusion is that the classically psychoanalytic stance, with less emphasis on support, coping strategies, warmth and openness, may be functional with analysands but much less so with patients in psychotherapy. Thus, to a large extent, the superiority of psychoanalysis over psychotherapy in this study depends on the fact that a fairly large number of psychotherapy cases seem to have been conducted in a dysfunctionally psychoanalytic way. There was a statistical tendency for these cases to have been provided primarily by therapists without psychoanalytic training. We are led to the conclusion that there is a negative transfer of the psychoanalytic stance into psychotherapeutic practice, and that this negative transfer *may be* especially pronounced when the psychoanalytic stance is not backed up by psychoanalytic training.

One other finding supporting this conclusion is that therapists who had been in extensive psychoanalysis for their training had worse outcomes with patients in psychotherapy than therapists who had had an ordinary, though equally long, personal psychotherapy. We suggest that being in psychoanalysis or being psychotherapeutically trained in the psychoanalytic vein may create identifications and ideals that become detrimental in the psychotherapeutic setting—and are really not extra beneficial in the psychoanalytic setting.

TRANSLATIONS OF SUMMARY

Cet article fait état des résultats d'une étude à grande échelle de la psychanalyse subventionnée et de la psychothérapie à long terme. Plus de quatre cents personnes dans des phases diverses, avant, pendant et après une psychanalyse subventionnée ou une psychothérapie psychodynamique à long terme furent suivies pendant une période de trois ans comprenant des entretiens privés, des questionnaires et des statistiques officielles. Nos analyses montrent que les patients qui avaient passé le plus de temps en traitement faisaient preuve d'amélioration progressive sur les mesures d'auto-évaluation des symptômes d'affliction et du moral, et c'était particulièrement frappant chez les patients en psychanalyse. Cependant, l'amélioration était également faible chez les deux groupes quant à l'auto-évaluation des mesures des relations sociales. Les facteurs de dosage (combinaison de la durée du traitement et de la fréquences des séances) justifient en partie les différents résultats obtenus entre ceux choisis en psychanalyse et ceux en psychothérapie à long terme. Les attitudes et idéaux existant chez les thérapeutes et analystes en ce qui concerne les buts et moyens de la psychothérapie étaient aussi associés aux résultats qu'obtenaient les patients, bien que cet aspect était présent de façon plutôt complexe. Une grande part des différences de résultats entre les patients en psychanalyse et ceux en psychothérapie pourrait s'expliquer par l'adoption, chez un grand nombre de thérapeutes, d'attitudes psychanalytiques orthodoxes qui apparurent contre productive dans la pratique de la psychothérapie mais pas dans la psychanalyse. Les auteurs suggèrent que ceci constitue peut-être un transfert négatif de la position psychanalytique dans la pratique psychothérapeutique, et peut être fort prononcé lorsque les attitudes ne sont pas soutenues par une formation psychanalytique.

In dieser Arbeit wird über die Hauptergebnisse einer grossangelegten Studie von subventionierten Psychoanalysen und Langzeit-Psychotherapien berichtet. Über 400 Leute in unterschiedlichen Phasen vor, während und nach subventonierten Psychoanalysen oder langfristigen psychodynamischen Psychotherapien wurden über einen Zeitraum von drei Jahren untersucht mit persönlichen Interviews, Fragebogen und offiziellen Statistiken. Unsere Analyse zeigte eine zunehmende Verbesserung, je länger Patienten in Behandlung waren—besonders beeindruckend bei Pa-

tienten in Psychoanalyse—in der Selbsteinschätzung des Leidens unter Symptomen und der Moral. Die Verbesserung war jedoch gleichermassen schwach in beiden Gruppen in der Selbsteinschätzung der sozialen Beziehungen. Dosierungsfaktoren (Behandlungsdauer und Sitzungsfrequenz kombiniert) waren teilweise verantwortlich für die unterschiedlichen Ergebnisse bei denen, die in Psychoanalyse und denen, die in Langzeit-Psychotherapie vermittelt wurden. Haltungen und Ideale unter Therapeuten und Analytikern in bezug auf Ziele und Mittel der Psychotherapie waren auch mit den Outcomes der Patienten verbunden, jedoch in eher komplexer Weise. Ein wesentlicher Teil der Outcome-Unterschiede zwischen Patienten in Psychoanalyse und denen in Psychotherapie lassen sich dadurch erklären, dass eine grosse Gruppe von Therapeuten orthodoxe psychoanalytische Haltungen einnahmen, die in der psychotherapeutischen, nicht aber der psychoanalytischen Praxis kontraproduktiv zu sein schienen. Nach Meinung der Autoren kann es sich bei dieser Wirkung um ein negatives Übernehmen einer psychoanalytischen Haltung in die psychotherapeutische Praxis handeln, und dies mag besonders ausgeprägt sein, wenn diese Haltungen nicht durch eine psychoanalytische Ausbildung untermauert sind.

Este artículo presenta los principales hallazgos de un trabajo hecho sobre una escala amplia de psicoanálisis que fueron subvencionados y de psicoterapia dinámica de larga duración. Se siguió, durante un período de tres años, con entrevistas personales, cuestionarios y estadísticas oficiales, a más de 400 personas en diferentes fases, antes, durante y después del psicoanálisis y de la psicoterapia. Nuestros exámenes revelaron una mejoría progresiva mientras más tiempo llevaban en tratamiento los pacientes. Sobre todo, fue considerable entre los pacientes en psicoanálisis, quienes se auto-evaluaron en cuanto a síntomas de angustia y ética. Sin embargo, la mejoría fue igualmente pequeña en ambos grupos en una auto-evaluación en cuanto a relaciones sociales. Diferentes factores (duración del tratamiento y frecuencia de las sesiones, combinados) dieron cuenta, en parte, de las diferencias entre los que estaban en análisis y los que estaban en una psicoterapia de larga duración. Se vio también una relación entre los resultados de los pacientes y las actitudes e ideales de los terapeutas y analistas en cuanto a las metas y al significado de la psicoterapia, aunque esto es bastante complejo. Una parte significativa de las diferencias en los resultados entre pacientes en psicoanálisis y en psicoterapia, podría ser explicada por el hecho de que un gran grupo de terapeutas adoptaron actitudes psicoanalíticas ortodoxas, que parecen haber sido contraproducentes en la práctica de la psicoterapia y que no lo son en psicoanálisis. Se sugiere que tal efecto puede ser un trasvase negativo de la actitud psicoanalítica a la práctica psicoterapéutica; y que esto puede ser aún más negativo cuando esas actitudes no están respaldadas por una formación psicoanalítica.

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