What is a psychoanalytic outcome?

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What is the Issue

- There is a substantial and growing body of empirical support for psychoanalysis and related treatments (Leischhenring & Rabung 2008).
- However, the psychoanalytic approach remains vulnerable for two reasons:
  - In treatment of more complex problems, it is unclear as to whether relative benefits are a function of treatment dose or treatment approach.
  - In treatment of simpler problems, the minimum effective dose (16-20 sessions) of a psychoanalytic therapy is probably twice that of CBT and three times that of PST.
- This means that psychoanalytic treatments may come to be viewed as effective but inefficient.
Is Outcome Measurement Part of the Problem?

- Proponents of Psychoanalysis typically argue that there are specific treatment related benefits.
- In particular benefits are associated with treatment of more fundamental, underlying problems rather than more superficial symptoms.

“A possible factor underlying the dodo bird effect is the use of manifest symptoms as the primary criterion of therapeutic outcome, mainly because symptom reduction can be realized not only through psychotherapy but also through a level of support from family and friends (e.g., Brown and Harris, 1978; Cohen and Willis, 1985) or through activities like writing about stressful experiences (e.g., Pennebaker, 1997). On the other hand, patients frequently seek psychotherapy for broader reasons—to find more effective ways of dealing with difficulty life circumstances and improved coping abilities—and these would certainly be a goal of all schools of psychotherapy” (Blatt & Auerbach, 2003, p 270)
Menninger Foundation Study (Kernberg et al 1972; Wallerstein, 1989; Blatt 1992)

- Predictive outcome variables – clinician rated
  - changes in symptoms;
  - manifest behavior patterns, and impulse-defense configurations;
  - structural alterations in the ego;
  - acquisition of insights

- HSRC scores
Menninger Foundation Study

- The Health Sickness Rating Scale (Luborsky 1962)
  - Seven dimensions (see below)
  - Clinician rated
  - Aggregated into a single 100 point scale (similar to the GAF)
    1. The patient’s need to be protected and/or supported by the therapist or hospital, vs. the ability to function autonomously.
    2. The seriousness of the symptoms (e.g., the degree to which they reflect personality disorganization).
    3. The degree of the patient's subjective discomfort and distress.
    4. The patient’s effect on his environment: danger, discomfort, etc.
    5. The degree to which he can utilize his abilities, especially in work.
    6. The quality of his interpersonal relationships (warmth, intimacy, genuineness, closeness, distortion of perception of relationship, impulse control in relationships).
    7. The breadth and depth of his interests.
Menninger Foundation Study

- In secondary analysis (Blatt, 1992), outcomes evaluated for two groups
  - for anaclitic (preoccupation with interpersonal relations, intimacy and sexuality) and
  - introjective (preoccupation with establishing and maintaining a viable sense of self) patients

- Measures (via Rorschach)
  - Thought disorder
  - Concept of the human object
  - Mutuality of autonomy
Overall Menninger study findings

- In primary analysis, little evidence of differential outcome for expressive (psychoanalysis) versus supportive psychotherapy with respect to any measure.
- In secondary analysis, some evidence that anaclitic patients benefited more from supportive psychotherapy and introjective patients more from psychoanalysis (mutuality of autonomy scale).
- Substantial process bleed across therapies.
Columbia Psychoanalytic Research Center Project (Weber et al 1985)

- Clinician rated scales measuring:
  - Level of impairment in primary and secondary areas of disturbance
  - Evaluation of social relations,
  - Work gratification,
  - Nature and extent of symptomatic impairment
  - Ego strength or adaptive balance
Findings

- Effect sizes were broadly comparable across all measures.
- Effect sizes were broadly equivalent for psychoanalysis and psychotherapy.
- Some dose effects were apparent for psychoanalysis but not psychotherapy.
STOPP (Sandell et al 2000)

- Compared outcomes for patients in receipt of psychoanalysis or psychotherapy
- Rating of clinical interviews to evaluate
  - Symptoms
  - Adaptive capacity
  - Self-insight
  - Basic conflicts (to measure structural change)
- Standardised scales measuring
  - Social adjustment (SAS)
  - Somatic and psychiatric symptoms (SCL-90)
  - Morale, vitality and optimism (SOCS)
Main findings

- At end of treatment both psychoanalysis patients and psychotherapy patients showed equivalent level of improvement across all measures, with SCL-90 most sensitive.
- On annual follow up patients in both groups continued to improve but the psychoanalysis patients improved to a greater degree (larger treatment effect size).
“… 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.’ Sandell et al, p 936

The authors go on to suggest that the SCL-90 can be understood as an index of structural change.
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 longterm beneficial change on the SAS.”
The Norwegian Transference Study (Hoglend et al 2008)

- Investigation of transference and non transference based brief (1 year) psychodynamic therapy using the following outcome measures:
  - Inventory of Interpersonal Problems (client rated)
  - Psychodynamic functioning scales (independent rater):
    - Quality of family relationships
    - Quality of friendships
    - Quality of romantic/sexual relationships
    - Tolerance for Affects
    - Insight
    - Problem-solving capacity
Findings

- Moderate effect sizes for both transference and non-transference interventions on both types of measure.
- Some indication that patients with more impaired object relations benefited more from interventions with transference interpretations.
Questions

1. Do the range of instruments used so far in research on outcome in psychoanalysis adequately measure outcomes distinctive or specific to the treatment?
2. If not, what other kinds of measures should be considered?
3. Is it credible to regard symptom change as evidence of a change in psychic structure?
4. If so, does this mean that any therapy that brings about symptom change has changed the underlying structure?
5. Why has there been so little evidence that psychoanalysis has a differential effect an areas such as interpersonal functioning?
6. Can psychoanalysis survive without establishing a clear case for differential (and superior) effectiveness?