

THERAPEUTIC AIMS AND OUTCOMES OF PSYCHOANALYSIS

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Psychoanalysts described real and ideal patients ending psychoanalysis with a Q-sort measure, the Shedler-Westen Assessment Procedure-200 (SWAP-200). Of 25 descriptions of patients ending analysis with mutual agreement between patient and analyst, 17 described patients ending psychoanalysis with and 8 described patients ending psychoanalysis without maximum benefit. A third group of 22 psychoanalysts described their ideal prototype of a patient at the end of analysis, providing a perspective on positive mental health. Analyses with maximum benefit were longer than those without maximum benefit ($M = 83.0$ vs. 52.4 months, $p = .05$). Patients ending analysis with maximum benefit were seen as happier and more comfortable with others than were patients ending analysis without maximum benefit. With the ideal, the person is able to love and work with contentment.

Keywords: psychoanalysis, outcome, ideal, benefit, prototype

In a report for the Joint Commission on Mental Illness and Health, Jahoda (1955) reviewed a wide range of perspectives on positive mental health related to what has become contemporary positive psychology (e.g., Seligman, Steen, & Park, 2005). In this early work on positive mental health, the views of Freud and subsequent psychoanalysts were central. Freud's views about the therapeutic aim of psychoanalysis generally concerned the person's becoming more efficient and more capable of enjoyment with reduced symptoms (e.g., Freud, 1923/1961, p. 251). Jahoda suggested research in which psychoanalysts would provide information about "patients as they appear after a successful analysis" (p. 90) as a strategy for understanding positive mental health.

One common theme in describing positive mental health in Jahoda's (1955) work concerned the ability to love, work, and play. Although Freud seems not to have ever written that the aim of psychoanalysis is that the patient be better able to love and work, this aim is in the spirit of his work, and the importance of love and work is reflected in much psychoanalytic writing. A current measure of functioning, the Global Assessment of Functioning (GAF) Scale in the *Diagnostic and Statistical Manual of Mental Disorders*

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(4th ed., or *DSM-IV*; American Psychiatric Association, 1994), asks the rater to consider the person's social, occupational, and psychological functioning. The GAF was derived from Luborsky's (1962) Health-Sickness Rating Scale and is grounded in psychoanalytic thinking. Although the theoretical and clinical literature concerning the goals of psychoanalysis is extensive (see Sandler & Dreher, 1996), there has been no direct empirical study of the therapeutic goals of psychoanalysis.

Studies of the outcome of psychoanalysis are implicitly related to the ideas about the aims of psychoanalysis. Psychoanalytic outcome studies have generally been of three types (Wallerstein, 2002). First-generation studies report on analysts' assessments of their patients at the end of analysis. The results of sequences of analyses have been reported, from Coriat's (1917) summary of the outcomes of analysis of 93 patients to Erle and Goldberg's (2003) summary of the outcomes of psychoanalysis among 161 analytic patients. Outcomes of first-generation studies have generally concerned analysts' reports of the relative therapeutic benefit of analysis as, for example, "excellent or substantial" or "minimal or none" (Erle & Goldberg, 2003). Second-generation studies provide more systematic information about the outcomes of treatment. Wallerstein (2002) and Bachrach, Galatzer-Levy, Skolnikoff, and Waldron (1991) summarized six of these studies of psychoanalysis, including, for example, the Columbia Records Project. As part of the Columbia Records Project, Bachrach, Weber, and Solomon (1985) reported that of 76 completed psychoanalytic treatments carried out by experienced analysts in independent practice settings, the treating analyst viewed 66% as ending with maximum benefit and 22% as ending much improved but without maximum benefit. In studying the outcomes of psychotherapy, Howard, Kopta, Krause, and Orlinsky (1986) formulated the psychotherapy dose-effect relationship using studies with outcome ratings by therapists and/or patients and sometimes researchers. That is, the global outcome ratings of patient improvement provided the improvement measures used to formulate the dose-effect relationship.

Third-generation studies of psychoanalysis are prospective studies in which analyses are followed from beginning to end. The classic and major example of such a study is the Menninger Foundation Psychotherapy Research Project (Kernberg et al., 1972; Wallerstein, 1986). Contemporary work includes the Stockholm study (Sandell et al., 2000) in which 400 people were followed before, during, and after psychoanalysis or dynamic psychotherapy in a complex cross-lagged panel design. The measures included patient self-reports on several standardized measures, and self-report data were compared with reports from a community sample and a student sample. Symptom reduction and morale improvement were greater for patients in psychoanalysis than for patients in psychotherapy at assessments 3 years after the end of treatment, with larger effect sizes for the reduction of symptoms measured at the beginning versus end of treatment among patients in psychoanalysis ($d = 1.55$) than for patients in psychotherapy ($d = 0.6$). Interestingly, social relations changed less than symptoms or morale, raising the possibility that social relations may change more slowly than symptom reduction and improved morale. In the German Psychoanalytic Association study (Beutel, Rasting, Stuhr, Ruger, & Leuzinger-Bohleber, 2004), 401 patients who had completed long-term psychoanalytic treatment were followed 4 or more years later, with data from the former patients, analysts, and independent psychoanalytic evaluators. Data on days of sick leave before and after treatment were available from a subset of patients. The number of days of sick leave was reduced after treatment as compared with before treatment. In contrast, the general population showed increases in the days of sick leave as people became older. Several

studies of data from the German Psychoanalytic Association project are ongoing; these are reviewed by Leuzinger-Bohleber and Target (2002) and by Fonagy et al. (2002).

Analysts' direct ratings of the outcome of psychoanalysis in the first- and second-generation studies may be seen as problematic because of the considerable investment of time and energy by the analyst, as well as the patient, in a psychoanalysis. Furthermore, the quantitative measures of treatment outcome in the first- and second-generation studies have been limited to a very few categories. Patients' reports can also be problematic. Even when standard self-report measures are used (e.g., the Symptom Checklist-90-R [Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974] used in several second-generation studies), people's reports can be biased in interesting ways. Shedler, Mayman, and Manis (1993) found that standard self-report scales were not able to differentiate between mentally healthy people and people high in defensiveness. Grounded in the work of Shedler et al. (1993), Shedler and Westen developed a clinician report measure, the Shedler-Western Assessment Procedure-200 (SWAP-200; Westen & Shedler, 1999a, 1999b). Two hundred statements that could apply to a person are sorted by the clinician into eight sets, ranging from those that describe the person very well to those that do not apply. The results of the sorts are correlated with the results of prototype sorts to yield scales of personality disorders, personality characteristics, and strengths. The most characteristic items provide additional information.

The present work has two goals. First, I use the SWAP-200 to consider psychoanalysts' prototypes of the ideal outcome of analysis as a way to understand positive mental health. Second, I examine differences between three SWAP-200 descriptions: (a) descriptions of the "ideal outcomes" of psychoanalysis; (b) descriptions of patients at the end of psychoanalysis with terminations mutually agreed on by the psychoanalyst and the patient and viewed by the treating analysts as having ended with maximum benefit; and (c) descriptions of patients at the end of psychoanalysis with mutually agreed-on terminations viewed by the treating analysts as having ended without maximum benefit. The progression from "without maximum benefit" to "maximum benefit" to "ideal outcome" may provide insight into the sequence of changes in the end phases of psychoanalysis.

Method

Participants

The participants included 47 psychoanalysts who were members of the American Psychoanalytic Association. Twenty-two psychoanalysts each described their prototype of an ideal patient at the end of psychoanalysis. Twenty-five psychoanalysts each described a patient of theirs who had recently completed psychoanalysis ending by mutual agreement between patient and analyst. Of the 25, 17 described a patient who, from the analyst's perspective, ended psychoanalysis with maximum benefit and 8 described a patient who ended psychoanalysis without maximum benefit. Characteristics of the psychoanalysts, patients, and analyses are summarized in Tables 1, 2, and 3.

Measures

Participants completed questions about their own characteristics (e.g., demographics and experience). Participants describing real outcomes of psychoanalysis each described characteristics of the index patient (e.g., demographics, Axis I and Axis II diagnoses at the start of treatment, and GAF at the end of treatment) and characteristics of the analysis

(e.g., frequency of sessions, length of treatment, and a description of the termination [by mutual agreement with or without maximum benefit, reasons external to the treatment, or the patient's unilateral decision]).

The SWAP-200 is a Q-sort procedure for assessing personality characteristics and psychopathology. The clinician sorts a set of 200 items into eight categories from most descriptive (Category 7) to least descriptive (Category 0). The distribution of the items in each category is predetermined with, for example, 8 items to be placed in Category 7 ("describes the patient very well") and 100 items in Category 0 ("does not apply"). The fixed distribution is based on the work of Block (1978) and resembles half of a normal distribution. The results of the sorts yield four types of information. First, normative data for Personality Disorder (PD) scores were obtained by Westen and Shedler (1999a) by correlating the data describing a real patient with a particular personality disorder with the sorts of clinicians describing prototypes of each of the *DSM-IV* personality disorders. There is also a "high functioning" score that assesses adaptive functioning. Second, the results of the sorts can also be scored for empirically derived personality groupings, called Q-factor scores, by correlating the data describing a real or prototypical patient with empirically derived categories derived from prototypical sorts. The Q-factors came from Q-analyses in which factor analysis was carried out on the basis of groups of people rather than variables (see Block, 1978; Westen & Shedler, 1999b). Personality Disorder and Q-factor scores are transformed into *T* scores ($M = 50$, $SD = 10$), based on empirically derived normative prototypes (Westen & Shedler, 1999a, 1999b). Third, the results of the sorts can be scored for 12 personality or trait factors, derived from factor analysis of SWAP-200 data (Westen & Muderrisoglu, 2003). The r-factor scores are also transformed into *T* scores (J. Shedler, personal communication, May 14, 2005) on the basis of normative prototype scores. The resulting *T* scores can be used categorically, with scores at 55 or above indicating traits and scores of 60 or above leading to a categorical diagnosis, or dimensionally, so that higher scores indicate more presence of the category. Finally, the endorsement of individual items can be considered. For example, the items most characteristic of a group can be listed. The relative endorsement of items by various groups can also be compared.

The reliability and validity of SWAP-200 PD and Q-factor scores have been assessed in several ways. The internal consistencies of the PD scores are in the .90s (Westen & Shedler, 1999a). The SWAP-200 descriptions of patients are highly correlated with clinician ratings of personality disorders for the patients (e.g., Westen & Muderrisoglu, 2003; Westen & Shedler, 1999a). GAF ratings by clinicians are related in expected ways to SWAP-200 PD scores (e.g., Westen & Shedler, 1999a). The SWAP-200 descriptions of clinicians describing real patients with particular personality disorders are highly correlated with prototype descriptions, and SWAP-200 descriptions are related in expected ways to criterion measures (e.g., Westen & Muderrisoglu, 2003; Westen & Shedler, 1999a). The empirically derived Q-factor scores have also been evaluated, and both reliability and validity are good (e.g., Westen & Shedler, 1999b). The validity of the r-factor scores has been explored by correlating the r-factor scores of treating clinicians and scores of independent clinicians viewing videotaped interviews, providing cross-informant agreement (Westen & Muderrisoglu, 2003). The SWAP-200 scores also differ between clinical groups in expected ways (e.g., Cogan & Porcerelli, 2005; Porcerelli, Cogan, & Hibbard, 2004; Westen & Harnden-Fischer, 2001).

Procedures

Participants were recruited from among members of the American Psychoanalytic Association. Requests for participants were posted on the group's electronic mailing list. To recruit participants describing people at the end of psychoanalysis, a post asked for volunteers who had had an analysis of an adult patient end within the previous month or two. This post was placed on the electronic mailing list two times over about a 6-month time period. Because analysis lasts an average of 5 years (Doidge et al., 2002) and an individual analyst is likely to have only a few ongoing analyses at any point in time, one would not expect any individual analyst to have an analysis ending within the previous month or two at any point in time. As study participants not only had to be willing to volunteer for a research project but also had to have an analysis that had recently come to an end, one would expect the potential number of participants on an electronic mailing list of about 600 to be limited. Another post (sent at two separate times and first asking for volunteers for a project unrelated to the present purposes) asked for volunteers willing to describe their ideas about the ideal characteristics of someone at the end of analysis.

A packet of materials was sent to each volunteer analyst, including the SWAP-200 materials. Packets involving real analyses included a 30-item questionnaire asking about characteristics of the analyst, analysis, and patient. One of the questionnaire items asked the analyst to tell about the ending of the analysis: mutual agreement with maximum benefit; mutual agreement without maximum benefit; reasons external to the treatment; or the patient's unilateral decision. Seventeen sets of materials described an analysis ending by mutual agreement with maximum benefit and 8 described an analysis ending by mutual agreement without maximum benefit. Not included in this study were three sets of materials describing analyses ending for reasons external to the treatment, one description of an analysis ending by the patient's unilateral decision, and two sets of materials describing analyses of patients under the age of 18 when the analyses began. Packets involving ideal analytic outcomes included a seven-item questionnaire asking about characteristics of the volunteer analyst.

Analysts describing a real patient at the end of analysis were asked to sort the SWAP-200 items to describe their patient within the past few weeks.

Statistical Analyses

Between-groups differences in categorical variables were assessed using Fisher's exact tests. First, differences between the ideal and the real groups were considered. Next, differences between the groups of real patients with maximum benefit and without maximum benefit were considered. Between-groups differences in continuous variables such as age were evaluated in the same way using *t* tests. Differences between the three groups in SWAP-200 scale scores were compared with the analysis of variance, with follow-up *t* tests to place group differences where appropriate. Because the statistical tests of differences in the SWAP-200 variables involved multiple tests on the same data, for each set of analyses (PD factors, Q-factors, r-factors, and items), the value required to conclude that group differences were significant was adjusted by dividing .05, the conventional *p* value, by the number of tests in the set (a Bonferroni correction). Finally, the correlation between the average ideal SWAP-200 prototype and the descriptions of real analyses with and without maximum benefit were calculated.

Results

Demographic differences between characteristics of the psychoanalysts in the three groups were minimal. There were more women in the ideal than in the real groups ($p = .03$), as can be seen in Table 1. There were more medical than nonmedical analysts in the maximum-benefit group as compared with the without-maximum-benefit group ($p = .003$; Table 1). The difference between medical and nonmedical disciplines may be an artifact of experience, which tended to differ between analysts in the maximum- and without-maximum-benefit groups ($p = .10$). In the maximum-benefit groups, medical ($N = 15$) and nonmedical analysts ($N = 2$) had 22.7 ($SD = 13.3$) and 21.5 ($SD = 17.7$) years of psychoanalytic experience, respectively. On the other hand, in the without-maximum-benefit group, medical ($N = 2$) and nonmedical ($N = 6$) analysts had 21.0

Table 1
Demographics of Analysts Describing an Ideal Outcome of Psychoanalysis or a Real Outcome, Mutually Agreed on by Patients and Analysts, With and Without Maximum Benefit

Psychoanalysts	Outcomes of psychoanalysis			<i>p</i>	
	Ideal (<i>N</i> = 22)	Real		Ideal vs. real	With vs. without maximum benefit
		With maximum benefit (<i>N</i> = 17)	Without maximum benefit (<i>N</i> = 8)		
Sex				.08	.39
Male					
<i>n</i>	8	12	4		
%	36.5	70.6	50.0		
Female					
<i>n</i>	14	5	4		
%	63.6	29.4	50.0		
Discipline				.38	.004
Medical					
<i>n</i>	12	15	2		
%	45.0%	88.2	25.0		
Nonmedical					
<i>n</i>	10	2	6		
%	55.0	11.8	75.0%		
Race				1.00	1.00
White					
<i>n</i>	22	16	8		
%	100.0	94.1	100		
Other					
<i>n</i>	0	1	0		
%	0.0	5.9	0.0		
Experience in years					
Professional				.19	.22
<i>M</i>	24.4	30.6	24.5		
<i>SD</i>	10.5	10.8	12.6		
Psychoanalytic				.10	.10
<i>M</i>	14.8	21.2	12.1		
<i>SD</i>	9.5	13.7	8.9		

($SD = 15.6$) and 9.3 ($SD = 3.8$) years of psychoanalytic experience, respectively. Alternatively, medical and nonmedical analysts may have somewhat different perspectives as to the maximum benefit of analysis.

There were no significant demographic differences between the characteristics of patients in the maximum- and without-maximum-benefit groups, as can be seen in Table 1.

Analyses of patients with maximum benefits were longer than analyses of patients without maximum benefit (83.0 months [$SD = 40.2$] vs. 52.3 months [$SD = 13.1$], respectively; $p < .01$, shown in Table 2).

When clinicians sort SWAP-200 items, they may err in placing one too many or one too few cards in a response group. If one too few cards is placed into one response set, one too many cards must be placed into some other set, leading to two sorting errors. There were few sorting errors ($M = 0.7$, $SD = 1.5$, range = 0–6 errors), and the groups did not differ in the number of sorting errors, $F(2, 44) = .89$, $p = .42$.

In terms of differences between the groups in measures of adaptive functioning, the two real groups did not differ on GAF scores. The groups did differ on the SWAP-200 High Functioning score, with ideal prototypes having the highest scores and the group ending analysis without maximum benefit having the lowest scores, shown in Table 3.

In terms of differences on the SWAP-200 PD scales, reflecting *DSM-IV* prototype personality disorders, the scores of all three groups were low, as would be expected. The three groups did not differ statistically on four of the 12 PD scales (Antisocial, Histrionic, Narcissistic, and Obsessive). The ideal prototype group had lower scores than the real outcome groups on several scales (Paranoid, Borderline, Avoidant, Dependent, Depressive, and Passive Aggressive PD scales). In terms of differences on the SWAP-200 Q-factor scales, reflecting empirically derived personality disorder scales, the three groups did not differ statistically on 9 of the 12 scales (Antisocial, Schizoid, Obsessional, Histrionic, Narcissistic, Avoidant, Depressive, Dependent, and Hostile). The ideal prototype group had lower scores than the real outcome groups on three scales (Dysphoric, Paranoid, and Dysregulated). The ideal prototype group scores did not differ statistically from the real outcome group scores on any r-factor scale other than Health, on which the ideal score was higher than scores of the real outcome groups, shown in Table 3.

Where there were differences between the groups on the scale scores, scores of the group ending psychoanalysis by mutual agreement between patient and analyst with maximum benefit did not differ statistically from scores of the ideal prototype group on two PD scales (Schizoid and Schizotypal). Scores of patients ending analysis with maximum benefit and without maximum benefit did not differ statistically on two PD scales (Paranoid and Dependent) and two Q-factor scales (Paranoid and Dysregulated). On several PD and Q-factor scales, scores of patients ending analysis with maximum benefit were lower than scores of patients ending analysis without maximum benefit (PD scales: Schizoid, Schizotypal, Borderline, Avoidant, Depressive, and Passive-Aggressive; Q-factor scale: Dysphoric).

When the SWAP-200 individual item scores were considered, differences emerged between the three groups. The ideal prototype scores were very highly correlated with the average scores of the group with maximum benefit ($r = .93$, $p < .0001$) and were correlated with the average scores of the group without maximum benefit ($r = .79$, $p < .0001$). Both correlations show large effect sizes, and the difference between the correlations reflects a large effect size (Cohen, 1977). The 10 items most characteristic of each group are shown in Table 4. As can be seen in Table 4, the characteristic items for the ideal prototype had the highest average rank scores and those of the without-maximum-benefit

Table 2
Demographics of Patients Ending Psychoanalysis With and Without Maximum Benefit

Patients	Outcomes of psychoanalysis		Test	<i>p</i>
	With maximum benefit (<i>N</i> = 17)	Without maximum benefit (<i>N</i> = 8)		
Sex			<i>F</i>	.36
Male				
<i>n</i>	13	4		
%	76.5	50.0		
Female				
<i>n</i>	4	4		
%	23.5	50.0		
Age			<i>t</i> = .75	.46
<i>M</i>	47.9	45.4		
<i>SD</i>	7.2	9.4		
Race			<i>F</i>	1.00
White				
<i>n</i>	16	8		
%	94.1	100		
Other				
<i>n</i>	1	0		
%	15.9	0.0		
Education			<i>F</i>	1.00
College				
<i>n</i>	3	2		
%	17.6	25.0		
Graduate/professional				
<i>n</i>	14	6		
%	82.4	75.0		
Axis I disorders at the beginning of analysis			<i>F</i>	1.00
Yes				
<i>n</i>	15	7		
%	88.2	87.8		
No				
<i>n</i>	2	1		
%	11.8	12.5		
Axis II disorders at the beginning of analysis			<i>F</i>	.67
Yes				
<i>n</i>	11	6		
%	64.7	75.0		
No				
<i>n</i>	7	2		
%	41.2	25.0		
Psychotropic medication			<i>F</i>	1.0
No				
<i>n</i>	13	6		
%	76.5	75.0		
Yes				
<i>n</i>	4	2		
%	23.5	25.0		
Analyses			<i>F</i>	.23
Frequency of sessions				

Table 2
(continued)

Patients	Outcomes of psychoanalysis		Test	<i>p</i>
	With maximum benefit (<i>N</i> = 17)	Without maximum benefit (<i>N</i> = 8)		
Three per week				
<i>n</i>	1	2		
%	5.9	25.0		
Four to five per week				
<i>n</i>	16	6		
%	94.0	75.0		
Present use of the couch			<i>F</i>	.36
Yes				
<i>n</i>	11	7		
%	64.7	87.5		
No				
<i>n</i>	6	1		
%	26.3	12.5		
Months of analysis			<i>t</i> = 2.84	.01
<i>M</i>	83.0	52.4		
<i>SD</i>	40.2	13.0		

group the lowest average rank scores, $F(2, 44) = 12.66, p = .0001$. Finally, there were statistically significant differences between the scores of the three groups on nine SWAP-200 items, with a Bonferroni correction requiring that p be less than .00025, shown in Table 5.

Discussion

Before considering similarities and differences between the three groups, it is helpful to look at the overall pattern of SWAP-200 values. Because the SWAP-200 is based on scores of real and prototypical patients with personality disorders, it is not surprising that the three groups here have low scores on most scales. In terms of the PD scales, only one group on one scale had a score of 50 or more (patients without maximum benefit on the Obsessive PD scale), and this is discussed later. In terms of the Q-factor scales, only two scales had scores of 50 or more: Obsessional and Dysphoric–High-Functioning Neurotic. The Obsessional Q-factor scale, like the Obsessive PD scale, includes items that would generally be regarded as positive and is the most highly correlated of the Q-factor scores with GAF scale scores ($r = .52$; Westen & Shedler, 1999b). The Dysphoric–High-Functioning Neurotic Q-factor scale is also highly correlated with GAF scores ($r = .37$; Westen & Shedler, 1999b) and includes many items indicating psychological strengths (e.g., articulate, having moral and ethical standards, appreciating humor). In terms of r-factor scores, three scales had scores of 50 or more: Obsessional, Oedipal Conflict, and Sexual Conflict. The r-factor Obsessional factor resembles the PD and Q-factor scales (Westen & Muderrisoglu, 2003). The r-factor Oedipal Conflict factor is also called Histrionic Sexualization and includes areas such as being interested in unavailable partners but also being sexually seductive or provocative, and fantasizing about finding ideal love. The r-factor Sexual Conflict factor includes a tendency to separate tender and

Table 3
Shedler-Westen Assessment Procedure-200 (SWAP) Scale T Scores for Patients With an Ideal Outcome of Psychoanalysis and for Patients Ending Psychoanalysis With and Without Maximum Benefit

SWAP scales	I (N = 22)	M (N = 17)	W (N = 8)	F	p	Effect size R ²	Tests after F
Personality Disorder scales ^a							
Paranoid	31.4 (3.0)	36.1 (4.9)	39.7 (6.2)	11.86	.0001	.35	I < M = N
Schizoid	37.7 (3.3)	37.7 (3.6)	43.5 (3.8)	8.92	.0006	.29	I = M < N
Schizotypal	33.4 (3.1)	33.5 (3.2)	38.5 (3.4)	7.94	.001	.27	I = M < N
Antisocial	41.2 (2.9)	42.5 (4.0)	43.7 (7.3)	1.11	.34		
Borderline	25.9 (3.7)	34.4 (5.2)	39.5 (7.9)	26.01	.0001	.54	I < M < N
Histrionic	36.0 (2.8)	40.5 (4.9)	41.2 (8.1)	5.85	.006		
Narcissistic	39.6 (3.7)	43.1 (5.4)	44.8 (8.9)	3.52	.04		
Avoidant	38.9 (4.6)	42.1 (3.8)	47.5 (4.8)	11.61	.0001	.35	I < M < N
Dependent	38.4 (4.7)	42.5 (4.5)	46.7 (6.5)	9.12	.0005	.29	I < M = N
Obsessive	46.8 (5.0)	48.5 (4.4)	52.2 (6.1)	3.42	.04		
Depressive	37.8 (4.2)	42.4 (4.0)	47.1 (5.6)	11.24	.0001	.34	I < M < N
Passive-aggressive	27.2 (4.1)	33.3 (5.3)	38.4 (10.4)	11.76	.0001	.35	I < M < N
Adaptive Functioning							
High Functioning	76.8 (4.0)	72.7 (6.0)	67.0 (8.9)	8.88	.0006	.29	I < M < N
Global Assessment of Functioning		88.2 (8.3)	84.8 (9.7)	.85	.37		
Q-factor scales ^a							
Dysphoric	39.9 (4.5)	44.3 (4.0)	48.4 (5.5)	12.04	.0001	.35	I < M < N
Antisocial	38.6 (2.8)	40.3 (3.3)	42.3 (7.7)	2.49	.09		
Schizoid	38.2 (3.6)	36.4 (3.4)	40.9 (3.2)	4.72	.01		
Paranoid	34.8 (3.4)	41.7 (5.1)	42.6 (5.3)	15.76	.0001	.42	I < M = N
Obsessional	70.0 (3.8)	67.7 (5.6)	66.1 (6.4)	2.14	.13		
Histrionic	47.1 (3.4)	49.5 (3.8)	48.1 (6.1)	1.65	.20		
Narcissistic	44.0 (4.5)	48.2 (7.3)	51.2 (11.7)	3.58	.04		
Dysphoric subscales							
Avoidant	45.4 (4.0)	45.0 (4.1)	47.3 (5.1)	.81	.45		
Depressive	66.4 (3.9)	66.6 (5.0)	63.3 (7.2)	1.40	.26		
Dysregulated	26.2 (2.7)	33.8 (5.7)	37.2 (4.8)	25.20	.0001	.53	I < M = N
Dependent	37.2 (3.2)	41.4 (5.6)	45.0 (7.5)	7.88	.001		
Hostile r-factor scales ^a							
Health	85.6 (2.7)	79.2 (7.6)	70.6 (11.0)	15.81	.0001	.42	I < M < N
Psychopathy	45.2 (2.7)	44.4 (1.7)	45.1 (5.9)	0.36	.70		
Hostility	39.7 (4.8)	43.6 (6.0)	41.9 (8.3)	2.12	.13		
Narcissism	47.6 (5.4)	47.4 (5.7)	48.2 (9.0)	.05	.96		
Dysregulation	38.9 (3.2)	42.2 (6.8)	42.2 (5.4)	2.42	.10		
Dysphoria	37.4 (5.3)	38.5 (3.9)	42.7 (3.0)	4.09	.02		
Schizoid	40.8 (4.8)	37.4 (4.2)	41.8 (4.4)	3.68	.03		
Obsessional	51.5 (5.0)	50.7 (6.1)	50.4 (6.4)	.15	.86		
Thought Disorder	46.1 (5.5)	45.5 (4.8)	42.7 (4.2)	.65	.53		
Oedipal	49.9 (6.0)	53.9 (9.1)	52.7 (10.5)	1.45	.25		
Dissociation	48.0 (5.0)	50.7 (3.9)	46.9 (8.7)	.72	.49		
Sexual Conflict	53.9 (8.5)	53.1 (9.6)	53.9 (11.4)	.04	.96		

Note. I = ideal; M = with maximum benefit; W = without maximum benefit.

^a Bonferroni adjusted *p* value = .004.

Table 4
Prototype of Patients With an Ideal Outcome of Psychoanalysis and of Patients With Terminations Mutually Agreed on by Patients and Analysts With and Without Maximum Benefit

SWAP items	<i>M</i>	<i>SD</i>
Prototype of ideal outcomes of psychoanalysis (<i>N</i> = 22)		
I1: Is capable of sustaining a meaningful love relationship characterized by genuine intimacy and caring.	6.7	0.6
I2: Is psychologically insightful; is able to understand self and others in subtle and sophisticated ways.	6.6	0.7
I3: Is able to find meaning and satisfaction in the pursuit of long-term goals and ambitions.	6.6	0.5
I4: Is able to form close and lasting friendships characterized by mutual support and sharing of experiences.	6.5	0.7
I5: Is able to use his/her talents, abilities, and energy effectively and productively.	6.5	0.7
I6: Generally finds contentment and happiness in life's activities.	6.4	0.7
I7: Appears to have come to terms with painful experiences from the past; has found meaning in and grown from such experiences.	6.4	0.8
I8: Has the capacity to recognize alternative viewpoints, even in matters that stir up strong feelings.	6.3	0.7
I9: Is able to assert him/herself effectively and appropriately when necessary.	6.3	0.8
I10: Has moral and ethical standards and strives to live up to them.	6.2	0.9
Average	6.4	0.3
Mutually agreed-on termination—maximum benefit (<i>N</i> = 17)		
M1: Is able to find meaning and satisfaction in the pursuit of long-term goals and ambitions.	6.2	1.3
M2: Is articulate; can express self well in words.	6.0	1.2
M3: Is psychologically insightful; is able to understand self and others in subtle and sophisticated ways.	5.9	1.3
M4: Has moral and ethical standards and strives to live up to them.	5.9	1.0
M5: Tends to be conscientious and responsible.	5.7	2.1
M6: Appears to have come to terms with painful experiences from the past; has found meaning in and grown from such experiences.	5.4	1.7
M7: Is able to assert him/herself effectively and appropriately when necessary.	5.4	1.7
M8: Is able to find meaning and fulfillment in guiding, mentoring, or nurturing others.	5.4	1.5
M9: Is able to use his/her talents, abilities, and energy effectively and productively.	5.4	2.2
M10: Is creative; is able to see things or approach problems in novel ways.	5.4	2.2
Average	5.7	0.8
Mutually agreed-on termination—not maximum benefit (<i>N</i> = 8)		
W1: Is articulate; can express self well in words.	5.9	1.0
W2: Enjoys challenges; takes pleasure in accomplishing things.	5.6	1.8
W3: Tends to be conscientious and responsible.	5.5	1.3
W4: Is psychologically insightful; is able to understand self and others in subtle and sophisticated ways.	5.4	1.4
W5: Appears to have come to terms with painful experiences from the past; has found meaning in and grown from such experiences.	5.0	2.4
W6: Has moral and ethical standards and strives to live up to them.	4.9	2.8
W7: Tends to fear s/he will be rejected or abandoned by those who are emotionally significant.	4.8	2.1
W8: Tends to feel guilty.	4.8	1.7
W9: Tends to feel anxious.	4.8	1.0
W10: Tends to be self-critical; sets unrealistically high standards for self and is intolerant of own human defects.	4.6	1.3
Average	5.1	1.2

Note. SWAP = Shedler-Westen Assessment Procedure-200 Scale; I = ideal; M = with maximum benefit; W = without maximum benefit.

Table 5
Shedler-Westen Assessment Procedure-200 (SWAP-200) Items With Significant Differences Between the Ideal Outcome of Psychoanalysis and Real Outcomes With and Without Maximum Benefit

SWAP-200 item	Real			<i>F</i>	<i>p</i>	Effect size <i>R</i> ²	Tests after <i>F</i>
	I (<i>N</i> = 22)	M (<i>N</i> = 17)	W (<i>N</i> = 8)				
Generally finds contentment and happiness in life's activities.				17.28	.0001	.44	I > M > W
<i>M</i>	6.4	5.3	2.9				
<i>SD</i>	0.7	2.0	1.8				
Has an active and satisfying sex life.				14.03	.0001	.39	I > M > W ^a
<i>M</i>	5.8	3.4	1.9				
<i>SD</i>	1.1	2.6	2.3				
Tends to avoid confiding in others for fear of betrayal; expects things s/he says or does will be used against him/her.				13.91	.0001	.39	I = M < W
<i>M</i>	0.5	0.4	2.8				
<i>SD</i>	1.1	0.8	1.6				
Tends to feel like an outcast or outsider; feels as if s/he does not truly belong.				13.89	.0001	.39	I = M < W
<i>M</i>	0.7	2.8	3.8				
<i>SD</i>	1.2	1.9	1.8				
Is capable of sustaining a meaningful love relationship characterized by genuine intimacy and caring.				13.73	.0001	.38	I > M = W
<i>M</i>	6.7	4.3	3.4				
<i>SD</i>	0.6	2.6	1.9				
Has the capacity to recognize alternative viewpoints, even in matters that stir up strong feelings.				12.66	.0001	.37	I > M > W
<i>M</i>	6.3	5.3	3.9				
<i>SD</i>	0.7	1.4	1.6				
Is able to find meaning and satisfaction in the pursuit of long-term goals and ambitions.				11.95	.0001	.35	I > M = W
<i>M</i>	2.0	0.8	0.8				
<i>SD</i>	1.5	1.1	1.5				
Is simultaneously needy of, and rejecting toward, others (e.g., craves intimacy and caring, but tends to reject it when offered).				11.10	.0001	.34	I < M < W
<i>M</i>	0.7	1.9	3.6				
<i>SD</i>	1.2	1.5	2.4				
Is able to form close and lasting friendships characterized by mutual support and sharing of experiences.				10.94	.0001	.33	I > M > W ^a
<i>M</i>	6.4	4.9	3.6				
<i>SD</i>	0.7	2.1	2.0				

Note. Bonferroni corrected $p = .05/200 = .00025$. I = ideal; M = with maximum benefit; W = without maximum benefit.

^a M vs. W = .08.

sexual feelings and a tendency to experience sexual guilt. It seems likely that the relatively higher scores on these r-factors have to do with more access to sexual fantasies among people with ideal or real experience with psychoanalysis.

Positive Mental Health From the Psychoanalytic Perspective

The first purpose of this project was to develop an empirical description of the prototypical ideal outcome of psychoanalysis as a way of understanding positive mental health. In the present data, there was most agreement among analysts as to the SWAP-200 items that would describe the ideal outcome of psychoanalysis, intermediate agreement as to the items characteristic of the group completing analysis with maximum benefit, and most variability as to items characteristic of the group completing analysis without maximum benefit.

The data show, not surprisingly, that the ideal prototype group has low scores on most scales of symptoms (r-factor scores) and on personality disorders (PD and Q-factor scores). The ideal of positive mental health from the psychoanalytic perspective involves the ability to love and relate to others (ideal Items 1, 2, and 4), work (ideal Items 3 and 5), and self-regulate (ideal Items 7, 8, and 9), with guiding moral standards (ideal Item 10) and a sense of happiness (ideal Item 6). As compared with real outcomes of psychoanalysis, the ideal involves even better functioning (PD High Functioning scale), fewer pathological characteristics (lower scores on several PD and Q-factor scales), and the highest levels of contentment, sexual satisfaction, and ability to love and work (SWAP-200 item scores). A descriptive summary of analytic goals might be that “the goal of analysis is to be able to love, work, and self-regulate responsibly with happiness.” If one assumes that problems with self-regulation develop in the context of struggles with love or work, and if one assumes that morality and happiness involve issues of love and work, then perhaps the present data support the simple lyrical quality of the well-known aphorism that the goal of analysis is to be able to love and work.

Outcomes of Psychoanalysis With and Without Maximum Benefit

The second purpose of the present project was to compare outcomes of analysis with and without maximum benefit (among analyses with terminations mutually agreed on by patient and analyst) and consider how these relate to the prototype of the ideal outcome of psychoanalysis.

People in the two outcome groups were highly educated (80% had a graduate or professional education) and were most often White (96%) and generally around 40 years old when the analysis began. The analyses lasted an average of slightly more than 5 years ($M = 73.6$ months, $SD = 37.3$). People in the two outcome groups were very likely to have had an Axis I disorder (88%) or an Axis II disorder (68%), respectively, when the analysis began. These findings are in accord with the findings of Doidge et al. (2002).

People in both of the groups at the end of analysis are seen as productive people who are generally contented with life. People in both groups were equally likely to be viewed as capable of sustaining a meaningful love relationship (SWAP-200 items in Table 5). The length of analysis in the two groups differed by many months (53.4 vs. 83.0 months). The present findings suggest that the end phase of analysis may take many months or even several years. The step from finishing analysis without maximum benefit to finishing with maximum benefit

seems to involve an increase in finding contentment, meaning, and satisfaction in life and a decrease in distress (fear of abandonment, guilt, anxiety, and self-criticism).

What is required next is to see whether the same findings obtain when analyses are followed longitudinally. Extending the present results, longitudinal study is likely to show that symptoms change early in analysis, work-related issues next, and relational issues last.

Limitations

The present study has limitations. The data on real outcomes of analysis have come from reports at the end of analysis rather than from longitudinal studies. Furthermore, the data on the real outcomes of analysis are entirely from the reports of the treating analysts. More work remains to be done, but I think that the present findings are helpful in adding to thinking about therapeutic goals in general. Although symptom reduction is an important aspect of therapeutic goals, outcomes such as being able to love and work and to be content in the face of life's challenges are of great importance to people and to understanding the outcome of intensive therapy.

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