Interpretive and Supportive Forms of Psychotherapy and Patient Personality Variables

William E. Piper, Anthony S. Joyce, and Mary McCallum
University of Alberta and University of Alberta Hospital Site

Hassan F. Azim
Lions Gate Hospital

A randomized clinical trial investigated the efficacy of interpretive and supportive forms of short-term individual psychotherapy and the interaction of each form with the patient's quality of object relations (QOR) and psychological mindedness (PM). The psychiatric outpatient sample included 144 therapy completers and 27 dropouts. Eight experienced therapists provided distinct forms of manual-guided therapy. Outcome was assessed by a comprehensive battery. The dropout rate was higher for interpretive therapy than for supportive therapy. Patients in both forms improved, but they did not differ on outcome from each other. A multivariate interaction effect indicated a direct relation between QOR and outcome for interpretive therapy and almost no relation for supportive therapy. A multivariate main effect indicated a direct relation between PM and outcome for both forms. The relevance of patient personality to outcome in different forms of therapy is addressed.

Although there has been a general shift toward eclecticism in the field in the past 20 years, recent surveys have indicated that a large proportion of therapists have maintained their allegiance to the psychodynamic model (Jensen, Bergin, & Greaves, 1990; Levenson, Speed, & Budman, 1992; Sammons & Gravitz, 1990). During the same period, the stature and prevalence of short-term therapies have increased substantially (Koss & Shiang, 1994). Despite their common model, psychodynamic therapists provide a wide range of techniques, especially in the case of short-term therapies. For example, a distinguishing feature of psychodynamic technique is interpretation, in particular the interpretation of transference. However, although some therapists actively provide interpretations (including transference interpretations) in short-term therapy, as advocated by Davanloo (1978), Malan (1976), Mann (1973), and Sifneos (1979), others do not. The former can be said to be practicing a more interpretive form of psychodynamic psychotherapy and the latter, a more supportive form. Others have expressed this distinction in terms of more expressive and more supportive forms of psychotherapy (Luborsky, 1984).

In recent years, supportive psychodynamic psychotherapy has been promoted as a prevalent and effective, although historically underrated, treatment for a variety of disorders (Rockland, 1989, 1992; Wallerstein, 1989; Winston, Pinsker, & McCullough, 1986). In supportive therapy, there is primary emphasis on improving the patient's immediate adaptation, whereas in interpretive therapy, there is primary emphasis on enhancing insight about repetitive conflicts and trauma that underlie the patient's problems. In addition to interpretation and focus on transference, other technical features serve as continua that differentiate the two forms of therapy (Piper, 1996). For interpretive therapy, these features include greater pressure on the patient to talk, exploration of uncomfortable emotions, and focus on past figures. For supportive therapy, they include greater gratification, praise, guidance, structured problem solving, and therapist disclosure. Because of these differences, the process of supportive therapy can be regarded as less depriving and anxiety arousing than the process of interpretive therapy.

Despite the prevalence of different forms of short-term dynamic psychotherapy, only a small number of controlled or comparative outcome trials have been conducted. In recent metaanalytic reviews, Svarterberg and Stiles (1991) included only 19 studies and Crits-Christoph (1992), only 11. The former review was relatively negative and the latter relatively positive about the efficacy of short-term psychodynamic therapy. A more recent review by Anderson and Lambert (1995), which attempted to reconcile the differences between the two previous reviews, included 26 studies and provided conclusions more similar to Crits-Christoph's. A limitation associated with review methods such as meta-analysis, which rely on extensive averaging, is that the effects of certain sources of variation, such as patient personality characteristics, therapist technique, and their interaction, are often masked. Although conclusions about the general efficacy of therapy are useful, specific information about the...
optimal matching of patients and techniques would be even more valuable (e.g., Beutler & Clarkin, 1990; Karasu, 1989; Shoham-Salomon, 1991). Researchers have been encouraged to investigate theory-based, a priori hypotheses about matching rather than engage in post hoc searches for significant findings.

In the present study, we investigated two theoretically relevant personality characteristics that have been cited frequently in the literature as important selection criteria for brief therapy (Lambert & Anderson, 1996) and were predictive of important clinical events in some of our previous trials of psychodynamic psychotherapies. Quality of object relations (QOR) refers to a person’s lifelong pattern of relationships, identified on a dimension ranging from primitive to mature. In our Montreal comparative psychotherapy study, the therapist’s rating of QOR was directly related to favorable process and outcome in an interpretive form of short-term individual therapy (Piper, de Carufel, & Szkrumelak, 1985). In our Edmonton controlled trial of interpretive, short-term individual therapy, QOR was directly related to the therapeutic alliance and favorable outcome (Piper et al., 1991). These findings are consistent with those reported by Horowitz, Marmar, Weiss, DeWitt, and Rosenbaum (1984) in a study of brief individual therapy. In addition, in our controlled trial of intensive day treatment, which involved an integrated set of interpretive and supportive forms of group therapy, QOR was directly related to remaining and benefiting (Piper, Joyce, Azim, & Rosie, 1994). We hypothesize that patients with higher levels of QOR are better able to tolerate, work with, and benefit from the more demanding aspects of interpretive therapy and, conversely, patients with lower levels of QOR are better able to work with and benefit from the more gratifying aspects of supportive therapy.

Psychological mindedness (PM) refers to a person’s ability to understand people and their problems in psychological terms. From a psychodynamic perspective, PM refers to the ability to identify components of intrapsychic conflict. In our controlled trial of an interpretive form of short-term group therapy, PM was directly related to remaining and working in the groups but not to benefiting (Piper, McCallum, & Azim, 1992). In our day treatment trial, however, PM was directly related to both working and benefiting. We hypothesize that patients with higher levels of PM are better able to work and benefit in interpretive therapy in which internal conflicts are explored repeatedly and, conversely, patients with lower levels of PM are better able to work and benefit in supportive therapy in which internal conflicts are not explored.

On the basis of the above rationale and previous findings, we made the following three predictions: (a) There will be no outcome differences between the two forms (interpretive vs. supportive) of therapy; both will be efficacious. (b) There will be an interaction between QOR and form of therapy, in that higher levels of QOR will be associated with more favorable outcome in interpretive therapy, and lower levels of QOR will be associated with more favorable outcome in supportive therapy. (c) There will be an interaction between PM and form of therapy, with higher levels of PM associated with more favorable outcome in interpretive therapy and lower levels of PM associated with more favorable outcome in supportive therapy.

The present study had two primary objectives. The first was to compare the efficacy of two different forms (interpretive vs. supportive) of time-limited, short-term, dynamically oriented individual psychotherapy. The second was to investigate the interaction of each of two personality characteristics (QOR and PM) with the two forms of psychotherapy. Other methodological objectives included the use of a randomized clinical trial design, a large clinical sample, a comprehensive set of outcome criteria, experienced therapists, therapy manuals, and technical adherence checks.

Method

Setting, Referrals, and Procedure

Patients were referred to the project from the walk-in clinic of the Department of Psychiatry, University of Alberta Hospital Site, Edmonton, Alberta, Canada. The walk-in clinic is part of a large, multifaceted, psychiatric outpatient service that is located within a 600-bed university hospital. Approximately 2,000 initial assessments are conducted in the clinic each year by a staff of 10 from the disciplines of psychology, social work, occupational therapy, and nursing. Approximately 18% of the patients are offered some form of weekly psychodynamic psychotherapy (individual, couple, family, or group). A variety of other treatments are also offered, and some patients are referred outside the clinic. During the referral period (September 1993 through March 1996), an average of 9 patients per month were referred, that is, about 6% of all assessments and 31% of available psychodynamic psychotherapy cases. Patient preference and therapist capacity to carry simultaneous cases influenced the referral rate to the project. The patients in the project were regarded by the referrers as representative of the psychotherapy cases within the clinic.

A total of 258 patients were referred to the project. Patients read a detailed information form and provided signed consent. Each patient was scheduled for a set of pretherapy interviews and questionnaire assessments that focused on predictor, demographic, diagnostic, and outcome variables. The assessors were unaware of the results of each other's assessments. The research coordinator matched patients in pairs on the basis of their QOR score; PM score; use of medication; and, when possible, gender and age. Exact matches on the continuous QOR and PM scales were not always possible. The best possible match was achieved from the group of patients who were currently available for assignment. One patient from each pair was randomly assigned to interpretive therapy and the other to supportive therapy for a given therapist. Therapist assignments were also made randomly. The therapist contacted the patient to arrange for treatment. Soon after therapy ended, patients were reassessed on the outcome variables. (Although not the focus of the present article, patients were also reassessed on the outcome variables 6 months and 12 months after therapy ended.)

Of the 258 referred patients, 69 (26.7%) did not complete the pretherapy assessments and proceed to therapy; they were labeled decliners. Of the 171 patients who started therapy with one of the project therapists, 27 dropped out prematurely; they were labeled dropouts. An attempt was made to reassess dropouts on the outcome variables at the time they otherwise would have completed therapy. Each dropout was replaced with another matched patient. The 144 patients who finished therapy were labeled completers. An additional 18 patients could not be matched and assigned to a project therapist in a timely manner and were therefore treated by a nonproject therapist in the clinic.

Patients

All of the 144 treatment completers received diagnoses according to the revised third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R; American Psychiatric Association, 1987). Axis I diagnoses were identified by the computer-administered
Mini-Structured Clinical Interview for DSM-III-R (Mini-SCID; First, Gibbon, Williams, & Spitzer, 1990) and validated by an independent clinical diagnosis assigned jointly by the intake assessor and a rounds psychiatrist, both of whom saw the patient on the day of intake. Axis II diagnoses were determined by the computer-administered Structured Clinical Interview for DSM-III-R Personality Questionnaire (SCID-II PQ) and Auto-Structured Clinical Interview for DSM-III-R (Auto-SCID II; First, Gibbon, Williams, & Spitzer, 1991). Rater reliability for the Axis II diagnoses was calculated for 10 randomly selected cases and five raters. A kappa was calculated for each pair of raters for each disorder: The mean kappa for all pairs and disorders was .70. A total of 72.9% of the patients received an Axis I diagnosis. The most frequent disorders were current major depression (48.6%) and dysthymia (26.4%), followed by anxiety disorder (7.6%), adjustment disorder (6.9%), and alcohol abuse (6.2%). A total of 60.4% of the patients received an Axis II diagnosis. The most frequent Axis II disorders (26.4%), followed by anxiety disorder (7.6%), and adjustment disorder (6.9%), and alcohol abuse (6.2%). A total of 60.4% of the patients received both Axis I and Axis II diagnoses. Patients with primary problems related to psychosis, substance abuse, or sociopathic behavior were excluded. The patients’ presenting problems were consistent with the preceding diagnostic profile and representative of an outpatient psychotherapy population, namely, difficulties with depression, anxiety, low self-esteem, and interpersonal conflict.

The average age of the patients was 34.3 years (SD = 9.6, range = 18–62). Sixty-one percent were women. Forty-two percent were married or living with a partner, 21% were separated or divorced, and 37% had never been married. Sixty-seven percent were educated beyond high school, and 71% were employed. The racial composition was White (94%), East Indian (2%), Native American (2%), Asian (1%), and Semitic (1%). Many (73%) reported receiving previous psychiatric treatment, but few (8%) had a history of psychiatric hospitalization.

Therapists

There were eight therapists (three psychologists, two social workers, two occupational therapists, and one psychiatrist). Seven were White and one was East Indian. Five were female. The therapists’ average age was 43.6 years (SD = 6.1, range = 37–52), and their average experience practicing individual psychotherapy was 11.8 years (SD = 4.9, range = 3–19). Each therapist treated 9 interpretive therapy patients and 9 supportive therapy patients.

Therapies

Each patient received a form of psychotherapy that emphasized interpretive or supportive features. The psychotherapies were labeled interpretive therapy and supportive therapy, respectively. The general contractual and structural features of the therapies were similar. The patient was scheduled for weekly 50-min sessions at a regular, prearranged time for 20 weeks. Punctual attendance was emphasized, and missed sessions were not rescheduled. The therapist was paid by a third party. Apart from these similarities, the overall objectives, session objectives, and therapist technique for the two forms of therapy were quite different. In interpretive therapy, the primary objective is to enhance the patient’s insight about repetitive conflicts (intrapsychic and interpersonal) and trauma that serve to underlie and sustain the patient’s problems. The therapist encourages the patient to explore uncomfortable emotions and withholds immediate praise and gratification. The therapist is active, interpretive, and transference focused. In supportive therapy, the primary objective is to improve the patient’s immediate adaptation to his or her life situation. The therapist attempts to minimize anxiety and regression in the session and provides praise and immediate gratification. The therapist is active, noninterpretive, and other focused (i.e., focused on the patient’s current external relationships).

Although the therapists were experienced in providing a variety of interpretive and supportive therapies in the clinic, they participated in a 6-month training seminar before taking cases in the project. This included treating pilot cases and attending a weekly training session in which technical principles were covered and cases were presented. The weekly seminar continued throughout the project. The therapists followed a two-part technical manual that described, illustrated, and compared the technical emphases associated with the two forms of therapy (Piper, Azim, Joyce, & McCallum, 1995).

All therapy sessions were audiotaped. Adherence to the technical manual was monitored by external observers (bachelor’s-level research assistants), who were unaware of the treatment conditions, using two measures. The first, the Adherence Scale, consists of 14 items (7 interpretive and 7 supportive) rated on a 5-point Likert-type scale ranging from 1 (no emphasis) to 5 (major emphasis) after the rater listens to the entire session. The full-scale score, which is keyed in the interpretive direction, ranges from 0 to 56. The rater reliability for the scale was assessed during three periods of the project (beginning, middle, and end) using the intraclass correlation coefficient (ICC; Shout & Fleiss, 1979). Each assessment involved seven raters and 8 patients. The average ICC (2, 1) for the three assessments was .93. The scale’s internal consistency was assessed during the middle period and involved seven raters and 16 patients.

The second measure of adherence was the Therapist Intervention Rating System (TIRS; Piper, Debbane, de Carufel, & Bienvenue, 1987). All therapist statements from each session are assigned to one of nine categories that range from simple utterances (e.g., “(MInHam)” to complex interpretations. The five lower categories include brief expressions, reflections, clarifications, questions, and directives that do not make reference to patient dynamic components such as wishes, anxiety, and defenses. Thus, they are defined as interventions but not interpretations. The four upper categories make reference to patient dynamic components and are defined as interpretations. They differ only in the number of dynamic components referred to, that is, one, two, three, or four. The rater reliability for the scale was assessed using one session from each of 12 randomly selected cases (6 interpretive and 6 supportive). Three raters scored each of the 12 sessions. A kappa was calculated for each pair for each session. The mean kappa for all pairs and sessions for the nine categories was .71. The TIRS was used with six sessions (3, 5, 7, 9, 11, 15, 17, and 19) for the first 80 completers. For the 40 interpretive therapies, the mean number of interventions, interpretations, and transference interpretations per session were 74.2, 14.4, and 3.7, respectively. For the 40 supportive therapies, the mean numbers of interventions, interpretations, and transference interpretations per session were 125.6, 3.3, and 0.2, respectively. Comparison by t tests revealed that in the interpretive therapies, therapists were significantly less active, t(78) = 6.28, p < .001; more interpretive, t(78) = 10.02, p < .001; and more transference oriented, t(78) = 6.26, p < .001.

The patient and therapist also rated the therapist’s technique after each session, using eight items that paralleled a subset of the Adherence Scale items. Each item was rated on a 5-point Likert-type scale from 1 (no emphasis) to 5 (major emphasis). The ratings for each item were averaged across the therapy sessions and then averaged across the eight items to create an overall score keyed in the interpretive direction. The overall score, both patients, t(140) = 11.28, p < .001; and therapists, t(142) = 43.98, p < .001, perceived significant differences in the techniques provided by the therapist in the two forms of therapy as intended. The evidence from the two adherence measures and the patient and therapist ratings indicates that the two forms of therapy were well-differ-
entailed and conformed to the technical manual. Session attendance for the two therapies was high. More than 94% of the patients attended 15 or more sessions. For both the interpretive and supportive therapies, the mean number of sessions attended was 18.0 (SD = 1.8 and 2.1, respectively).

Medication

Management of medication was conducted by an independent project psychiatrist, who met with each patient before and after therapy. Sixty (41.7%) of the 144 completers were prescribed a therapeutic dosage of a psychotropic medication. In nearly all cases (93.3%), the medication was an antidepressant (tricyclic or selective serotonin reuptake inhibitor). For an antidepressant, a therapeutic dosage was defined as equivalent to 150 mg/day of imipramine for a minimum of 6 weeks. In the remaining cases (6.7%), an anxiolytic or hypnotic was prescribed.

Patient Personality Variables

Patients were matched on two personality variables—QOR and PM—before being randomly assigned to one of the two therapies. QOR is defined as a person’s enduring tendency to establish certain types of relationships that range along an overall dimension from primitive to mature (Azrin, Piper, Segal, Nixon, & Duncan, 1991). A 9-point scale was used in an unstructured interview conducted in two 1-hr sessions held a week apart. The patient’s lifelong pattern of relationships was explored in reference to criteria that characterize five levels of object relations: primitive, searching, controlling, triangular, and mature. The criteria refer to behavioral manifestations, regulation of affect, regulation of self-esteem, and historical antecedents. The predominant characteristics associated with the two extreme levels of the scale are as follows: A tendency toward mature object relations means the person enjoys equitable relationships characterized by love, tenderness, and concern for other objects. A capacity to mourn and tolerate unobtainable objects. A tendency toward primitive object relations means the person reacts to perceived separation or loss of the object, or disapproval or rejection by the object, with intense anxiety and affect. There is an inordinate dependence on the object, who provides a sense of unobtainable relationships. A tendency toward primitive object relations: primitive, searching, controlling, triangular, and mature. The interview measure was assessed during the project using the ICC (2, 1) of .99, indicating high reliability. The overall score from the 64-item Inventory of Interpersonal Problems (Horowitz, Rosenberg, Bar, Ureno, & Villaseñor, 1988) was used to measure interpersonal distress. A modification of the Social Adjustment Scale interview (Weissman, Paykel, Siegal, & Klerman, 1971) was conducted by an independent assessor (bachelor’s-level research assistant) to measure interpersonal functioning in six areas: work, social, family of origin, sexual, partner, and parent. Rater reliability for this interview measure was assessed during the project using the ICC (2, 1) with six raters and 12 patients. The ICCs were .88 for work, .91 for social adjustment, .83 for family of origin, .95 for sexual adjustment, .94 for partner, and .94 for parent. This represents a mean reliability of .91 and a range of .83-.95.

For psychiatric symptomatology, depression was assessed by the 13-item short form (Beck & Beck, 1972) of the Beck Depression Inventory (Beck & Steer, 1987); anxiety, by the 20-item Trait Anxiety Scale (Spielberger, 1983); and general symptomatic distress, by the Global Severity Index of the 90-item Symptom Distress Checklist—Revised (SCL–90–R; Derogatis, 1977). Self-esteem was measured by Rosenberg’s (1979) 10-item Self-Esteem Scale. Life satisfaction was measured by a single item rated on a 7-point Likert-type scale from 1 (completely dissatisfied) to 7 (completely satisfied). The 40-item Defensive Style Questionnaire (Andrews, Singh, & Bond, 1993) was used to measure the patient’s report of derivatives of defensive mechanisms. For this recently developed questionnaire, Andrews et al. reported moderate to high internal consistency (Cronbach’s alphas = .58-.80) and high test–retest reliability (range = .75-.85) for the three subscales. In the present study, a principal components analysis with orthogonal rotation of the three subscales revealed two factors, which represented use of mature defenses and maladaptive defenses. Individualized target objectives were formulated by the patient with the assistance of an independent assessor (bachelor’s-level research assistant). The patient’s average rating and the assessor’s average rating of severity of disturbance for the objectives were used as outcome scores. A rater reliability determination for the assessor’s rating, using five raters and 15 cases, yielded an ICC (2, 1) of .99, indicating high reliability.

Outcome Variables

Assessment included nine measures (questionnaire or interview) that covered 16 variables in the areas of interpersonal distress and functioning, psychiatric symptomatology, self-esteem, life satisfaction, and use of defenses. Severity of disturbance associated with individualized target objectives was also assessed.

The overall score from the 64-item Inventory of Interpersonal Problems was used as the predictor score. A rater reliability determination for the assessor’s rating, using five raters and 15 cases, yielded an ICC (2, 1) of .99, indicating high reliability.
disturbance variables was examined. Second, dropouts were examined. Third, change over the course of therapy on outcome variables for all completers and for completers in each form of therapy was investigated and compared. Because multivariate analyses of variance (MANOVAs) and multivariate analyses of covariance (MANCOVAs) require complete data, three of the interpersonal functioning outcome variables (work, partner, and parent) that were applicable to only part of the sample were deleted to avoid analyses based on a small, unrepresentative sample. A total of 130 patients (64 interpretive and 66 supportive) had complete data for the remaining 13 outcome variables.

Fourth, the interaction of each of the two predictor variables (QOR and PM) and form of therapy on outcome was examined.

**Similarity Between Interpretive and Supportive Therapy Samples**

There were no significant (p < .05) differences between the two samples on the primary matching variables QOR (original interviewer's score and average of two raters' scores), PM (Scenario 1 and 2 scores), and use of medication (initial use and pattern of use during treatment). No significant differences were found for the demographic variables age, gender, educational status, employment status, marital status, race, previous psychiatric treatment, and previous psychiatric hospitalization. Similarly, no significant differences were found for presence of the following diagnostic categories: Axis I, Axis II, Axis I and Axis II, Current Mood, Current Anxiety, and Adjustment. Initial disturbance was investigated by examining the pretherapy scores for the 13 outcome variables, which are listed in Table 1. A one-way (interpretive vs. supportive therapy) MANOVA on the pretherapy scores for the 13 outcome variables was significant, $F(13, 116) = 2.63, p < .003$. However, inspection of the means for both therapies revealed that the interpretive therapy patients were more disturbed on 5 of the variables and the supportive therapy patients were more disturbed on 8 of the variables. Corresponding univariate, one-way analyses of variance (ANOVAs) yielded two significant differences. Supportive therapy patients were initially more disturbed in the areas of social functioning, $F(1, 128) = 7.64, p = .007$, and sexual functioning, $F(1, 128) = 6.26, p = .014$. Considering the entire set of matching, demographic, diagnostic, and initial-disturbance variables, the two patient samples were well balanced.

**Dropouts**

Of the 27 dropouts, 22 (81.5%) were from interpretive therapy and 5 (18.5%) were from supportive therapy. This represents 23.4% of the patients who started interpretive therapy and 6.3% of the patients who started supportive therapy. The difference in dropouts between the two therapies was significant, $X^2(1, N = 171) = 7.88, p < .006$. Additional analyses revealed no significant relationship between either QOR or PM and dropping out. Also, no significant interaction was found between either QOR or PM and form of therapy. Additional analyses (t test, chi-square analysis, and MANOVA) were conducted to determine whether all dropouts differed from all completers on demographic and initial-disturbance variables and whether interpretive therapy dropouts differed from interpretive therapy completers on QOR, PM, demographic variables, and initial-disturbance variables. None of the tests were significant. Most dropouts (73% of interpretive therapy dropouts and 80% of supportive therapy dropouts) left during the first third of therapy. Unfortunately, in regard to reassessment of the dropouts

**Table 1**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Interpretive therapy</th>
<th>Supportive therapy</th>
<th>Effect size</th>
<th>Interpretive therapy</th>
<th>Supportive therapy</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretherapy</td>
<td>Posttherapy</td>
<td></td>
<td>Pretherapy</td>
<td>Posttherapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>M        SD</td>
<td>M        SD</td>
<td>n</td>
<td>M        SD</td>
<td>M        SD</td>
<td>n</td>
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<tr>
<td>Interpersonal distress</td>
<td>1.40     0.56</td>
<td>1.21     0.58</td>
<td>69</td>
<td>0.34     0.54</td>
<td>1.13     0.63</td>
<td>70</td>
</tr>
<tr>
<td>Social functioning</td>
<td>4.3      1.3</td>
<td>3.9      1.3</td>
<td>67</td>
<td>0.34     1.6</td>
<td>4.2      1.4</td>
<td>70</td>
</tr>
<tr>
<td>Family functioning</td>
<td>4.2      1.4</td>
<td>3.8      1.4</td>
<td>67</td>
<td>0.34     1.1</td>
<td>3.8      1.2</td>
<td>70</td>
</tr>
<tr>
<td>Sexual functioning</td>
<td>4.2      2.1</td>
<td>3.6      2.0</td>
<td>67</td>
<td>0.26     2.1</td>
<td>4.6      2.3</td>
<td>70</td>
</tr>
<tr>
<td>Depression*</td>
<td>19.8     11.7</td>
<td>11.1     10.0</td>
<td>69</td>
<td>0.74     17.3</td>
<td>8.5      8.7</td>
<td>70</td>
</tr>
<tr>
<td>Anxiety</td>
<td>52.3     9.9</td>
<td>45.4     10.1</td>
<td>69</td>
<td>0.70     52.7</td>
<td>11.4     70</td>
<td>1.03</td>
</tr>
<tr>
<td>General symptomatic</td>
<td>1.14     0.59</td>
<td>0.72     0.55</td>
<td>69</td>
<td>0.71     1.13</td>
<td>0.64     0.56</td>
<td>70</td>
</tr>
<tr>
<td>distress</td>
<td>3.7      2.0</td>
<td>2.5      1.9</td>
<td>69</td>
<td>0.59     3.8</td>
<td>2.0      1.9</td>
<td>70</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>3.1      1.2</td>
<td>4.3      1.2</td>
<td>67</td>
<td>0.96     3.2</td>
<td>1.1      1.3</td>
<td>68</td>
</tr>
<tr>
<td>Life satisfaction*</td>
<td>4.8      1.2</td>
<td>5.3      1.2</td>
<td>69</td>
<td>0.40     4.5</td>
<td>1.1      1.2</td>
<td>69</td>
</tr>
<tr>
<td>Maladaptive defenses</td>
<td>4.2      0.9</td>
<td>4.1      1.0</td>
<td>69</td>
<td>0.14     4.4</td>
<td>0.8      0.9</td>
<td>69</td>
</tr>
<tr>
<td>Target severity (patient)</td>
<td>3.9       0.6</td>
<td>2.5       0.6</td>
<td>68</td>
<td>2.31     3.8</td>
<td>0.7      2.5</td>
<td>1.1</td>
</tr>
<tr>
<td>Target severity (assessor)</td>
<td>3.7       0.6</td>
<td>2.3       1.1</td>
<td>67</td>
<td>2.15     3.7</td>
<td>0.7      2.2</td>
<td>1.1</td>
</tr>
</tbody>
</table>

*a Prorated to approximate a 21-item inventory score.  
b High scores are favorable.
on the outcome variables, compliance was poor, with only 5 dropouts providing complete data.

Change Over the Course of Therapy

Statistical significance. A one-way (pretherapy vs. posttherapy) MANOVA on the 13 outcome variables for all patients was significant, $F(13, 117) = 29.44, p < .001$. All 13 univariate $F$ tests were also significant at $p = .009$. Similarly, both the one-way MANOVA for interpretive therapy patients, $F(13, 51) = 13.18, p < .001$, and the one-way MANOVA for supportive therapy patients, $F(13, 53) = 19.59, p < .001$, were significant. For interpretive therapy, 11 of the 13 univariate $F$ tests were significant ($p = .017$). Only the $F$ tests for sexual functioning and maladaptive defenses were nonsignificant. For supportive therapy, 12 of the 13 univariate $F$ tests were significant ($p = .005$). Only the $F$ test for sexual functioning was nonsignificant. All significant tests indicated favorable change. To compare the change for the two therapies, a one-way (interpretive vs. supportive) MANOVA on the residual gain scores (pretherapy vs. posttherapy) of the 13 outcome variables was conducted. The multivariate $F$ test indicated no significant difference between the two therapies. Thus, the analyses indicated evidence of significant improvement for both therapies, which did not differ from one another.

Magnitude of effect. Magnitude of effect was investigated by calculating an effect size for each of the 13 variables for each form of therapy according to the formula provided by Cohen (1988): $\text{Effect size} = \frac{\text{pretherapy mean} - \text{posttherapy mean}}{\text{posttherapy standard deviation}}$ (see Table 1). All indicated favorable change. For interpretive therapy, the average effect size was $.77$; for supportive therapy, the average effect size was $.90$. In general, the largest effect sizes were for the target objective severity variables, followed by the life satisfaction and symptomatology variables. The effect sizes for the interpersonal and defensive-style variables were smaller.

Clinical significance. Clinical significance was investigated using the two-part procedure (clinical cutoff criterion and reliable change index) developed by Jacobson and colleagues (Jacobson, Follette, & Revenstorf, 1984; Jacobson & Revenstorf, 1988; Jacobson & Traux, 1991) and refined by others (Christensen & Mendoza, 1986; Tingey, Lambert, Burlingame & Hansen, 1996). According to the first part, a patient must move from a dysfunctional range to a functional range on an outcome variable. According to the second part, a patient must change by a reliable amount, taking into account measurement error.

In the present study, clinical significance was investigated for each of three of the outcome variables that have considerable normative data. For the Beck Depression Inventory, Beck and Steer (1987) reported a mean of 17.5 for 99 dyshymic patients, and Nettel, Russell, Hemmings, and Gretter (1987) reported a mean of 7.2 for a large sample of college/general population participants from 12 studies. For the Trait Anxiety Scale, Spielberger (1983) reported a mean of 48.8 for 60 anxiety reaction patients and a mean of 34.8 for 451 female working adults. For the SCL-90-R global severity index, Derogatis (1977) reported a mean of 1.26 for 1,002 psychiatric outpatients and a mean of .31 for 974 nonpatients. The pretherapy means of the interpretive and supportive therapy patients for the three outcome variables (see Table 1) confirmed the clinical nature of our sample.

With Jacobson and Revenstorf’s (1988) formula, the clinical cutoff criteria were 12.1 for the Beck Depression Inventory, 40.1 for the Trait Anxiety Scale, and 61 for the SCL-90-R. Only patients whose pretherapy scores were above the criteria were considered. The numbers of such patients were similar between the two therapy conditions. For interpretive and supportive therapy, respectively, there were 52 and 45 patients for the Beck Depression Inventory, 60 and 60 patients for the Trait Anxiety Scale, and 55 and 56 patients for the SCL-90-R. In the case of interpretive therapy, the percentages of patients who traversed the criteria were 53.8%, 28.3%, and 57.2%, respectively. With the exception of the percentage for anxiety, which was lower, these figures are similar to those reported in our previous controlled trial of interpretive therapy (Piper, Azim, McCallum, & Joyce, 1990). (In that study, the percentages were 57%, 52%, and 56%, respectively.) In the case of supportive therapy, the percentages of patients who traversed the criteria were 55.6%, 48.3%, and 53.6%, respectively. Chi-square analysis revealed that the number of patients who traversed the cutoff criterion for anxiety was significantly higher for supportive therapy than for interpretive therapy, $x^2(1, N = 120) = 4.27, p < .04$.

According to the modified formula of Jacobson and Revenstorf (1988), as reported in Tingey et al. (1996), the reliable-change indices were 8.7 for the Beck Depression Inventory, 11.0 for the Trait Anxiety Scale, and .55 for the SCL-90-R. The percentages of interpretive therapy patients who achieved reliable change were 53.6%, 34.8%, and 37.7%, respectively. The percentages of supportive therapy patients who achieved reliable change were 45.7%, 38.6%, and 45.7%, respectively. There were no significant differences between the two therapies in the number of patients who achieved reliable change for these outcome variables.

Finally, the percentage of patients who both traversed the clinical cutoff criteria and achieved reliable change was calculated. In the case of interpretive therapy, the percentages were 46.2%, 20.0%, and 36.4%, respectively, for the Beck Depression Inventory, Trait Anxiety Scale, and SCL-90-R. In the case of supportive therapy, the percentages were 48.9%, 31.7%, and 41.1%, respectively. There were no significant differences between the two therapies in the number of patients who met both conditions.

QOR and Form of Therapy

To investigate the interaction of QOR and form of therapy, we conducted a MANCOVA on the residual gain scores of the 13 outcome variables. Form of therapy (interpretive vs. supportive) was the independent variable, and QOR (a continuous variable) was the covariate. Using the SPSS program (Norusis, 1993), the MANCOVA determines an effect for the independent variable, an effect for the covariate, and an effect for the interaction between the independent variable and the covariate. Of the three, only the interaction effect was significant, $F(13, 114) = 2.18, p < .015$. Five of the corresponding univariate interaction effects were significant. These included sexual functioning, $F(1, 126) = 7.92, p < .006$; anxiety, $F(1, 126) = 4.32, p < .040$; self-esteem, $F(1, 126) = 5.19, p < .024$; life satisfaction, $F(1,
PM and Form of Therapy

The PM scores from Scenarios 1 and 2 were analyzed separately. A MANCOVA on the residual gain scores was conducted for each. For Scenario 1, there were no significant effects. For Scenario 2, only the main effect for PM was significant, $F(13, 115) = 7.43, p < .007$; sexual functioning, $F(1, 127) = 5.02, p < .027$; general symptomatic distress, $F(1, 127) = 8.06, p < .005$; and life satisfaction, $F(1, 127) = 5.11, p < .025$. Table 3 presents the Pearson correlation coefficients between PM (Scenario 2) and the outcome variables. One significant relationship between PM and favorable outcome was found for interpretive therapy patients, three for supportive therapy patients, and six for all patients.

Discussion

Similar patient samples were treated with one of two forms of time-limited, short-term individual therapy. The interpretive and supportive therapies were differentiated according to the impressions of patients, therapists, and external observers. At posttreatment, patients in both therapies experienced substantial improvement on a range of outcome variables, as evidenced by criteria of statistical significance, magnitude of effect, and clinical significance. The greatest improvements involved target objectives, life satisfaction, and symptomatology. Less improvement occurred for interpersonal distress, interpersonal functioning, and defensive style. The latter variables may be more resistant to change in short-term therapy, which is consistent with the findings of our previous controlled trial of individual interpretive therapy (Piper et al., 1990).

In terms of statistical significance, patients in supportive therapy did not differ from patients in interpretive therapy on overall improvement. In terms of magnitude of effect, the mean effect size for supportive therapy was a little higher but essentially similar to the mean for interpretive therapy. In terms of clinical significance, more supportive therapy patients than interpretive therapy patients met the clinical cutoff criterion for anxiety. The emphasis in supportive therapy on minimizing anxiety during the sessions may have resulted in a report of less anxiety after therapy ended. However, supportive therapy was not superior to interpretive therapy in achieving reliable change or the combination of the clinical cutoff criterion and reliable change for anxiety. In addition, there were no substantial differences on the criteria of clinical significance for depression or general symptomatic distress. In general, the benefits associated with the two therapies were similar. The results suggest that when treatment is carried out by experienced therapists who follow a treatment manual, time-limited supportive therapy can be as efficacious as time-limited interpretive therapy. The findings are consistent with recent claims regarding the usefulness of supportive therapy. However, controlled trials of supportive therapy are required before more definitive conclusions regarding its efficacy can be made.

Table 2

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<th>Variable</th>
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<th>Supportive therapy patients (n = 66)</th>
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*p < .05. **p < .01. ***p < .001.

Table 3

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* High scores are favorable.
PRETENSIONS ABOUT SENSITIVE TOPICS, INCLUDING TRANSFERENCE, WERE TO SUPPORTIVE THERAPY, THE INTERPRETIVE THERAPY SITUATION WAS MORE USUALLY LOW. THE DIFFERENCE IN DROPOUT RATES MAY REFLECT SOME OF THE SALIENT DIFFERENCES IN THE TWO THERAPY SITUATIONS. RELATIVE TO SUPPORTIVE THERAPY, THE INTERPRETIVE THERAPY SITUATION WAS MORE DEMANDING, DEPRIVING, AND ANXIETY-ARousing. THE PATIENT WAS EXPECTED TO BEGIN EACH SESSION AND ASSUME RESPONSIBILITY FOR WHAT FOLLOWED. THERE WAS ONGOING PRESSURE FOR THE PATIENT TO TALK, AND THE THERAPIST ABSTAINED FROM PROVIDING DIRECT GRATIFICATION OR PRAISE. THE THERAPIST ENCOURAGED THE PATIENT TO EXPLORE CONFLICTS, WHICH OFTEN INVOLVED UNCOMFORTABLE EMOTIONS. INTERPRETATIONS ABOUT SENSITIVE TOPICS, INCLUDING TRANSFERENCE, WERE OFTEN MADE. THESE FEATURES OF THE INTERPRETIVE SITUATION MAY HAVE CREATED TENSION THAT EXCEEDED THE THRESHOLD OF TOLERANCE FOR DROPOUTS, PARTICULARLY AT THE BEGINNING OF THERAPY, WHEN MOST DROPOUTS OCCURRED. LESS STRICT ADHERENCE TO INTERPRETIVE FEATURES BY THE THERAPIST AND GREATER PROVISION OF SUPPORTIVE FEATURES MIGHT HAVE RESULTED IN FEWER DROPOUTS IN INTERPRETIVE THERAPY. THE OPTIMAL MIX OF INTERPRETIVE AND SUPPORTIVE FEATURES REMAINS A TOPIC FOR FUTURE INVESTIGATION.

REGARDLESS OF THE EXPLANATION, THE LOW DROPOUT RATE FOR SUPPORTIVE THERAPY IS A DEFINITE ADVANTAGE. PREMATURE TERMINATION CONSTITUTES A SELECTION FAILURE AND USUALLY REPRESENTS A WASTE OF TIME AND EFFORT FOR BOTH PATIENT AND THERAPIST. IT IS OFTEN ACCOMPANIED BY NEGATIVE AFFECT FOR BOTH PARTIES. IF A SENSE OF FAILURE CONCERNING PREMATURE TERMINATION CAN BE AVOIDED, IT SHOULD BE. THE DROPOUT FINDING SUGGESTS THAT SUPPORTIVE THERAPY MAY BE MORE BROADLY APPLICABLE TO AN OUTPATIENT POPULATION THAN INTERPRETIVE THERAPY.

THE FINDING OF SIGNIFICANT IMPROVEMENT FOR EACH THERAPY BUT NONSIGNIFICANT DIFFERENCES BETWEEN THE TWO THERAPIES IS A FAMILIAR GENERAL FINDING IN THE PSYCHOTHERAPY LITERATURE. EXPLANATIONS OFTEN REFER TO BENEFICIAL COMMON FACTORS, SUCH AS THE PRESENCE OF A HELPING RELATIONSHIP, A CONVINCING RATIONALE, AND FEEDBACK CONCERNING PROGRESS, WHICH ARE BELIEVED TO INCREASE MORALE, A SENSE OF MASTERY, AND POSITIVE EXPECTATIONS. COMMON-FACTOR EXPLANATIONS ARE CERTAINLY PLAUSIBLE IN THE PRESENT STUDY. HOWEVER, WE ALSO WISHED TO INVESTIGATE THE POSSIBLE UNIQUE EFFECTS OF THEORETICALLY RELEVANT, PATIENT PERSONALITY VARIABLES SUCH AS QOR AND PM. SUCH EFFECTS MAY BE OVERLOOKED IF ONE CONSIDERS ONLY AVERAGED FINDINGS.

A SIGNIFICANT INTERACTION EFFECT WAS FOUND FOR QOR AND FORM OF THERAPY. THE PATTERN INDICATED A DIRECT RELATIONSHIP BETWEEN QOR AND IMPROVEMENT IN INTERPRETIVE THERAPY, WHICH REPLICATED THE FINDING FROM OUR PREVIOUS CONTROLLED TRIAL OF INTERPRETIVE THERAPY, AND ALMOST NO RELATIONSHIP BETWEEN QOR AND OUTCOME IN SUPPORTIVE THERAPY. WE BELIEVE THAT THE INTERACTION EFFECT CAN ALSO BE UNDERSTOOD BY CONSIDERING THE DIFFERENCES BETWEEN THE TWO THERAPY SITUATIONS.


A SIGNIFICANT DIRECT RELATIONSHIP BETWEEN PM AND OUTCOME WAS FOUND FOR THE COMBINED INTERPRETIVE AND SUPPORTIVE THERAPY SAMPLES. THE RELATIONSHIP FOR INTERPRETIVE THERAPY HAD BEEN PREDICTED BECAUSE OF THE ASSUMED USEFULNESS OF PM TO UNDERSTANDING AND WORKING WITH INTERPRETATIONS. THE RELATIONSHIP FOR SUPPORTIVE THERAPY HAD NOT. NEVERTHELESS, SEVERAL EXPLANATIONS ARE APPARENT. IN SUPPORTIVE THERAPY, HIGH-PM PATIENTS MAY HAVE ENGAGED IN EXPLORATION OF INTERNAL CONFLICTS DURING THEIR THERAPY SESSIONS OR OUTSIDE OF THEIR SESSIONS, DESPITE THE FACT THAT THEIR THERAPISTS DID NOT FACILITATE IT. ALTERNATIVELY, PM MAY REFLECT A USEFUL GENERAL ABILITY TO ANALYZE CONFLICTS AND SOLVE PROBLEMS, WHETHER THE CONFLICTS ARE INTERNAL OR EXTERNAL. Thus, PM MAY BE OF VALUE TO A VARIETY OF INDIVIDUAL THERAPIES, EVEN THOSE OF DIFFERENT THEORETICAL AND TECHNICAL ORIENTATIONS (E.G., COGNITIVE–BEHAVIORAL THERAPY).

INTEGRATING THE QOR AND PM FINDINGS, SUCCESS IN THERAPY MAY BE FACILITATED BY TWO FACTORS, A POSITIVE PATIENT–THERAPIST RELATIONSHIP AND A PROCESS OF PSYCHODYNAMIC WORK. BOTH THE PATIENT AND THERAPIST CONTRIBUTE TO THESE FACTORS. IN INTERPRETIVE THERAPY, WHERE THE THERAPIST ACTIVELY STIMULATES PSYCHODYNAMIC WORK THROUGH INTERPRETATIONS, IT MAY BE PARTICULARLY BENEFICIAL IF THE PATIENT BRINGS IN A STRONG POTENTIAL (HIGH QOR) TO FORM A POSITIVE RELATIONSHIP. HIGH PM MAY ALSO BE USEFUL, THOUGH NOT AS IMPORTANT AS HIGH QOR. IN SUPPORTIVE THERAPY, WHERE THE THERAPIST ACTIVELY CREATES A POSITIVE RELATIONSHIP, IT MAY BE PARTICULARLY BENEFICIAL IF THE PATIENT BRINGS IN A STRONG POTENTIAL (HIGH PM) TO FOCUS ON COMPONENTS OF INTERNAL CONFLICT WITH PAST, CURRENT, AND IMMEDIATE FIGURES. THE MATCH BETWEEN PARTICULAR PATIENT CHARACTERISTICS AND FORM OF THERAPY APPEARS TO BE IMPORTANT. IN THE CURRENT STUDY, THE MATCH WAS BETWEEN PATIENT PERSONALITY DIMENSIONS AND FORM OF THERAPY. THIS IS SOMETHING DIFFERENT THAN THE MORE COMMON SEARCH IN THE FIELD FOR DIFFERENT TREATMENTS FOR DIFFERENT DISORDERS.

IF INTERPRETIVE THERAPY IS PROVIDED, THE CURRENT FINDINGS SUGGEST THAT THE THERAPIST SHOULD BE ATTENTIVE TO EARLY SIGNS OF DIFFICULTIES IN THE THERAPY PROCESS AND BE PREPARED TO DEAL WITH THEM PROMPTLY IN AN EFFORT TO AVOID PREMATURE TERMINATION. THE FINDINGS ALSO INDICATE THAT IMPROVEMENT CAN BE ENHANCED BY SELECTING PATIENTS WITH HIGHER QOR SCORES. THE MORE DEMANDING NATURE OF THE THERAPY PROCESS MAY BE AN IMPEDIMENT TO PATIENTS WITH A LONG-TERM HISTORY OF PROBLEMATIC RELATIONSHIPS. THE FINDINGS FURTHER SUGGEST THAT IMPROVEMENT CAN BE ENHANCED FOR EITHER THERAPY BY SELECTING PATIENTS WITH HIGHER PM SCORES. PM APPEARS TO HAVE A BENEFICIAL EFFECT REGARDLESS OF THE NATURE OF THE CONFLICTS AND DIFFICULTIES BEING EXPLORED IN THERAPY. AS TO TIME, THE ASSESSMENT OF PM IS CLEARLY MORE EFFICIENT THAN THE ASSESSMENT OF QOR. HOWEVER, IT MAY BE POSSIBLE TO INTEGRATE THE ASSESSMENT OF QOR WITH ROUTINE CLINICAL PROCEDURES, SUCH AS HISTORY TAKING.

LIMITATIONS ASSOCIATED WITH THE PRESENT REPORT CONCERN A NUMBER OF ISSUES. FIRST, TWO CAVEATS CONCERNING THE DESIGN OF THE
study are important. Because the design did not include a no-treatment or placebo control condition, the findings do not address the basic efficacy question concerning each of the two forms of therapy. Although some controlled studies have provided support for the efficacy of interpretive forms of short-term psychodynamic therapy (Anderson & Lambert, 1995), there are almost no controlled studies of supportive therapy (Piper, 1996). Also, because the design did not include a randomized medication or combination of medication and psychotherapy condition, conclusions concerning the effects of medication are not possible. In addition, although the use of medication was balanced in the two therapy conditions, the improvement that was achieved may have been enhanced by the approximately 42% of patients in each condition who additionally were prescribed psychotropic medication.

Second, characteristics of the patients, therapists, and technique may limit the extent to which the findings can be generalized. The patients were fairly well educated and primarily Caucasian. In addition, they represented a subset of all patients assessed at the outpatient clinic, that is, those who were regarded as suitable for some form of weekly, psychodynamic psychotherapy. The therapists were experienced in providing forms of interpretive and supportive therapy. The therapies were time limited and manual guided. Third, the PM findings involved only Scenario 2. Reasons for the low correlation between Scenarios 1 and 2 and the absence of significant findings for Scenario 1 are not apparent. In our previous day treatment trial that involved the group treatment of somewhat lower functioning patients (Piper et al., 1994), Scenario 1 was a stronger predictor than Scenario 2. We suspect that the higher functioning individual therapy patients of the present study identified more with the patient portrayed in Scenario 2, but this remains a speculation.

Fourth, the present report focuses primarily on outcome findings. It does not emphasize the assessment and analysis of process variables, such as the patient-therapist relationship (therapeutic alliance) or the extent of patient work, which might reveal mechanisms that underlie the outcome findings. That remains a task for future investigation. Finally, the outcome findings extend only to the end of therapy. Whether the follow-up findings will be similar remains to be determined.

References


Received March 7, 1997
Revision received August 13, 1997
Accepted September 25, 1997