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Close Family or Mere Neighbours? – Some Empirical Data on the Differences between Psychoanalysis and Psychotherapy[1]

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A General Background

Ever since Freud's times there has been discussion about the differences and similarities between psychoanalysis and psychoanalytically oriented therapies. The questions discussed are theoretical, practical, and political in nature: Are the differences in indications, technique and processes mainly a matter of *degree* or

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of *quality,* the latter being a stricter distinction? Is it possible to develop a genuine psychoanalytic process in once- or twice-a-week treatment? Are psychoanalysts automatically qualified to do and teach psychotherapy? Should psychotherapy be taught as part of the psychoanalytic training ?

The degree of segregation among the treatment modalities in the psychoanalytic part of the psychotherapy spectrum seems to vary between different countries. In Sweden psychoanalysts and psychoanalytically orientated therapists are quite careful – some would say meticulous - about the distinctions.[2] In Germany, on the other hand, the distinction is less clear and the expanded term "intensive psychotherapy" (Dossmann, Kutter, Heinzel & Wurmser, 1997) seems to be used to refer to a grey zone between psychoanalysis proper and low frequency psychotherapy on a psychoanalytic footing. In this paper we will simply use the terms *therapy* and *therapist* as generic terms when we refer to the entire spectrum of psychoanalytic treatments and the terms *psychoanalysis* and *psychotherapy* when we refer to psychoanalysis and psychoanalytically oriented psychotherapy specifically.

In 1954 the American Psychoanalytic Association set up four full-day conference panels on the differences and similarities between psychoanalytically oriented psychotherapy and psychoanalysis proper. In the discussions two groups of participants emerged, those who viewed psychoanalysis and psychoanalytic psychotherapy as distinctively separate modalities (e.g., Bibring, 1954; Gill, 1954; Rangell, 1954) and those who would blur the boundaries or see none at all (e.g. Alexander, 1954; Fromm-Reichmann, 1954). Today, almost 50 years later, it seems as if the issues discussed and the groupings are pretty much the same, Kernberg (1999), for example, being in favour of clear distinctions, and Fosshage (1997) favouring no clear distinction[3].
From an empirical point of view there is indeed no evidence leading to a strict distinction between psychoanalysis and psychotherapy. To this day, the most ambitious project making a relevant comparison seems to be the Psychotherapy Research Project (PRP) of the Menninger Foundation, launched as early as in the 50's. Based on the accumulated findings in the PRP, Wallerstein concluded clearly in favour of those who would blur the boundaries: "The therapeutic modalities of psychoanalysis, expressive psychotherapy, and supportive psychotherapy hardly exist in ideal or pure form in the real World of actual

[2] There has been a sometimes heated dispute between the two Swedish societies as to whether psychoanalysis could be conducted three times a week or whether this, by definition, should be called psychotherapy.
[3] It is interesting to note that, with few exceptions, it is psychoanalysts who discuss these issues.

practice. /…/ (treatments) are intermingled blends of expressive-interpretative and supportive-stabilising elements…. and /…/ the overall outcomes achieved by more analytic and more supportive treatments converge more than our usual expectations for those differing modalities would portend; and the kinds of changes achieved in treatment from the two end of this spectrum are less different in nature and in permanence than is usually expected." (Wallerstein, 1989, p. 205). Thus, contrary to what was expected, there were no differences in outcomes after psychotherapy and psychoanalysis; the mean effects of either treatment were quite modest; supportive techniques were as powerful as more interpretative ones; and psychoanalysts used supportive techniques to a larger extent than what was usually assumed.

We believe that the findings of the Menninger study have been vitalising to the discussion on the psychotherapy versus psychoanalysis issue by putting some empirical "facts" in focus. There is a need for more such empirical data. Unfortunately, there has been a strange disinterest among psychoanalysts, psychotherapists and, indeed researchers, in collecting systematic data on long-term psychoanalytic psychotherapy and psychoanalysis. Further, the quality of the few systematic outcome studies that have indeed been undertaken (as reviewed by Bachrach, Galatzer-Levy, Skolnikoff & Waldron, 1991; Doidge, 1997; Kantrowitz, 1997) has generally been poor (Fisher & Greenberg, 1996). At the same time, research on process and outcome in short-term psychoanalytic treatment abound. Apart from making psychoanalysis and long-term psychotherapy vulnerable to attacks from adherents to so called empirically validated (usually short-term) treatments, the lack of empirical data has tended to transform important theoretical discussions into introvert academic hair-splitting, with little or no impact on training or practice. Humbly, we hope that the facts presented here will contribute to further the discussion.
In 1993 we launched the Stockholm Outcome of Psychotherapy and Psychoanalysis Project (henceforth, STOPP). In this paper we offer a condensed account of some of the results and, for the first time, present a questionnaire, The Therapeutic Attitudes Scale (TASC) which consists of three different scales, mapping what we like to think of as the *therapeutic milieu* which therapists provide for their patients. We have tried to avoid heavy technical and methodological descriptions and instead focus on results that we believe may challenge some of the conclusions drawn from the Menninger project.

Our approach will be as follows. We begin with the background and the basic design of STOPP. Then, we will present data on patient characteristics and the

general outcome. We will then introduce the Therapeutic Attitudes Scale (TASC) and some empirical differences between psychotherapists and psychoanalysts with respect to what they believe and what they do, or at least claim to do, in their offices. Finally, we present some data and a discussion on how the beliefs and attitudes of the treatment providers interact with treatment modality, producing differential effects in psychotherapy and in psychoanalysis.

Where We Started – The Study Background

In 1989, the Swedish national health insurance authorities decided to specially fund projects to alleviate illnesses that were particularly burdensome to the national health insurance and health care systems. Among the different projects funded, one was for psychoanalysis and long-term psychotherapy with therapists in private practice. In Sweden, therapy is covered by the national health insurance system only as long as a medical doctor provides it. However, a majority of the licensed therapists are not physicians. Since many people do not have the possibility, or are not prepared, to pay for long-term intensive treatment, we have, in effect, a situation with long waiting lists for therapy with medical doctors and an under-utilised capacity of therapy with non-physicians. The STOPP project was launched with grants from the national health insurance authorities. The main purpose was to study which people, under what circumstances, seek psychoanalysis or psychoanalytic psychotherapy and what benefits they were able to derive from their treatments.

A program supervisor decided on the subsidisation of a treatment. To have subsidy the patient should first have contracted a licensed therapist and then have a written referral from another therapist, with a description of his or her need, and suitability for the suggested treatment. The subsidy covered all costs up to three years with no extensions allowed. (However, patients were free to continue treatment beyond the three years financing it in other ways.) One effect of this quite bureaucratic procedure, clearly not intended, was that most patients' treatments had already started at the time of the referral. Also, we strongly suspect that in most cases the referring therapist made only a passive judgement of whether the person could benefit from the suggested treatment, rather than an independent assessment of what he or she believed was the treatment of choice for this particular patient. Hence, we believe that to a large extent we are dealing with "ordinary", usually highly motivated, patients who have actively chosen both their therapist and their mode of treatment.

What We Did and Why – The Basic Structure of the Study

The project involved almost 1 200 patients in all. Our sample consisted initially of 756 persons: the 202 who had received subsidy between the years 1991-1993 and the first 554 on the waiting list for subsidy at the time of the first of three waves of follow-up, in 1994.

First, we read all the referrals in order to map what kind of patients we were dealing with. As it turned out many patients were already in treatment at the time of the referral, assessment of pretreatment status had to be based first and foremost on the referrals. To complicate further, diagnoses had to be made retrospective for those who had already begun treatment. - What was the case when the patients started? Fortunately, most referrals described patients history in such a way as to make this possible. However, exact diagnoses could not be done with such database, so each patient was only grossly diagnosed by a research assistant (psychologist) as having or not having a DSM-IV axis I or II diagnosis (American Psychiatric Association, 1994). We also assessed each person according to the Global Assessment of Functioning scale (GAF; DSM-IV, axis V). Besides current state, based on the descriptions we also made a rating of the lowest level of functioning after age 18, which is an invention for this study. The reliability of our diagnostic efforts where checked with three judges making three independent diagnoses on a subsample of 20 patients. Despite the difficulties, the interrater reliabilities were found to be acceptable to very good: *ICC* = .69 for the presence of an axis I diagnosis and .51 for the presence of an axis II diagnosis, and .69 and .88 for current and lowest GAF, respectively.

Two postal questionnaires were the basic motors in our design. (a) The *Well-being Questionnaire* (*WbQ*), which was sent to all the patients in May 1994, 1995 and 1996, and (b) the *Therapeutic Identity* (*ThId*), which was sent to all treatment providers, i.e. therapists and analysts, in the spring of 1996.

The WbQ is a 24-page booklet, specifically designed for this project. It contained a series of questions and items focusing on demographic, familial, and socio-economic conditions; data on frequency and duration of ongoing or terminated treatment(s); previous treatments; sickness and health care utilisation. It also included a number of well-known self-rating scales: the Symptom Check List-90 (SCL-90; Derogatis, Lipman, Rickels, Uhlenhuth & Covi, 1974); the

Sense of Coherence Scale (Antonovsky, 1987), and the Social Adjustment Scale (Weissman & Bothwell, 1976), all of which have high or very high reliabilities (between .60 and .90 in different studies). In this paper we will concentrate on the SCL-90 only[4]. The SCL-90 consists of 90 items for each of which the patient is asked to check on a five-point scales ranging from 0 (*not at all*) to 4 (*very much*), to what extent he or she has been troubled by various signs of somatic and psychic distress during the last seven days (for references on the reliability and validity of SCL-90 see Bridges & Goldberg, 1989).

After three reminders about 60% of the sample had remained in the panel through all three waves. In this paper we will present data from 331 persons who were in, or had been in, long-term psychotherapy, and 74 persons whose main treatment was, or had been, psychoanalysis.[5] An analysis of the attrition revealed only small and typical differences between responders and non-responders. Those who did not want to partake in the study at all had lower current GAF before treatment, and those who dropped out of the study had lower levels of education and lower level of functioning according to current GAF (p's < .05; two-tailed t-tests and chi-squares). However, there were no differences in response rates among patients in psychotherapy versus psychoanalysis.

The ThId was distributed in 1996 to all 316 treatment providers (therapists and analysts) who had at least one patient (the range was 1-11 patients) in the project. For norming and standardising purposes the ThId was also sent to a random sample of 325 Swedish therapists. The ThId has about 150 questions and/or items, divided in different sections. Apart from the TASC, which will be described in detail later on, there were three sections dealing with (a) basic education and professional training; (b) professional experience; and (c) personal therapy or training analysis.

It took four reminders to get 227, or 69%, of the national sample and 209, or 66%, of the 316 psychotherapists and psychoanalysts in the STOPP sample to complete the questionnaire. Chi-square analyses showed that attrition was not systematic (all p's < .05), except for the fact that therapists over 65 years of age in the national sample tended to abstain from responding on account of their retirement.

[4] These three scales were highly correlated which means that they either measure the same thing, or that they are dependent on eachother.

[5] Twenty persons were excluded because of incomplete data and 12, highly unrepresentative persons who never started their treatments were excluded and 13 patients in various kinds of low-dose therapies, viz. brief, low frequency, group, or family therapies were excluded.

Who Seek Psychotherapy and Who Seek Psychoanalysis?

Psychoanalytically orientated psychotherapists and psychoanalysts are sometimes accused of treating only "the worried well". There is a widespread notion that the typical patient in psychoanalytically oriented treatments is a "YAVIS" (Young, Attractive, Verbal, Intelligent, and Social), that is, well-off Woody-Allen-like characters whose main problem is an addiction to therapy. But when one review studies on consumers of psychotherapy and psychoanalysis, one will find that the typical patient bears only slight resemblance to this picture. In fact, she is an urban, middle-aged, well-educated, professional female, typically in a health-care, educational, or artistic profession (Carlsson, 1991; Carlsson, 1993; Garfield, 1994; Olfson & Pincus, 1994 b; Vessey & Howard, 1994; Weber, Solomon & Bachrach, 1985). At the same time, however, she is typically in a fairly bad shape in terms of her general medical condition, health-care consumption, and capacity to work. Indeed, this seems to be the case both in Sweden (Carlsson, 1991; Carlsson, 1993; Schubert & Blomberg, 1994), in the United States (Olfson & Pincus, 1994 a; Olfson & Pincus, 1994 b; Doidge, Simon, Gillies & Ruskin, 1994), and in Germany (Dossman, Kutter, Heinzel & Wurmser, 1997).
In analysing the referrals we found that, in line with earlier findings, the patients in our sample appeared as a highly qualified group, educationally and vocationally. They were clearly not a representative sample of the general population, apparently rather belonging to the cream of the crop. However, based on the coarse pre-treatment diagnoses and some complementary pre-treatment data from the WbQ, we found that the patients were quite vulnerable and often highly distressed, with long self-reported histories of suffering and histories of psychiatric (mainly out-patient) care and use of psychoactive drugs. The typical patient had had psychiatric problems for more than five years, and the most frequent symptom was feelings of self-blame and stress for not having things done properly or on time (items 26 and 86 on the SCL-90).

Table 1 shows the differences between patients in psychotherapy and psychoanalysis, respectively. Although they are similar in some respects, there were also some significant differences. As can be seen, there were relatively more men among the analysands. Analysands were also a few years older, had higher levels of education (which were already high among the psychotherapy patients), were more often married or divorced and had more frequently children. Psychiatrically, there were no, or only small, diagnostic differences or differences with respect to syndromes or level of disturbance according to the

GAF scales. However, before the present treatment, psychotherapy patients tended to have utilised institutionalised psychiatry (inpatient or outpatient clinics, emergency rooms etc.) to a larger extent, whereas analysands had rather turned to psychotherapy for help.

Table 1. Sociodemographic and Diagnostic Breakdown of Analysands and Psychotherapy Patients.

		Psychotherapy Patients (n = 331)	*Analysands* (n = 74)	
Sociodemographic Characteristics				
Men	%	20	37	**
Age	*M*	36	40	**
Married and/or divorced	%	38	60	**
Cohabiting with a partner	%	45	47	
Has children	%	49	66	*
Have some college education	%	76	94	**
DSM-IV Categories				
Psychiatric syndrome (axis I)	%	58	54	
Personality disorders (axis II)	%	12	11	
No psychiatric diagnose (V-codes)	%	33	36	
Level of Functioning				
GAF, current	*M*	60	61	*
GAF, lowest after 18 years of age	*M*	52	54	
Previous Psychiatric Treatments				
Any psychiatric treatment at all	%	79	91	*
Psychotherapy	%	63	75	*
Psychoactive drugs	%	55	56	
Outpatient psychiatric care	%	56	45	
Psychiatric emergency room	%	38	26	
Hospitalized	%	21	10	*

Note. * $p <$ .05; ** $p <$ .01, by *Chi-square* and two-tailed t-tests for differences between the two modalities.

We conclude that, despite great similarities, there are some interesting differences between persons how seek psychotherapy and those who seek psychoanalysis. It seems that socio-economic and socio-cultural factors are the most important ones to distinguish between the two groups: The higher the social status of the patients, the more likely he or she is in psychoanalysis. One may only speculate on why this is the case. In general, highly educated people, especially in the social, educational, and health-care sectors or in the humanities, are familiar with, and take an active interest in, psychoanalytic thinking. They are, as Kadushin (1969) puts it, the "friends and supporters" of (psychoanalytic) therapy. The difference also mirrors the status or prestige differential between psychotherapists and psychoanalysts. Is it the patients or the therapists who generates it? Who chooses whom? Several studies suggest that the relationship between the social status of the psychotherapist and his or her patients indeed has to do with the fact that high status therapists tend to choose high status patients (Garfield, 1986; Kadushin, 1969; Lubin, Hornstra, Lewis & Bechtel, 1973; Weber, Solomon & Bachrach, 1985). No doubt, the social selectivity is a political problem insofar as the treatment is paid for by public money. In Sweden the attacks on psychoanalysts and psychotherapists for their alleged lack of social concerns are frequent and, sometimes, harsh. Biological psychiatry and the cognitive-behavioural treatments maintain an attitude of being more attuned to "ordinary" or "lower- class" patients -- by implication those who "really suffer". As psychoanalysts and long-term psychotherapists lack empirical data, they tend to withdraw into a defensive position; sometimes claiming that the severe psychiatric patients are not really suitable for psychoanalytically orientated treatments. For one thing, this does indeed not seem to be the case, as far as our data show, for another, this offers an advantage to other kinds of treatments in the battle for public subsidy. The "worried-well" accusation does really not seem to be fair. Our interpretation is that it is the "burnt-out" and distressed professionals who seek therapy rather than bored housewives and artists looking for pastime. A majority of them have tried different treatments, including drugs, before entering long-term treatment. Also, many had tried other types of, usually less intensive, psychotherapy before. A related question of great interest is whether retakes or new treatment are made less probable by long-term treatments? In fact, some findings of ours suggest that this may be the case (Blomberg, et. al, 1997, June).

Did Patients get any Better? – The Treatment Effects

In order to answer this question we had to partition our two treatment groups in such a way as to allow some form of comparison between subgroups before, during and after treatment. Remember that many of the patients had already started treatment when we started our project, because they had not waited for subsidy but started whenever they had found any way to finance it. Hence, we had no control over when patients in fact started or terminated treatment. Indeed, the timing of our follow-up questionnaire (the WbQ) was totally independent of where any one particular patient was in his or her treatment process. What we had, then, was a pool of patients in different phases of their treatment processes. Consequently, our first follow-up questionnaire "hit" the patient randomly with respect to where he or she was in the treatment process, before, during, or after treatment. Figure 5.1 is an attempt to illustrate this pictorially.

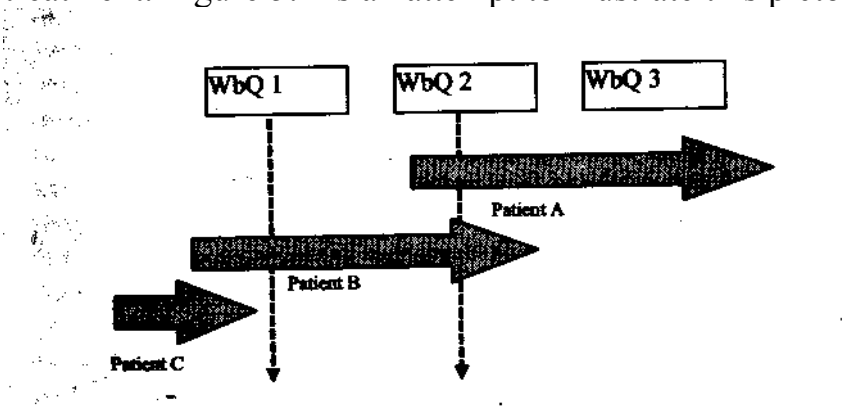


Figure 5.1. Examples of Patients at Different Stages of Treatment, in Relation to Waves of Administration of the Well-being Questionnaire in 1994 (WbQ1), 1995 (WbQ2) and 1996 (WbQ3).

Consider three persons, A, B, and C, with treatments extended in time as indicated by the thick arrows. At the time of our first administration of the WbQ, patient A had not yet begun her treatment, whereas patient B was in treatment and patient C had already finished hers. At the second administration (WbQ 2), patient A had recently begun treatment, patient B was a little bit further in hers, whereas patient C was one year further post-treatment. At the time of the third administration (WbQ 3), patient A was still in treatment, at a later stage in her treatment, whereas patient B had now terminated treatment. Patient C was yet another year further in her post-treatment process.

The story of *Alice's Adventures in Wonderland* may be used as an analogy for how we designed our data-analyses[6]. At one point in the story, Alice had wept violently, creating a pool of tears crowded with birds and animals that had fallen into it. The Dodo then suggested a "Caucus-race" to get them dry:

> "First it marked out a race-course, in a sort of circle (the exact shape doesn't matter, it said), and then all the party were placed along the course, here and there. There was no 'one, two, three, and away,' but they began running when they liked, and left off when they liked, so that it was not easy to know when the race was over. However, when they had been running half an hour or so, and were quite dry again, the Dodo suddenly called out 'The race is over!' and they all crowded round it, panting, and asking 'But who has won?' (Carroll, 1865, p. 32-33).

Using this analogy, in our "race", instead of the "race-is-over" call-out, we had three intermediate checkpoints (where we administered the WbQ), with one-year intervals. At each of these checkpoints we measured the patients' well being (just as the Dodo might have measured the animals' pulse, if he'd been interested enough). At any of these checkpoints any one patient then could be before, during, or after treatment. After collecting all data we grouped each of the 1 250 checkpoint scores or observations according to where the patient was in his or her treatment at the time, before, during or after treatment and, more specifically, in various subdivisions of each. In effect, we were able to position each checkpoint observation in one of the following seven phases on a relative time scale[7].

Table 2. The Number of Observations at Each of the Seven Treatments Phases on a relative Time Scale (N = 1250).

Phase		No. of observations
1.	pre-treatment [8]	35
2.	early treatment	186
3.	mid treatment	207
4.	late treatment	227

[6] This story is often used to illustrate another phenomenon in psychotherapy research, namely the so-called Dodo bird verdict, according to which "all (therapies) have won and all must have prizes".

[7] Technically, we had a quasi-experimental design that is partly cross-sectional (across stages of treatment; across treatment modalities) and partly longitudinal (across successive stages of treatment).

[8] In principle, we had indeed *three* phases before treatment, one with a number of observations on patients who never started any treatment at all and one with observations only on a small number of patients who were in other kinds of treatments than psychoanalysis or psychotherapy. These observations and, accordingly, these phases, were therefore discarded.

5.	early posttreatment	232
6.	mid posttreatment	207
7.	late posttreatment	156

In analysing the SCL-90 scores we simply calculated and plotted the mean scores across all observations in each position along the seven-point time scale. Figure 5.2 shows a decay curve for each treatment group[9].

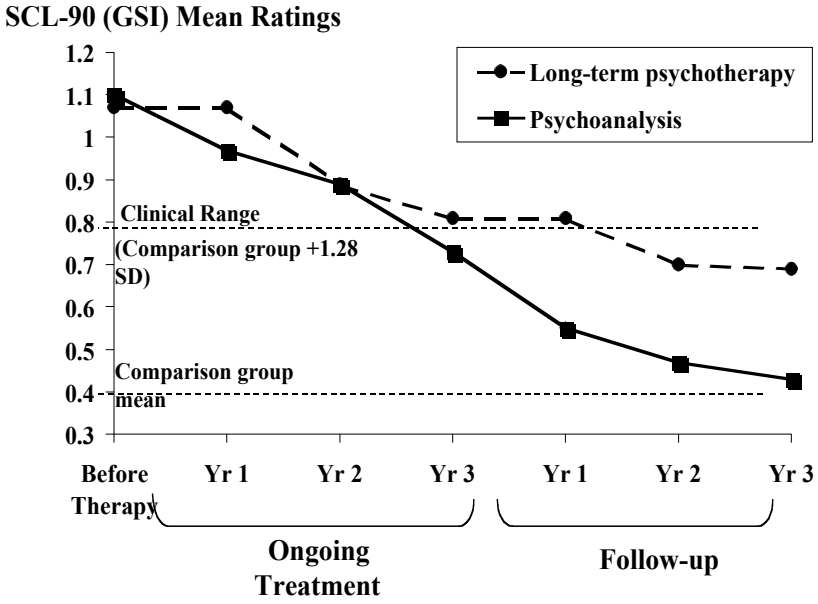


Figure 5.2. SCL-90: Decay Curves: Mean SCL-90 scores for Patients in Psychotherapy and Psychoanalysis Across Different Phases of the Treatment Process.

As can be seen, the analysands and psychotherapy patients started off at almost identical levels of symptom distress before treatment and both groups then got better at about equal pace. However, after treatment termination the analysands got progressively better, whereas the mean outcome flattened out asymptotically after psychotherapy. Analysing the linear trends the intercepts and *b coefficients* were both significantly different from 0 in both groups, t (6) = -8.07, $p < .001$. Also, the difference between the slopes in the two groups was significant, t (12) = 4.08, $p < .010$. In terms of so-called effect size (d) the difference between the first and last values in the series was 0.59 for psychotherapy and 1.55 for psychoanalysis. According to research conventions d's between 0.50 and 0.75

[9] In technical terms we have created a partly within- and partly between subjects design which we consider this equivalent to randomisation since our follow-ups was random with respect to patients treatment processes (Chambless & Hollon, 1998).

are moderate and over 1.00 are large. Hence, the effect size for analysis is *very* large when compared to the effect sizes in the oft-cited meta-analyses of, for example, Smith, Glass and Miller (1980) and Shapiro and Shapiro (1982).

Now, how do we know that these differences do not stem from differences in patient characteristics? In fact and as already noted, the patients were indeed not very different in absolute terms, in the first place. However, to make sure, using regression-analyses, we partialled out diagnostic and demographic factors statistically and found that this did not change the differential trend.

More important, one might ask whether these differences were caused mainly by "extrinsic" factors such as treatment dose (frequency x duration), by the providers' formal competence, or mainly by "intrinsic" factors such as the therapeutic techniques used and the therapeutic processes that developed? There were indeed great differences with respect to the number of sessions in the two groups. The psychoanalyses were three to five times per week (M = 3.6; SD = 0.7) with a member of one of the psychoanalytic societies in Sweden (one within the IPA and one, at the time, within the IFPS), and the psychotherapies were once- or twice-a-week (M = 1.5, SD = 0.5) with a psychotherapist licensed by the National Board of Health and Welfare. At an average then, the psychoanalyses had a total of 642 sessions (SD = 324) over about four and a half years (M = 54 months; SD = 23) and the psychotherapies 233 sessions (SD = 151) over nearly four years (M = 46 months; SD = 24).

The obvious question now is whether these extrinsic time factors, frequency, duration and dose (the total number of sessions) account for the differences in effect we observe? We have tried to sort this out in great detail using a sophisticated statistical procedure known as structural equation modeling (Jöreskog & Sörbom, 1986; Kline, 1998). It would bear too far to give an account here. However, we found the time factors *alone* could not explain the differences: neither frequency, nor duration had any effects in and by themselves or separately, whereas their interaction could explain *some* of the outcome variance (Sandell, Blomberg & Lazar, 2000). Since patient variables could not explain the variance, we believe that other variables must be at work accounting for at least some of the differences. Next, we will turn to one of these.

Different Folks provide Different Strokes! Differences and Similarities among Treatment Providers

One important lesson from the Menninger project is that, in comparing psychotherapy and psychoanalysis, one cannot rely on any notion of a "standard" psychoanalytic or psychotherapeutic technique, since psychoanalysts and psychotherapists vary considerably in how they actually practice, despite similar orientations and training. Clearly, one main problem with our study was the lack of *direct* observations — through recordings or notes—of what had really been going on in treatment.

Of course, we might have tried to collect retrospective data from patients and therapists, but such retrospective data are indeed problematic, both from a methodological and an ethical perspective. Our way of handling this was to develop a set of measures on therapist variables that we thought would be *related to* what might have been going on in the treatments. Of course, one can not assume any one-to-one correspondence between words and deeds, and a therapist's technique will probably vary somewhat with the patient. However, it was—and is—our assumption that the therapist's beliefs and values in therapeutic matters help determine the general approach and technique he or she actually uses. Also, several studies indicate that therapists intentions are in fact as strong, or even stronger, predictors of outcome than the their actual deeds (Hill, 1988; Taylor, Adelman & Kayser-Boyd, 1986). If we think of the consulting room as a therapeutic "black box", one could say that we have not been able hear exact what they are saying in it, but we can hear the tone of their voices.

The inventory we created is called the Therapeutic Attitudes Scale (TASC) and is part of the larger Therapeutic Identity questionnaire (ThId). The TASC consists of three sets of subscales:

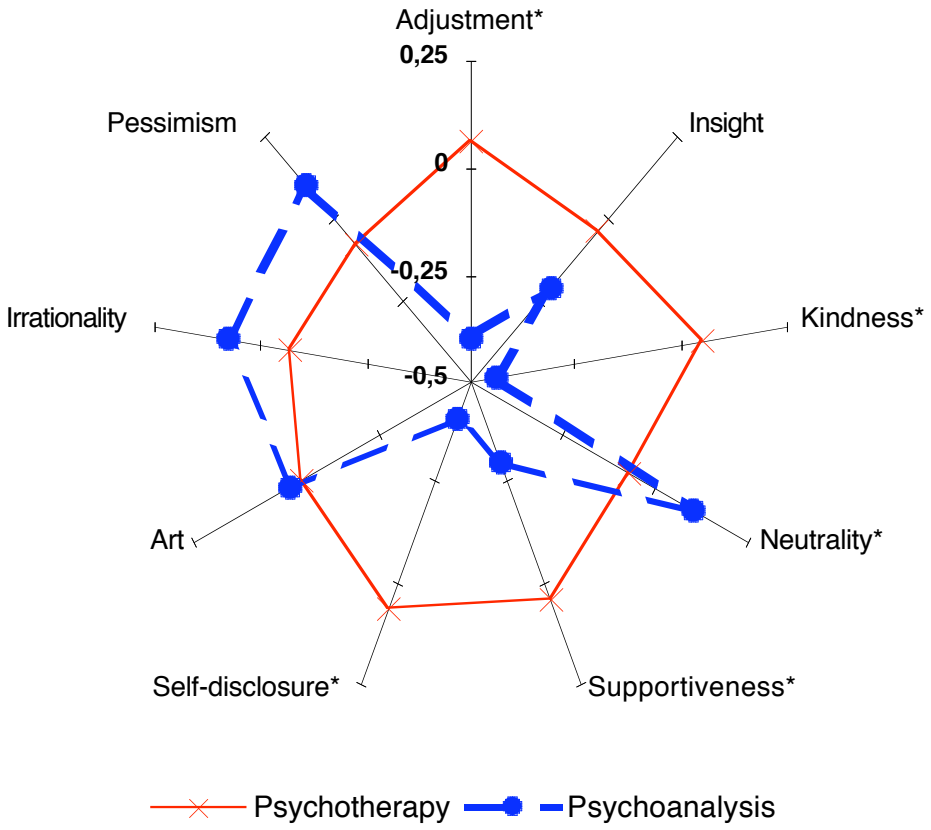
- Curative factors
- Therapeutic style
- Basic assumptions

The *Curative factor* scales were based on 33 items, initially, to rate the therapist's beliefs in the curative value of each of a number of ingredients of therapy (e.g., Helping the patient avoid anxiety-provoking situations). The instruction ran as follows, "What do you think contributes to long-term and

stable therapeutic change?" and the rating of each item was made on a five-step scale, from 0 (*not at all*) to 4 (*a lot*).

The *Therapeutic style* scales were based on 31 original items to describe the therapist's own manner of conducting psychotherapy, in the general case ("What are you like as a therapist?"). Again, the items (e.g., I keep my personal opinions and circumstances completely outside the therapy) were rated on a five-point scales, from 0 (*not at all*) to 4 (*a lot*).
The *Basic assumptions* scales were based on an initial series of 16 items relating to one's more basic assumptions about the nature of psychotherapy and the nature of the human mind, partly inspired by Hjelle and Ziegler (1981). The rating scales were continuous bipolar scales, with anchors at each of the poles offering a completion of the item stem (e.g., Psychotherapy may be described ... as a science/as a form or art). The ratings were later transformed to five-point scales. To encourage wider use of the scales, the scales and their items are presented in the Appendix.

When we analysed the TASC-scales we found several important and significant differences within the sample. Figure 3 shows the relative difference between the treatment providers. As can be seen, patients in psychotherapy, (which were indeed sometimes conducted by people with psychoanalytic training), were treated in a therapeutic milieu that was more similar to what we had found characteristic of behavioural and cognitive therapists in the national sample. The psychotherapy providers did put significantly greater value than the psychoanalysis providers on promoting *adjustment* and showing *kindness* as curative factors (d's > 0.43, p's $< .05$). Psychotherapy providers also preferred a technique that was less *neutral* and higher on *supportiveness* and s*elf-disclosure* (d's > 0.26; p's $< .05$) than the psychoanalysis providers. However, there were no significant differences with respect to the basic assumptions, although those providing psychoanalysis were a little bit higher on *pessimism* and *irrationality* (d's > 0.23; n.s.).



* = $p <$ .05.

Figure 5. 3. Mean z-scores on the TASC for Treatment Providers in Psychoanalysis (broken line) and in Psychotherapy (unbroken line). Curative factors (Adjustment, Kindness and Insight), Therapeutic style (Supportiveness, Self-disclosure, Neutrality), and Basic Assumptions (Art, Irrationality, Pessimism).

Based on the scores on all nine sub-scales (using Cluster analyses) each therapist was then assigned to one of the four standard clusters, based on the national sample, described in the Appendix. The distribution was as follows:

- 42% were assigned to psychoanalytic cluster
- 34% and 24%, respectively, were assigned to the eclectic clusters
- 0% to the cognitive/cognitive-behavioural cluster.
-

Thus, if we are to believe that treatment is carried out in rough correspondence with what the treatment provider believes and values—or at least claims to believe and value, we find that neither psychoanalysis, nor psychotherapy, are unique or specific designations of any particular technical approach. The division of the therapists in three—or at least two—distinct clusters is all the more interesting, in light of the fact that, in response to a direct question in the ThId, 95% of the therapists in our sample claimed to endorse a "psychoanalytic

orientation". That psychoanalytically orientated psychotherapists as well as psychoanalysts hold insight in high esteem and value neutrality as a technical attitude is, of course, not astounding—although the value of neutrality may not be as great, generally, in conducting psychotherapy as in psychoanalysis. Over and above sharing these basic tenets, however, therapists will vary in a number of other respects that we assume will make an essential difference in the treatment office. This is news, we believe. If we characterise the treatments on the basis of the therapist's cluster membership, there was a minority (30%) of eclectically orientated psychoanalyses (and hence 70% classically psychoanalytic). Among the psychotherapies, there was a more even distribution of treatments conducted in an orthodox psychoanalytic vein (43%), or in a more eclectic way (57%), with attitudes more characteristic of cognitive and cognitive-behavioural therapies.

Thus, what we have found quite frequently among so-called psychoanalytically orientated psychotherapists, and not infrequently among psychoanalysts, is a particular constellation of attitudes that we would consider as a more sociable, if not humane, attitude in relating to the patient—and which is partly at odds with the neutral attitude—or with a generally psychoanalytic attitude. In conjunction with the positive valuation of insight and neutrality, these attitudes reflect what we have chosen to call an eclectic type of approach which we would hypothesise is more closely connected to what is usually described as the aims of psychoanalytic psychotherapy than to those of psychoanalysis proper.

The Relationship between Therapeutic Milieu and Outcome

Now, the obvious question is "Which type of therapist did best?" Although this question may seem simplistic, few therapists would doubt that the personal and professional qualities are of great importance in contributing to good or not-so-good treatment results. Also, most training institutes put heavy weight on "suitability" for becoming a therapist. However, there is little or no empirical support for any given characteristic, even though therapist expectations and qualities are among the most frequently studied variables in outcome research. In summarising this research, Beutler, Machado and Neufeldt (1994) draw three conclusions: (1) Individual therapist variables account for more variance in outcome than mode of therapy; (2) some therapists are better than others; and (3) some therapists are detrimental to clients. However, apart from this, the relationships between outcome and therapist variables are highly unclear: There is little or no consensus as to which traits of therapists are predictive of outcome. And, according to the well-known Dodo bird verdict, theoretical orientation *per*

se–-in terms of the usual coarse distinctions we make, psychodynamic, cognitive, or behavioural, are obviously not predictive of outcome.

In order to study the relationship between therapists' values and patient outcome we paired all patients with their respective therapists. We then had data from 330 therapist-patient couples, 55 in psychoanalysis and 275 in long-term psychotherapy.

When the three clusters were compared on the basis of outcomes among their patients, we found that, in general, therapists providing an orthodox psychoanalytic milieu did significantly *worse* than what those providing a more eclectic milieu did. Also, when we compared therapists high (above the median) on single TASC scales with therapists low (below the median), we found significant differences in favour of attitudes on which the members of the psychoanalytic cluster were low. Thus, the strongest associations with good outcome were found with therapists high on kindness and supportiveness, neither of which were favoured by the orthodox attitude; art, favoured by neither the orthodox nor the eclectic attitude; and neutrality, favoured by the orthodox view, all p's < .05. Clearly, these findings came as a surprise, since they were rather at odds with the fact that patients treated in psychoanalysis did better. How could this be? The riddle got its answer when we distinguished between the psychotherapy and the psychoanalysis cases and assigned the cases of each type to one of the two main groups, those who had been offered an eclectic milieu and those treated in an orthodox psychoanalytic milieu. The former group was formed of those cases where treatment was provided by therapists in any of the two eclectic clusters and the latter of cases treated by therapists in the orthodox analytic cluster. Figure 5.4 shows the results.

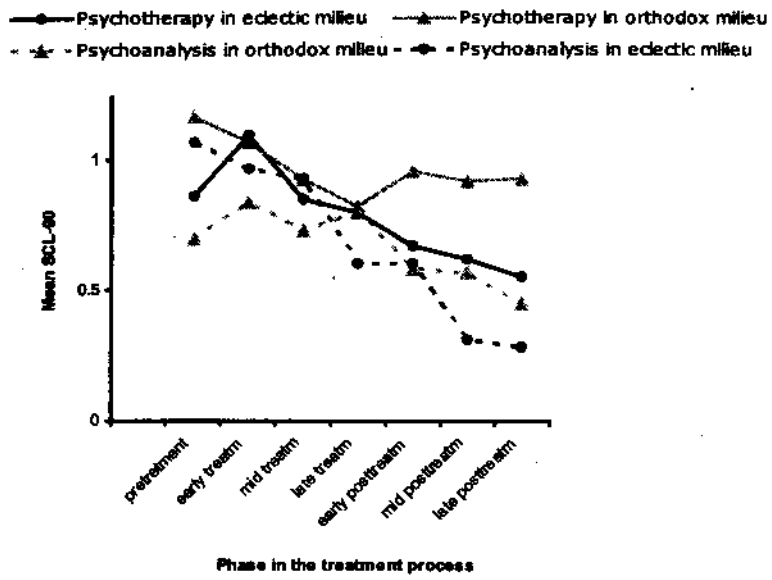


Figure 5.4. SCL-90: Decay Curves for Patients Treated in an Orthodox Psychoanalytic Milieu or in an Eclectic Milieu: Mean SCL-90 Scores for Patients in Psychotherapy (unbroken lines) and Psychoanalysis (broken lines).

Obviously, for patients treated in psychotherapy the two types of therapists did significantly differently. Psychotherapy provided in an orthodox psychoanalytic milieu had significantly worse outcomes than psychotherapy in an eclectic milieu. In fact, the mean change among the former cases did not differ significantly from 0, b = -0.007, t (6) = 0.33, n.s. In the eclectic group, b = -0.101, p = .000. Among the psychoanalysis cases there was indeed a difference in the same direction but not at all significant, b = -0.140, p = .006 versus b = -0.087, p = .012. Thus, what seems to make a *large* difference in psychotherapy, does not (as much) in psychoanalysis, apparently.

Closing Comments

There currently seems to be a trend towards blurring of the boundaries between psychoanalytic psychotherapy and psychoanalysis proper. The lack of data supporting a clear distinction, the multiplicity of psychoanalytic theories, and the pluralism and relativistic trend within psychoanalysis (Fosshage, 1997), all work in this direction.

Although there are indeed great similarities between the two, our results indicate that there are also some very important differences between psychoanalytic psychotherapy and psychoanalysis: patients, outcome, therapist attitudes and techniques. The most interesting finding, however, is that a strict psychoanalytic attitude does not seem to be really appropriate in psychotherapy. The “as-if

psychoanalyses" are clearly not successful. This is, we believe, a very important finding that may justify the theoretical discussions.

However, it seems that the theoretical discussions on differences and similarities very often are based on the (explicit or implicit) assumption that a psychoanalytic process is always a good one. Often, it seems that the proponents of a clear distinction as well as those against such a division end up drawing similar conclusions. For example, Gill (1988), a "separatist", closes a discussion on the conversion of psychotherapy into psychoanalysis, thus: "The question of converting psychotherapy into psychoanalysis should rarely arise in the practice of a psychoanalyst because almost always he should be practising psychoanalysis" (p. 262). Fosshage (1991), from the other position, ends up concluding that "What's critical is not the differentiation between psychoanalytic psychotherapy and psychoanalysis, but the consistent application of expanded psychoanalytic technique within the work that we do as psychoanalysts, /…/. In this sense, psychoanalytic psychotherapy cannot be substituted for (or, I will add, converted into) psychoanalysis, it *is* psychoanalysis." (pp. 70-71). No matter the starting point or line of argument, then, there seems to be a norm where "the more psychoanalytic the better" !

Our results challenge such a view. Gill (1954, 1984) has suggested two definitions of psychoanalysis. The "intrinsic criteria" are, analysis of transference, a neutral analyst, the induction of a regressive transference neurosis and the resolution of that neurosis by interpretation; whereas the extrinsic criteria are, "frequent sessions, the couch, a relatively well integrated (analysable) patient/…/, and a fully trained psychoanalyst." Indeed, there have been many articles dealing with the question of whether a psychoanalytic process (the intrinsic criteria) can take place when extrinsic criteria are not met. However, we want to approach the question from a slightly different point-of-view.

Assuming a relationship between what we have called "the therapeutic milieu" and Gills' intrinsic criteria, the interaction between therapeutic milieu and treatment modality could be interpreted to mean that an orthodox psychoanalytic attitude is indeed sub-optimal or even dysfunctional in a setting which is not psychoanalytic. Put another way: Both the intrinsic and the extrinsic criteria should be met in order for psychoanalysis to be successful. It may be, that a psychoanalytic process, as fostered by an orthodox neutral, interpretative and transference-focused stance of the analyst, may become destructive, mystifying, or confusing to the patient when the extrinsic criteria are not met. The primary

question, then, is not whether a genuine psychoanalytic process *can* take place when extrinsic criteria are not met, but rather whether it is good that it does ?

We suggest that, instead of thinking of psychoanalytic psychotherapy as a diluted, or second-rate, form of psychoanalysis, it is more productive to think of it as a unique way of treating patients. Even if it relies on the psychoanalytic theories about pathogenesis and about psychic life in general, psychoanalytic psychotherapy may find its future in openness to other bases of knowledge *as well* as the psychoanalytic, when therapeutic technique is concerned. This does not necessarily mean that psychoanalytically oriented psychotherapists (or, for that matter, psychoanalysts doing therapy) should adopt whatever is in fashion, but rather that they should develop an openness to the multiplicity of therapeutic schools currently at hand. We agree with Kernberg's (1999) view that an active experimentation with different techniques paired with critical systematic research is the best basis for providing fruitful technical advances in both psychoanalytic psychotherapy and psychoanalysis proper.

This leads to the question of whether psychoanalysts are automatically qualified to do and teach psychotherapy? Our answer would be that there are good reasons for psychoanalytic institutes to teach psychotherapy to their candidates. Many psychoanalysts have nowadays a hard time trying to earn a living on doing psychoanalysis only. Therefore they do psychotherapy, instead. It is important that they realise that they should then not engage in some kind of diluted, "as-if" psychoanalysis. Also, in Sweden, psychoanalytically oriented therapists are usually trained and supervised by psychoanalysts. Based on our findings, the sometimes elevated status of psychoanalysts in Swedish training institutes for psychotherapists could be questioned. Again, we agree with Kernberg (1999): a clear delimitation between psychoanalysis and psychoanalytic psychotherapy could help provide a good basis for a broadening and deepening of the understandings of curative factors and the different pathways to therapeutic change. We conclude that courses in psychotherapy within the analytic institutes could enrich both the analysts' educational experience and contribute to a mutually productive exchange between psychotherapists and psychoanalysts.

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Appendix

Standardisation of the Therapist Attitude Scales (TASC)

For standardisation purposes, the items in the TASC subscales were factor analysed, using data from the national random sample of licensed therapists. In an exploratory series of analyses, using various extraction and rotation methods and various principles for determining the number of factors, we found for each of the three item sets a stable and interpretable solution when three factors were extracted and rotated for each section. The highest-loading items in each such factor were subsequently used for forming factor scales. Thus, for each of the three first components in each set, a score was computed as the mean across all high-loading items (after transforming scores on items in the section on basic assumptions to a five-point scale, as for the other scales). As high-loading items we considered those that had routinely turned up with loading higher than, or around, .5 in the exploratory series of analyses. For items in the basic assumptions section our criterion had to be set a bit lower, at .4, in order to have enough items left. The items constituting each of the nine scales are listed in the end of the Appendix.

As a validation of the scales, we tested whether they differentiated as expected between therapists with different theoretical orientations and with different schools of training as the basis for their licensing. The results of these tests are exhibited in Figures 5 and 6. For reasons of readability, the relatively small groups of therapists with family or group training were excluded from Figure 6. As will be seen, neither Irrationality nor Pessimism had any significant relations with theoretical orientation, as rated by the therapists themselves. They were also less strongly associated with training varieties. Further, Kindness discriminated not as well among groups with different theoretical orientations (Figure 5), otherwise, however, the TASC was strongly discriminative in a pattern that is wholly consistent with theoretical suppositions.

In order further to study the variation among the treatment providers, we then performed a series of cluster analyses. As before, we used the national random sample of therapists and applied Anderberg's (1973) nearest neighbour method as a suitable technique with large samples. After an exploratory series of analyses, we finally settled for a four-cluster solution which meaningfully and significantly related to different theoretical orientations and different training sites. The cluster profiles are shown in Figure 7. Thus, we found one 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 persons with psychoanalytic training (but also including persons with regular psychotherapeutic training); and two with profiles high on the self-rating scales where the cognitive and cognitive-behavioural therapists were high and the psychoanalysts were low (Adjustment, Kindness, and Supportiveness) and *also* high on those where the psychoanalysts were high and the cognitive and behavioural ones were low (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 values. However, the profile of the larger of the two eclectic clusters was generally closer to the cognitive-behavioural cluster, whereas the profile of the smaller eclectic cluster was closer to the psychoanalytic cluster.

Table 3. The Therapeutic Attitudes Scale.

Curative Factors (”What do you think contributes to long-term and stable therapeutic change?”)

Promoting adjustment (“Adjustment”)
1. Giving the patient concrete goals
2. Working for adjustment to prevailing social circumstances
3. Helping P avoid anxiety-provoking situations
4. T takes the initiative and is leading the sessions
5. Stimulating P to think about his problems in more positive ways
6. Working with P’s symptoms
7. Giving P concrete advice
8. Helping P control his/her feelings
9. Helping P avoid repeating his/her mistakes
Promoting insight (“Insight”)
10. Helping P understand that old reactions and relations are repeated with T
11. Helping P see the connections between his/her problems and his/her childhood

12. Supporting P to ponder, in the therapy, painful early experiences
13. Working with P's defences
14. Bringing P's sexuality to the fore
15. P has the opportunity to work with his/her dreams
16. Help P understand that old behaviours and relations are being repeated
17. Interpret P's body language
18. Working with P's childhood memories

Showing kindness ("Kindness ")

19. The therapist is warm and kind
20. The patient feels well liked by the therapist
21. Supporting and encouraging the patient
22. Consideration and good care-taking
23. Let the patient get things off his chest

Therapeutic style factors ("What are you like as a therapist?")

Neutral attitude ("Neutrality")

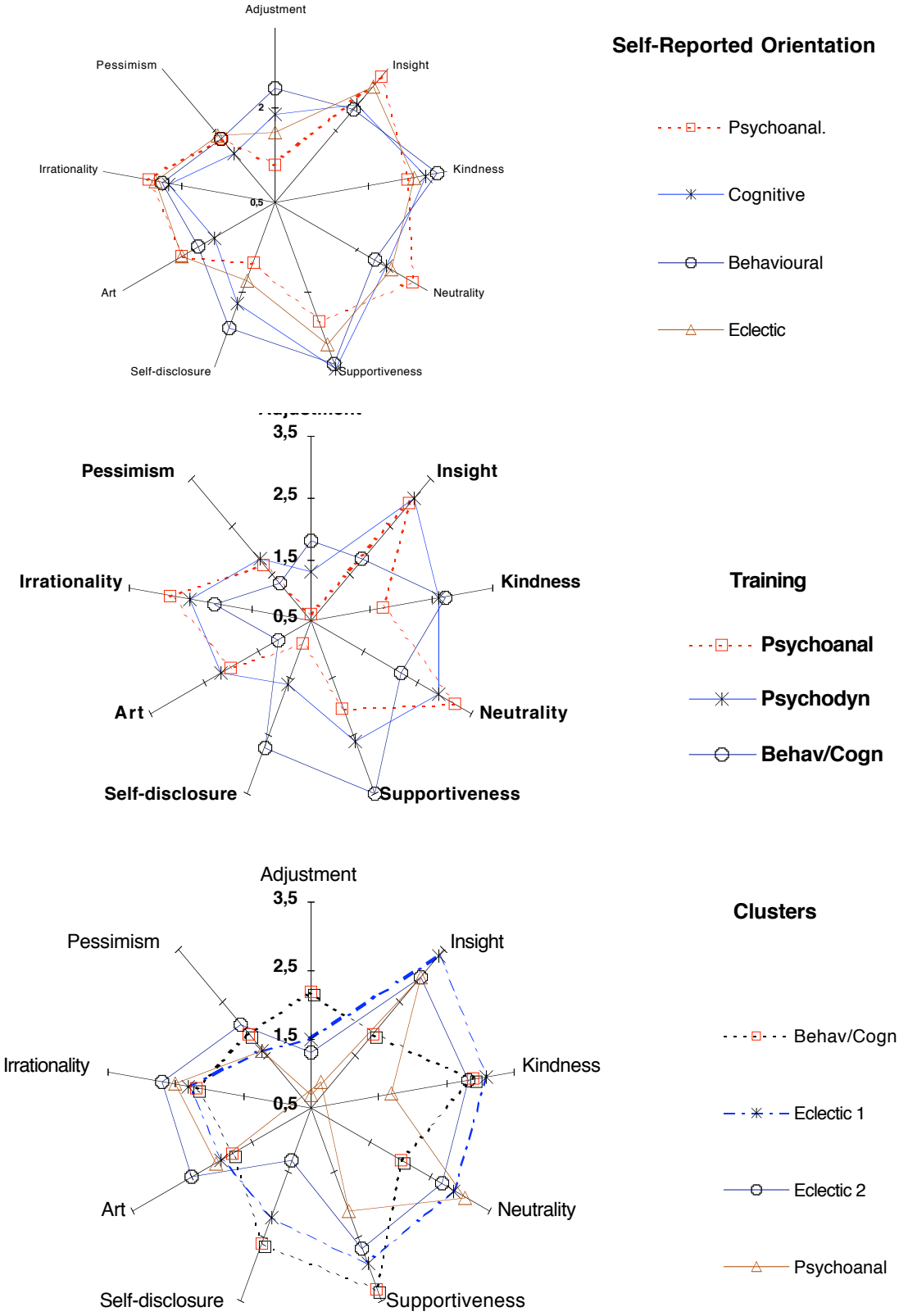
1. I do not answer personal questions from the patient
2. I keep my personal opinions and circumstances completely outside the therapy
3. I am more neutral than personal in therapy
4. I do not express my own feelings in the sessions
5. My verbal intervention are brief and concise
6. Keeping the therapeutic frame is an important instrument in my work

Supportive attitude ("Supportiveness")

7. I often put questions to the patient
8. It is important to convey hope
9. It is important to order and structure the material

10. I am rather active in sessions

Self-disclosing attitude ("Self-disclosure")
11. I always communicate the therapeutic goals to the patient in the beginning of a therapy
12. I always make the therapeutic goals explicit to myself during a therapy
13. I admit my own mistakes to the patient
Basic assumptions ("What are your general beliefs about the human mind and about psychotherapy?")
Rationality v. irrationality ("Irrationality")
1. Human behavior is governed ... by free will/by uncontrollable factors
2. By nature, man is ... rational/irrational
3. Human behavior is governed ... by external, objective factors/internal, subjective factors
Craft v. Art ("Art")
4. Psychotherapy may be described ... as a craft/as free creative work
5. Therapeutic work is governed ... by training/by personality
6. Psychotherapy may be described ... as a science/as a form or art
7. Psychotherapeutic work is governed by … systematic thinking/intuition
Optimism v. pessimism ("Pessimism")
8. The basic principles of human behavior may be understood ... completely/not at all
9. Humans can develop ... infinitely/not at all
10. Therapeutic work is governed by the fact ... that everything may be understood/that *not* everything may be understood



Figures 5 to 7. Relationship between TASC Scores and Self-Reported Theoretical Orientation (upper panel), Type of Training, (middle panel), and Cluster (lower panel).