

SHORT-TERM AND LONG-TERM PSYCHOANALYTIC PSYCHOTHERAPY: ARE THEY DIFFERENT?

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In the last few years, the question of whether the techniques used in psychodynamic psychotherapies and psychoanalysis should be differentiated categorically or dimensionally has generated substantial discussion (Kächele 2010). In the field of psychoanalysis, a categorical differentiation between the technique of psychoanalysis and that of psychodynamic psychotherapy is still preferred, a differentiation that has not been scientifically demonstrated on the basis of empirical analysis of the techniques used in actual practice. The Psychotherapy Process Q-set method (PQS; Jones 2000) allows such a differentiation to be made.

The divergence between the ideal of a treatment orientation and its actual practice can be studied by the application of prototypes representing the ideal conception of a psychoanalytic hour. Ablon and Jones (1998) have developed a psychoanalytic prototype by clustering PQS ratings done by experienced psychoanalysts. In a later study (Ablon and Jones 2005), the correlation

of that prototype with actual psychoanalytic sessions was shown to be $r = .58$. What would happen, we asked, if we correlated only those items from the prototype that represent the analyst's *techniques* and omitted those representing the analyst's other contributions to the session, as well as the patient's contributions? Would we obtain a higher correlation? In this study we examine, using the PQS analytic prototype, whether long-term psychodynamic psychotherapy and psychoanalysis foster more analytic process and technique than short-term psychodynamic psychotherapy does.

Therapeutic techniques represent a significant part of the therapist's contribution to the therapeutic process. Therapeutic techniques are defined as "formal and deliberate responses that therapists make to help resolve their patient's personal difficulties, based on their expert understanding of the patient's presentation and the recommendations of the treatment model they follow" (Lambert 2004, p. 337). Because the various schools of therapy teach different techniques, therapists have different degrees of confidence in the effect a given technique has on the process of change (Orlinsky, Rønnestad, and Willutzki 2004). Over the past sixty years a considerable number of studies concerning therapeutic technique and its correlation to outcome have found variously that interpretation has a positive or a negative effect on treatment results (Orlinsky, Rønnestad, and Willutzki 2004). For instance, earlier findings suggesting that transference interpretation ought to be avoided in brief psychotherapies (Henry et al. 1994) have been criticized in a recent study by Høglend (2006).

The present study compares the therapeutic techniques used in psychoanalysis (PA) and in long-term and short-term psychodynamic psychotherapy (LTDP and STDP). Among the 100 items from the PQS, several items can be identified that describe psychotherapeutic techniques. Referring to the techniques defined and presented in the research literature (Lambert 2004; Leichsenring 2005; Hilsenroth et al. 2005; Gabbard 2009; Fonagy and Kächele 2009), we identified 25 suitable PQS items. *T* tests were computed between the PQS items referring to techniques identified in the STDP and LTDP samples.

This poster reports investigations into (1) whether PA and LTPD show more resemblance to the PQS psychoanalytic prototype than STPD, (2) whether there are differences between PA, LTPD, and STPD at the level of therapeutic technique, and (3) whether interpretation (among other techniques) differs between STPD and LTPD.

METHOD

Participants and Procedure

Two hundred two therapeutic sessions were analyzed using the Psychotherapy Process Q-Set (PQS; Jones 2000). Thirteen psychoanalyses (PAs), fifteen long-term psychodynamic psychotherapies (LTDPs), and thirty short-term psychodynamic psychotherapies (STDPs) are included.

In the PA sample, the thirteen patients were diagnosed with a range of different disorders. Nine patients were female and four male. Their average age was 33 (21–48) years. The analyses were conducted on the couch three times a week for an average of 5 (3–7) years and a mean of 340 (250–350) sessions. Four recorded sessions from each treatment were rated with the PQS by two trained and independent raters. The sessions were chosen to capture different points in the treatment process (T1 = 2%; T2 = 33%; T3 = 67%; T4 = 98%).

The LTDP sample comprises fifteen patients diagnosed with major depression. All but two were female; they ranged in age from 21 to 44 years. The treatments were conducted by psychoanalytically oriented psychotherapists or psychoanalysts twice a week for periods ranging from fifteen months to three years ($M = 2$ years). One treatment comprised 70 sessions, with all the others running for more than 100 sessions, 210 being the upper limit ($M = 160$). Four therapy hours from each of the treatments were rated with the PQS (T1 = 2%; T2 = 33%; T3 = 67%; T4 = 98% using video or audio recordings).

The STDP sample includes thirty patients (twenty female and ten male) with a range of neurotic disorders. The nonmanualized short-term psychodynamic psychotherapies were conducted once a week for 16 sessions. The mean age of the patients was 51 (20–81) years. The fifteen treating therapists had all received specialized training in brief psychodynamic therapy and considered the psychodynamic model their primary theoretical orientation. For reasons of availability, only three sessions from each treatment (instead of four) were Q-sorted (T1 = 6.25%; T2 = 31.5%; T3 = 87.5%).

Data Provenience

PA data come from the Munich Attachment and Effectiveness Project (MBWP), a collaboration between the Department of Psychology of the Ludwig Maximilian University of Munich and the Academy for Psychoanalysis and Psychotherapy (Munich). LTDP data come from the Ulmer

Textbank (Ulm, Germany) and from the Berkeley Psychotherapy Project Archive, now housed at the Psychotherapy Research Program at Massachusetts General Hospital, which also includes the STDP material (originally from the Mount Zion Psychotherapy Research Group, San Francisco). This archival sample has been previously described (Jones, Parke, and Pulos 1992; Karlsson and Kermott 2006) and compared with other samples (Ablon and Jones 2005).

The Psychotherapy Process Q-Set

The PQS (Jones 2000) is a 100-item instrument that is rated by independent clinical judges kept blind to treatment condition and outcome. The method is intended to capture the nature of the therapeutic interaction between patient and practitioner, focusing on patients' and therapists' attitudes and behaviors. Raters view an entire treatment session and then sort the 100 PQS items into a set of categories ranging from 1 ("least characteristic") to 9 ("most characteristic"). The middle rating, 5, is reserved for items deemed either neutral or irrelevant to the session being rated. Raters follow a forced normal distribution when allocating the PQS items to the categories. All raters must be trained for correct application of the method. Each treatment session was evaluated by two raters, whose ratings were averaged to increase reliability (composite score). If reliability was below .05 (Pearson correlation coefficient), a third rater was added. Interrater reliability in the three samples ranged from .54 to .94.

Prototype of Ideal Analytic Process

Responses by expert psychoanalysts to the PQS were used to develop a prototype of analytic process. An expert panel of eleven analysts were asked to rate each of the 100 PQS items on a scale from 1 to 9, according to how characteristic each item was of their understanding of an ideally conducted treatment hour. Reliabilities demonstrated that the level of the analysts' ratings was high (.94). The prototype was then created using a small-sample statistical method called the Q-technique or Q-type factor analysis. The psychoanalytic prototype was then used by Ablon and Jones (2005) to score actual sessions of psychoanalysis and psychotherapy in order to determine how close the Q-ratings of the actual treatment hours were to the prototype of analytic process. As was expected, analytic sessions were most like the prototype of an ideal analytic hour, and brief therapy sessions were least like it. This prototype has since been used in numerous studies (e.g., Pole, Ablon, and Lynn 2008) to measure the degree

Table 1. STDP, LTDP, and PA correlations with the PQS psychoanalytic prototype

Sample	PQS psychoanalytic prototype (All Items; $n = 100$)	PQS psychoanalytic prototype (Technique Items; $n = 20$)
STDP	$r = .55$	$r = .76$
LTDP	$r = .54$	$r = .70$
PA	$r = .50$	$r = .58$

of analytic process in a given treatment hour. For further information on the construction of the prototype, see Ablon and Jones (1998).

RESULTS

Correlation with the Analytic Prototype

All three samples achieved a correlation of .50 or higher with the PQS psychoanalytic prototype. The STDP sample correlated the most with the prototype ($r = .55$), followed by the LTDP sample ($r = .54$). The lowest correlation is observed with the PA sample ($r = .50$). When correlating only the technique items of the samples and the PQS prototype, the order of higher correlation is maintained, but the correlation scores are higher for all samples. The technique items of the STDP sample achieve the highest correlation (.76) with the technique items included in the psychoanalytic prototype. In Table 1 it becomes clear that the differences between samples are not striking in regard to the fostered psychoanalytic process and technique.

Similarities and Differences among Therapeutic Techniques

Overall a similar application of therapeutic techniques could be found among STDP, LTDP, and PA. The most significant differences, identified through t tests, were found on seven techniques, the items printed boldface in Table 2. For example, psychoanalysts were observed to be more empathic toward their patients than were STDP therapists. No significant differences could be found between PA and LTDP therapists.

DISCUSSION

The present results show that most techniques are applied in a similar manner in PA, LTDP, and STDP. Not only was the use of general techniques (e.g., reformulating the patient's communication, facilitating the patient's

Table 2. Therapeutic technique items with mean scores for STDP (N = 30), LTDP (N = 15), and PA (N = 13) and comparison across samples

PQS#	Item Description	STDP	LTDP	PA	<i>t</i> (43) diff	<i>t</i> (41) diff	<i>t</i> (26) diff
		Mean (<i>SD</i>)	Mean (<i>SD</i>)	Mean (<i>SD</i>)	<i>t</i> (<i>p</i> val.)	<i>t</i> (<i>p</i> val.)	<i>t</i> (<i>p</i> val.)
3	T's remarks are aimed at facilitating P's speech.	6.23 (1.13)	5.98 (.76)	6.38 (.78)	.76 (.45)	-.44 (.66)	-1.37 (.18)
6	T is sensitive to P's feelings; attuned to P; empathic.	6.75 (.71)	7.24 (.87)	7.86 (.88)	-2.05 (.05)	-4.37 (.00)	-1.85 (.08)
22	T focuses on guilt.	5.39 (1.09)	5.01 (.78)	4.50 (.89)	1.21 (.23)	2.59 (.01)	1.61 (.12)
24	T's own emotional conflicts intrude into the relationship.	3.04 (.64)	4.08 (.59)	4.15 (.49)	-5.26 (.00)	-5.60 (.00)	-3.38 (.71)
27	T gives explicit advice or guidance (vs. defers even when pressed to do so).	3.89 (.86)	4.81 (.97)	4.54 (1.21)	-3.21 (.00)	-1.99 (.05)	.65 (.52)
28	T accurately perceives the therapeutic process.	6.62 (.53)	7.59 (1.35)	6.85 (1.14)	-2.70 (.02)	.70 (.50)	1.57 (.13)
32	P achieves a new understanding or insight.	5.56 (.93)	5.65 (.79)	5.14 (.79)	-.31 (.76)	1.41 (.17)	1.68 (.11)
31	T asks for more information or elaboration.	7.28 (.71)	6.92 (.53)	6.63 (.94)	1.76 (.09)	2.54 (.02)	1.04 (.31)
36	T points out P's attempts to ward off awareness of threatening information or feelings.	5.41 (1.08)	6.94 (1.37)	5.14 (.85)	-4.08 (.00)	.79 (.43)	4.07 (.00)
37	T behaves in a teacher-like (didactic) manner.	3.87 (.75)	4.18 (1.02)	3.43 (.70)	-1.14 (.26)	1.80 (.08)	2.21 (.04)
40	T makes interpretations referring to actual people in P's life	6.32 (.80)	6.06 (.85)	6.33 (.99)	1.00 (.32)	-.04 (.97)	-.77 (.45)
43	T suggests meaning of others' behavior.	4.67 (.78)	4.61 (.78)	5.38 (1.44)	.25 (.81)	-1.68 (.11)	-1.80 (.08)
45	T adopts supportive stance.	4.64 (1.02)	4.11 (1.64)	5.50 (1.65)	1.35 (.19)	-1.73 (.10)	-2.23 (.04)
50	T points out P's unacceptable feelings.	6.15 (1.18)	5.99 (1.02)	5.06 (.93)	.44 (.66)	2.97 (.01)	2.52 (.02)
57	T explains rationale behind his or her technique or approach to treatment or suggests that P use certain techniques.	4.01 (.51)	4.72 (.42)	4.73 (.36)	-4.62 (.00)	-4.56 (.00)	-.08 (.94)

(continued)

Table 2. (continued)

PQS#	Item Description	STDP	LTDP	PA	<i>t</i> (43) diff	<i>t</i> (41) diff	<i>t</i> (26) diff
		Mean (<i>SD</i>)	Mean (<i>SD</i>)	Mean (<i>SD</i>)	STDP-LTDP <i>t</i> (<i>p</i> val.)	STDP-PA <i>t</i> (<i>p</i> val.)	PA- LTDP <i>t</i> (<i>p</i> val.)
62	T identifies a recurrent theme in P's experience or conduct.	6.98 (1.02)	6.87 (1.12)	6.51 (.91)	.35 (.73)	1.44 (.16)	.91 (.37)
65	T restates or rephrases P's communication in order to clarify its meaning.	6.91 (.72)	6.95 (.71)	7.1 (.85)	-.16 (.87)	-.85 (.40)	-.60 (.55)
67	T draws P's attention to wishes, feelings, or ideas that may not be in awareness.	6.27 (.82)	7.04 (1.39)	6.01 (1.49)	-2.00 (.06)	.73 (.47)	1.90 (.07)
68	T actively distinguishes reality from fantasy.	4.94 (.61)	4.96 (.52)	5.00 (.45)	-.09 (.93)	-.32 (.75)	-.60 (.55)
81	T emphasizes P's feelings to deepen them.	6.57 (1.08)	5.78 (.96)	5.86 (1.31)	2.39 (.02)	1.86 (.07)	-.18 (.86)
82	P's behavior during the hour is reformulated by T in a way not explicitly recognized previously.	5.26 (.78)	5.47 (.66)	4.57 (.37)	-.93 (.36)	3.03 (.00)	4.39 (.00)
89	T intervenes to help P avoid or suppress disturbing ideas or feelings.	2.59 (.87)	1.90 (.98)	3.38 (1.42)	2.42 (.02)	-2.26 (.03)	-3.26 (.00)
92	P's feelings or perceptions are linked to situations or behavior of the past.	6.75 (1.37)	5.93 (.77)	6.09 (.81)	2.56 (.02)	1.62 (.11)	-.51 (.61)
93	T refrains from stating opinions or views of topics P discusses.	5.78 (1.12)	4.57 (1.99)	5.09 (1.73)	2.19 (.04)	1.58 (.12)	-.73 (.47)
99	T raises questions about the P's view (vs. validates the P's perceptions).	5.49 (1.31)	5.40 (.83)	5.00 (1.04)	.29 (.78)	1.21 (.24)	1.14 (.27)
100	T draws connections between the therapeutic relationship and other relationships.	5.09 (1.32)	5.33 (.98)	5.36 (.78)	-.62 (.54)	-.66 (.51)	-.07 (.95)

Note: <-> item 32 is part of therapy technique only when observed in association with item 28.
P = patient; T = therapist.

speech) highly characteristic for all therapies, but so also was the use of specific PA techniques. The therapists in STDP did not behave in a more didactic way than psychoanalysts and LTDP therapists. Didactic techniques, more common in cognitive-behavioral therapies, were fairly uncharacteristic and irrelevant in all three samples, a reflection no doubt of the common psychoanalytic orientation of the therapies being studied.

Remarkably, PA techniques were not less common in the STDP therapies, as one might have expected from the research literature. Interpretation is highly PA, and its use in brief therapies often gives rise to controversy (Henry et al. 1994; Orlinsky, Rønnestad, and Willutski 2004). Yet in our study no significant differences were found among the three types of treatment regarding the application of interpretation. All the therapists tended to interpret unconscious wishes or feelings, with fewer interpretations referring to actual people in the patient's life. Still, with regard to interpretation, the therapist's suggesting the meaning of others' behavior was rated almost neutral or irrelevant in all three samples. Some other PA techniques were even more characteristic for the STDP sample. For example, work with the patient's past experiences and the identification of recurrent themes were both more frequent for STDP than for the other two samples. One cannot generalize that all so-called STDPs apply this amount of PA technique, but we can definitely conclude that *short-term* does not mean *nonpsychoanalytic*.

Nevertheless, nuances differentiate our therapy samples, tending to support the dimensional perspective. For example, although empathy is a core technique for any therapist (Lichtenberg, Bernstein, and Silver 1984), the psychoanalysts and LTDP therapists showed more empathy than did the STDP therapists. Most likely this confirms the idea that empathy is more easily developed through longer-lasting personal interaction. Time seems to be an important factor in how patient and therapist get to know each other. An empathic therapist may conclude, to a certain extent, how the patient may think, feel, and perceive certain situations (Lichtenberg, Bernstein, and Silver 1984), an important ability for various aspects of therapeutic process. Overall, fewer differences in technique were found between LTDP and PA. It seems that their comparable length of treatment influences the resemblance of these two types of therapy more than the face-to-face vs. lying down distinction differentiates them.

One of the most striking results of this study is the higher correlation of the STDP sample with the PQS psychoanalytic prototype. LTDP therapies share almost the same higher correlation with the PQS prototype as STDP. Notably, the PA sample had the lowest correlation. Our results clearly

contradict Ablon and Jones's findings (2005). The provenience of our STDP sample may be the main reason, since it comes from a highly specified center in psychodynamic psychotherapy. Still, our LTDP sample also has a higher correlation with the prototype than does the PA sample. Here we open the discussion: What is the psychoanalytic PQS prototype about? We briefly enumerate a few key aspects to consider. While looking in greater detail into the PQS prototype items, the most defining aspects represent certain extremes in what is to be considered PA. For example, the highest factor is not a technique at all, but a content: patients' dreams, an item deemed neutral or irrelevant in the STDP and LTDP samples but characteristic for PA). Consequently, one must ask which psychoanalytic orientation the eleven American psychoanalysts who constructed the prototype represented. PA may be practiced differently in the U.S. than in Europe (our PA sample is from Germany). Did the widespread ego psychology orientation in America (found less in Europe) influence the PQS prototype, in this way explaining its weak correlation with our European PA sample? For PA research it would be worthwhile to construct a new prototype, one based on more psychoanalysts' ratings, considering the various PA schools and cultures.

CONCLUSION

Our study has a number of limitations, including sample size and heterogeneity. The diverse diagnoses in our samples and varying provenience of our clinical material certainly influence our data analysis. Nevertheless, our results indicate little dimensional differentiation in the techniques used in PA, LTDP, and STPD. Length of treatment seemed to have more influence in the differences found than does the lying down vs. face-to-face distinction. Regarding the samples' correlation with the PQS psychoanalytic prototype, it turned out, surprisingly, that the STDP sample showed a high number of psychoanalytic features. This study opens an interesting discussion about the construction and use of prototypes in the field of PA. Finally, the study showed empirically more similarities than differences among PA, LTDP, and STDP.

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