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WHY WE RECOMMEND ANALYTIC TREATMENT FOR SOME PATIENTS AND NOT FOR OTHERS

One hundred consecutive patients applying for analysis completed a comprehensive battery of structured interviews and self-report questionnaires assessing dimensions of psychopathology and psychological functions that analysts consider important when evaluating patients for analysis. Patients were evaluated for analysis by a candidate supervised by a training analyst. Fifty patients were accepted for analysis and fifty rejected. In both groups, psychiatric morbidity and psychosocial impairment were high, with a 50% current and 74% lifetime diagnosis of mood disorder, 56% current and 61% lifetime history of anxiety disorder. The mean Beck Depression Inventory score fell in the moderate range, 19.1 (*SD* = 11.0), mean Hamilton Depression score in the mild range, 14.1 (*SD* = 7.8), and the mean Hamilton Anxiety score in the moderate range, 14.6 (*SD* = 8.1), with 57% meeting criteria for an Axis II diagnosis, and mean social adjustment in the moderate to high pathology range. Patients accepted and rejected for analysis did not differ with regard to any of these dimensions. Accepted patients scored lower on measures of impulsivity, aggression, and sociopathy, and on scores of personality rigidity, primitive defenses, and outward aggression. The major finding was the striking similarity between patients accepted and rejected for psychoanalytic treatment.

Why psychoanalysts recommend psychoanalytic treatment for some patients and not for others is a topic long discussed and little researched. Some believe the decision should be based on diagnosis—for instance, that higher-level personality disorders should be treated with

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analysis, whereas severe personality disorders, substance abuse, or sociopathy should not (Kernberg 1999). Others believe referral for analysis depends not on diagnosis but on the presence of particular psychological functions, for example, ego strength or psychological mindedness (Galatzer-Levy et al. 2000; Wallerstein 1994). Yet another group suggest that it is not possible to predict who will engage and benefit from psychoanalysis, and therefore recommend a "trial of analysis" for all who are willing (Rothstein 1994).

Implicit in the concept of "selection" of patients for analysis is the belief that there are variables in patients that predict a positive outcome in psychoanalytic treatment. These predictors would be considered treatment "moderators." A moderator is a factor that suggests on whom or under what conditions a treatment produces its effect (Baron and Kenny 1986). Moderators are variables that precede the initiation of treatment—that is, they are baseline variables. For example, variables that may (or may not) be moderators of outcome in analytic treatment include the patient's age, gender, DSM-IV diagnosis, personality organization, quality of object relations, and/or psychological mindedness. Other potential moderators, not patient-based, include the treatment setting (clinic, private practice), mode of referral, the therapist's experience level and training. Moderators are distinguished from mediators, which are variables that mediate the effect of treatment on outcome (Baron and Kenny1986). In contrast to moderators, which precede treatment, mediators are variables in its implementation. For example, frequency of sessions, the use of transference interpretation, expression of empathy, and the therapeutic alliance between patient and analyst are all potential mediators of outcome in analytic treatment.

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When an analyst evaluates a patient and recommends analysis, we infer that the analyst is basing this determination on presumed moderators of positive outcome—indicators that this type of person with this type of problem will do well in analysis. However, there is a paucity of empirical data to support this approach. Several large-scale studies (Wallerstein 2000; Bachrach 1993; Erle 1979; Kantrowitz 1993) have retrospectively looked at predictors of outcome and found that baseline variables proved to be poor predictors of outcome. Nonetheless, it appears that this approach is used by most analysts in clinical practice, and therefore merits further study.

Our study began with the assumption that patient selection reflects a belief regarding who will and who will not do well in analytic treatment, and that this belief is based on the assessment of moderators that the analyst makes during the evaluation. We reasoned that while some of these putative moderators are likely to be fully articulated in the mind of the analyst and explicitly evaluated during clinical assessment, others might be further from the analyst's conscious conceptualization and not part of a list of explicit criteria that he or she uses for selection. We concluded that by beginning with a population of patients seeking treatment, and then comparing patients recommended for analysis with those referred for other forms of treatment, we could identify the moderators that analysts believe predict outcome in psychoanalysis. To do this we assessed patients using standardized assessment instruments with established psychometric properties and compared the results in patients who were accepted for analysis with those in patients rejected by a subsequent clinical evaluation uninformed by our results. Before beginning this project, the research team agreed on the following hypotheses:

1. There will be no differences between patients accepted and patients rejected for analysis in the rate of DSM-IV Axis I mood and anxiety disorders and/or symptoms of anxiety and depression.

2. The rate of diagnosis of schizotypal, schizoid, paranoid, borderline, narcissistic, and antisocial personality disorder will differ between the accepted and the rejected groups.

3. Patients rejected for analysis will display more pathology on the personality dimensions of identity formation, defensive operations, personality rigidity, quality of object relations, ethical functioning, and aggression compared with patients accepted for analysis.

4. Patients rejected for analysis will have higher scores on impulsivity, aggression, and sociopathic traits compared with patients accepted for analysis.

5. Patients rejected for analysis will have poorer social adjustment compared with patients accepted for analysis.

METHOD

Measures

We constructed a comprehensive battery of measures that assess dimensions of psychopathology and psychological functions that analysts reported to us they consider important when evaluating patients for analysis. This battery of self-report measures and structured interviews assesses psychiatric diagnosis, symptom severity, descriptive personality pathology, identity consolidation, quality of object relations, impulsivity, general level of functioning including work, leisure, and interpersonal relationships, capacity for self-reflection, and ego rigidity. Though we made an effort to construct a comprehensive assessment battery that covered a broad range of patient characteristics, we recognized that the battery might nevertheless fail to include variables that significantly influence the decision to accept or reject a patient for analysis. Therefore, we also collected data directly from both the candidate and the supervisor who made the decision to determine the reasons they recommended or did not recommend analysis. To do this we developed a 34-item Clinician Rating Form (CRF; see Appendix A), which was filled out by candidates and supervisors after completing the clinical evaluation. The CRF asks the clinicians to rate their assessment of the patient across many of the same dimensions of psychopathology measured in the standardized assessment battery. The CRF also includes ratings of the subjective aspects of the interaction (e.g., did the candidate like the patient?) and practical matters such as the patient's ability to pay for treatment. Diagnostic items were scored on a present/not-present basis (e.g., for DSM personality disorder); all other items were scored on a Likert scale, from 1 to 5, with lower numbers indicating greater difficulty (e.g., more anxiety, less "likable").

A research assistant performed the Structured Clinical Interview for DSM-IV-TR Axis I Disorders (SCID-I), the Hamilton Rating Scale for Depression (HRSD), and the Hamilton Anxiety Scale (Ham-A) interviews. Patients were also seen by a clinical psychologist trained to administer the Structured Interview of Personality Organization (STIPO). In addition, patients completed a battery of self-report instruments comprising the Beck Depression Inventory (BDI), the Spielberg State Trait Anxiety Inventory (STAI), the Social Adjustment Scale (SAS), the Schedule for

Nonadaptive and Adaptive Personality (SNAP), the Inventory of Personality Organization (IPO), the Ego Resilience Scale (ER), and Self-Understanding of Interpersonal Problems (SUIP). (Appendix B describes these instruments.)

Procedures

This study ran from October 2002 to November 2007, and includes all patients evaluated for analysis in the psychoanalytic clinic of the Columbia Center for Psychoanalytic Training and Research during that period. The standard procedure at Columbia is that applications for analysis are reviewed by the clinic director (MH); patients who are psychotic, suicidal, or dependent on drugs or alcohol are triaged to appropriate clinical settings. All others are referred for clinical evaluation. Candidates meet with patients for three to six evaluation sessions, with the evaluation process supervised by a training and supervising analyst. At the end of the evaluation, candidate and supervisor come to a decision about whether to recommend analysis. This procedure was not changed for purposes of this study.

After triaging, but before the clinical evaluation, informed consent was obtained and the assessment battery performed. The decision to accept or reject the patient for analysis was made solely on the basis of the clinical evaluation; the results of the research battery were kept separate from the patient's clinical file and were not available to the evaluation team. After the evaluation process was finished, the clinic director distributed the Clinician Rating Form to the evaluating candidate and supervisor. All patients signed informed consent, and the study was approved by the New York State Psychiatric Institute IRB (#5420R).

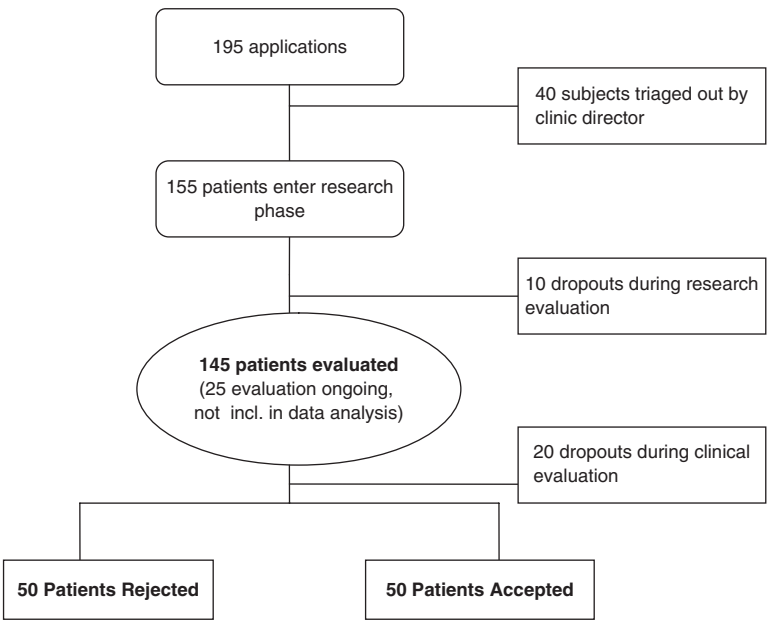
Statistical Analysis

Differences between the accepted for psychoanalysis group and the not accepted group were compared using chi-square tests of independence for categorical variables and two-tailed *t* tests for continuous variables. All tests were evaluated for statistical significance at the $p < .05$ level.

RESULTS

We planned to analyze the data once a hundred patients had completed both the research and the clinical evaluation phases of the study. From October 2002 to November 2007, 195 applications for analysis were received, 40 applicants were triaged and not evaluated, 10 dropped out before completing the research evaluation, 145 patients completed the

Figure 1. Sample Selection



research evaluation, and 20 patients dropped out during the clinical evaluation process (see Figure 1). The dropout rate during the research and clinical evaluations combined, 21%, was not significantly different from the rate of evaluation dropout in the five years prior to instituting the research battery in the clinic. There were 25 cases in the evaluation process at the time of data analysis, and they are not included in this report. Fifty patients were accepted for analysis, and 50 were rejected.

Descriptive Statistics

Fifty-seven percent of the sample was female, and the mean age was 33.1 years (SD = 8.8). Eighty percent of the patients had been in psychotherapy before, 62% had previously taken a psychotropic medication, and 27% were currently on psychotropic medication, predominantly antidepressants. Accepted patients did not significantly differ from rejected patients with regard to number or duration of previous treatments, current medication, or medication history. Fourteen percent of patients met criteria for a current substance use disorder, defined as abuse or dependence within one month of their evaluation. Twenty-five

percent of all patients met criteria for a substance use disorder at some point in their lives. The most common substance abused was alcohol (16% of all patients, current or past history), followed by marijuana (10%), cocaine (3%), and hallucinogens/PCP (1%). There were no significant differences between accepted patients and rejected patients regarding the presence of a current substance use disorder or a history of one.

Hypothesis Testing

Fifty percent of the patients met criteria for a current mood disorder (Major Depressive Disorder or Dysthymic Disorder), 74% had a lifetime history of mood disorder, 56% met criteria for a current anxiety disorder (Generalized Anxiety Disorder, Social Phobia, or Panic Disorder), and 61% had a lifetime history of anxiety disorder. Forty percent of depressed patients had HRSD scores equal to or greater than 18, which is often the cutoff for entry into antidepressant clinical trials and corresponds with symptoms in the moderate range. Five percent of patients had HRSD scores falling in the severe range of 27 or greater. The mean BDI score fell in the moderate range, 19.1 (SD = 11.0), as did the mean Ham-A score, 14.6 (SD = 8.1).There were no significant differences between the patients accepted for analysis and those rejected across any diagnostic or symptom dimensions measured by SCID, Ham-A, HRSD, BDI, or STAI (see Table 1).

According to the Schedule for Nonadaptive and Adaptive Personality (SNAP), 57% percent of the patients met criteria for a DSM-IV Axis II disorder. There was no significant difference between patients accepted for analysis and patients rejected with regard to frequency, type, or cluster of Axis II diagnosis (see Table 2).

The SAS measures functioning over the past two weeks in six dimensions with regard to both behavior and feelings. Mean scores for both accepted and rejected patients most often fell between scores of a normal community sample and an acute depressive sample as observed by Weissman et al. (1978). There were no differences between accepted and rejected patients with regard to social adjustment.

We hypothesized that there would be differences with regard to accepted and rejected patients on the personality dimensions of identity formation, defensive operations, personality rigidity, quality of object relations, ethical functioning, and aggression. We found no such differences in the means of these dimensions between the groups on the IPO (see Table 3).

Table 1. Patient Characteristics

	Mean (*SD*)			Test		
	All pts	Accepted	Not Accepted	*T* (χ2 where noted)	*df*	*p*
	N = 100	*N* = 50	*N* = 50			
Gender	57 female (57%)	32 female (64%)	25 female (50%)	χ^2 = 2.00	1	.16
Age in years	33.1 (8.8)	30.9 (7.2)	35.2 (9.8)	**–2.50**	**98**	**< .05**
On Medication	27/100 (27%)	17/50 (34%)	10/50 (20%)	χ^2 = 2.49	1	.12
Mood Disorder						
Current	50/100 (50%)	25/50 (50%)	25/50 (50%)	χ^2 = 0	1	--
Lifetime	74/100 (74%)	39/50 (78%)	35/50 (70%)	χ^2 = .832	1	.36
Anxiety Disorder						
Current	56/100 (56%)	24/50 (48%)	32/50 (64%)	χ^2 = 2.6	1	.11
Lifetime	61/100 (61%)	27/50 (54%)	34/50 (68%)	χ^2 = .36	1	.54
Personality Disorder	52/92 (57%)	25/48 (52%)	27/44 (61%)	χ^2 = .81	1	.37
Hamilton Rating Scale for Depression	14.1 (7.8)	13.3 (8.0)	14.8 (7.6)	–0.93	98	.35
Hamilton Anxiety Scale	14.6 (8.1)	14.2 (8.3)	14.9 (8.0)	–0.42	98	.68
Beck Depression Inventory	19.1 (11.0)	17.5 (10.3)	20.6 (11.5)	–1.43	98	.16
Spielberger State-Trait Anxiety Inventory	48.2 (14.5)	45.7 (14.0)	50.7 (14.6)	1.74	97	.09

In contrast to the IPO, the STIPO is a clinician-administered assessment of the same personality dimensions. Patients accepted for analysis had significantly lower mean scores on dimensions of personality rigidity, primitive defenses, outward aggression, and moral values (see Table 4). The hypothesis that patients rejected for analysis will have higher scores on impulsivity, aggression, and sociopathic traits compared with patients accepted for analysis was supported (see Tables 4 and 5).

The results of the CRF were consistent with the findings of the standardized assessment battery. Of note, candidates' ratings of the patients'

Table 2. Social Adjustment Scale (SAS-SR)

Dimension	Patient Means (*SD*)			Population Means (*SD*)[1]		*T* test for Equality of Means (Accepted vs. Rejected)			95% Confidence Interval of the Difference	
	All pts	Accepted	Not Accepted	Community Sample	Acute Depressives	*t*	*df*	*p*	Lower	Upper
***T* score** (Normalized Total)	69.6 (14.6)	67.1 (14.4)	72.3 (14.5)	50 (10.0)	76 (10.0)	−1.75	95	.08	−0.69	10.96
Work Role	2.14 (.70)	2.16 (.66)	2.13 (.75)	1.40 (.46)	2.48 (.75)	0.21	88	.84	−0.33	0.27
Social and Leisure	2.32 (.60)	2.21 (.58)	2.44 (.61)	1.83 (.52)	2.85 (.66)	−1.85	94	.07	−0.02	0.47
Extended Family	2.12 (.64)	2.03 (.60)	2.22 (.68)	1.34 (.33)	2.15 (.69)	−1.49	91	.14	−0.07	0.46
Primary Relationship	2.42 (.84)	2.20 (.65)	2.68 (.97)	1.75 (.48)	2.45 (.55)	−1.68	30	.1	−0.10	1.08
Parental Role	1.76 (.56)	1.50 (.71)	1.93 (.51)	1.40 (.42)	2.27 (.81)	−.81	3	.48	−1.27	2.13
Family Unit	2.24 (1.03)	2.02 (.99)	2.43 (1.03)	1.46 (.58)	2.83 (.89)	−1.73	71	.09	−0.06	0.88

Scores reflect mean response for questions in each dimension, ranging from 1 (no difficulty) to 5 (most difficulty).

[1] Weissman et al. (1978)

Table 3. Inventory of Personality Organization (IPO) Scores

	Mean (*SD*)			*T* test for Equality of Means			95% Confidence Interval of the Difference	
	All pts	Accepted	Not Accepted					
Dimension	*N* = 100	*N* = 50	*N* = 50	*t*	*df*	*p*	Lower	Upper
Identity Diffusion	54.1 (15.0)	53.1 (14.5)	55.2 (15.6)	–.68	98	.50	–3.92	8.04
Primitive Defenses	38.6 (10.9)	36.8 (9.8)	40.3 (11.8)	–1.61	98	.11	–0.82	7.78
Reality Testing	33.3 (11.2)	31.4 (9.4)	35.1 (12.5)	–1.68	98	.10	–0.67	8.11
Aggression	25.4 (6.8)	24.2 (5.9)	26.6 (7.6)	–1.76	98	.08	–0.31	5.07
Moral Values	21.5 (6.1)	20.7 (5.8)	22.3 (6.3)	–1.37	98	.17	–3.92	8.04

Table 4. Structured Interview for Personality Organization (STIPO)

	Mean (*SD*)			*T* test for Equality of Means			95% Confidence Interval of the Difference	
Dimension	Overall	Accepted	Not Accepted	*t*	*df*	*p*	Lower	Upper
Identity	.97 (.38)	.94 (.35)	1.00 (.41)	0.731	88	.47	–.10	.22
Primitive Defenses	.93 (.43)	.83 (.36)	1.04 (.47)	2.328	88	**.02***	.03	.38
Coping/ Rigidity	1.15 (.37)	1.03 (.30)	1.28 (.40)	3.236	88	**.002***	.09	.39
Object Relations	.92 (.38)	.86 (.36)	.98 (.39)	1.517	88	.13	–.04	.28
Moral Values	.59 (.45)	.50 (.38)	.68 (.49)	2.012	88	**.05***	.00	.37
Overall Aggression	.43 (.30)	.37 (.27)	.48 (.32)	1.695	88	.09	–.11	.32
Aggression (self-directed)	.51 (.51)	.46 (.47)	.57 (.55)	0.971	88	.33	–.02	.23
Aggression (outward)	.38 (.26)	.33 (.24)	.44 (.28)	1.951	88	**.05***	.00	.22

ability to pay higher fees and flexibility with regard to scheduling did not differ between accepted and rejected patients; patients accepted for analysis were rated by candidates as having higher intelligence, $t(92) = 4.571$,

Table 5. Schedule for Nonadaptive and Adaptive Personality (SNAP) scores

	Mean (SD)			*T* test for Equality of Means			95% Confidence Interval of the Difference	
Scale	All pts	Accepted	Rejected	*T*	*df*	*p*	Lower	Upper
Negative Temperament	16.7 (7.0)	15.5 (6.9)	18.0 (6.9)	−1.734	90	.09	−0.64	5.13
Mistrust	6.3 (5.0)	5.8 (5.2)	7.0 (4.6)	−1.143	87	.26	−0.89	3.28
Manipulativeness	5.8 (4.0)	5.3 (4.0)	6.4 (4.0)	−1.375	87	.17	−0.52	2.87
Aggression*	**4.7 (3.7)**	**3.8 (2.9)**	**5.7 (4.1)**	**−2.608**	**87**	**.01***	0.44	3.48
Self-Harm*	**6.2 (3.5)**	**5.4 (3.2)**	**7.0 (3.5)**	**−2.289**	**89**	**.02***	0.21	3.03
Eccentric Perceptions	3.6 (2.9)	3.6 (3.3)	3.6 (2.5)	−.014	88	.99	−1.23	1.24
Dependency	6.2 (3.6)	5.6 (3.0)	6.9 (4.1)	−1.660	88	.10	−0.24	2.73
Positive Temperament	13.2 (5.8)	13.6 (5.5)	12.8 (6.2)	.649	89	.52	−3.23	1.64
Exhibitionism	7.9 (4.0)	4.6 (4.1)	8.2 (4.0)	−.718	88	.48	−1.08	2.30
Entitlement	7.0 (3.7)	6.5 (3.2)	7.6 (4.1)	−1.384	87	.17	−0.49	2.65
Detachment	7.4 (4.7)	7.0 (4.5)	8.0 (4.9)	−.954	87	.34	−1.03	2.94
Disinhibition	11.1 (5.7)	10.3 (5.7)	12.0 (5.6)	−1.423	87	.16	−0.68	4.07
Impulsivity*	**6.9 (3.6)**	**6.0 (3.3)**	**7.9 (3.8)**	**−2.505**	**89**	**.01***	0.39	3.38
Propriety	8.5 (4.4)	7.9 (3.9)	9.3 (4.8)	−1.481	87	.14	−0.47	3.20
Workaholism	8.7 (4.1)	8.9 (4.0)	8.4 (4.2)	.539	90	.59	−2.18	1.25

Patients accepted for analysis scored significantly lower on the impulsivity, aggression, and antisocial traits subscales of the SNAP than did patients who were rejected.

$p < .001$; more personal appeal, $t(92) = 6.434$, $p < .001$, and as better liked by the evaluating candidate, $t(92) = 6.624$, $p < .001$, than patients who were rejected. Candidates were also explicitly asked which factors were influential in their decision to accept or reject a patient. Ninety percent of candidates viewed the patient's quality of interpersonal relationships as influential. Other items often viewed as important included structural diagnosis (83%) and level of motivation for analysis (76%), while financial issues (20%) and level of sexual inhibition (35%) were less often rated as influential. Appendix A ranks all CRF items (with sufficient response rate) from *most often* influential to *least often* influential. It should also be noted that there were items with disparate results for decision to accept versus decision to reject. Level of intelligence, for example, was often rated as an influential factor when accepting a patient

(88%), but much less often as a decisive factor in rejecting a patient (25%). Conversely, the possibility (be it high or low) of life events interrupting treatment was more often influential in a decision to reject a patient (57%) than one to accept a patient (29%).

DISCUSSION

In this well-characterized and relatively large sample of patients accepted for analytic treatment, 50% had current major depressive disorder (MDD) or dysthymia, and 56% had current anxiety disorder; 48% met criteria for a DSM-IV personality disorder, mean score on the Beck Depression Inventory fell in the mild to moderate range, and mean scores on the Social Adjustment Scale were within the moderate to high pathology range. In sum, patients accepted for analytic treatment presented with chronic and severe psychiatric morbidity and psychosocial impairment and had previously undergone psychotherapy and medication treatments; in this sample, psychoanalysis is not a treatment for the "worried well." However, the most striking finding was that the patients accepted for analysis were not significantly different from those rejected.

Consistent with the first hypothesis, the presence or absence of Axis I diagnoses and severity of symptoms did not predict acceptance. We conclude that when analysts make decisions about which patients to accept for analysis, these decisions are apparently not being made on the basis of evaluation of psychiatric diagnosis and severity of symptoms of depression or anxiety.

The small sample size makes it difficult to evaluate findings with regard to our second hypothesis. The presence of a DSM-IV Axis II personality disorder did not predict acceptance or rejection for analysis. Whether the presence of specific personality disorders (schizotypal, schizoid, paranoid, borderline, narcissistic, antisocial) predicts rejection, as we hypothesized, can be addressed only with a larger sample.

Both the third and the fourth hypotheses were supported by the results. On the SNAP, patients not accepted for analysis scored higher than accepted patients on dimensions measuring impulsivity, aggression, and antisocial behavior. The same group also scored higher on several STIPO personality dimensions, indicating more pathology on the dimensions of primitive defenses, coping/rigidity, moral values, and outward aggression. However, these differences must be considered with caution. Some of the

instruments we used measure overlapping or redundant dimensions, and without a correction for type 1 error, it is unclear whether the statistical differences are in fact of significance.

The most salient finding is that regardless of whether data were collected using structured interviews, self-report instruments, or clinicians' impressions, the patient's psychopathology and social adjustment did not influence decision making with regard to referral for analysis. Specifically, Axis I diagnosis, Axis II diagnosis, the severity of symptoms of depression and anxiety, level of social adjustment, ego resilience, self-awareness of interpersonal problems, and medication status were no different in patients accepted for analysis than in those who were rejected.

However, there may be dimensions of personality that do influence analysts' decision making when evaluating patients for analysis. Specifically, we found that the descriptive personality traits of impulsivity, aggression, and sociopathy as measured both by the SNAP self-report and the clinician-rated CRF are more prominent in patients not accepted for analysis. It is unclear whether this reflects specific beliefs on the part of analysts that patients who are impulsive, aggressive, and/or sociopathic are likely to do poorly in analysis, or whether analysts are using these personality traits as markers of more severe psychopathology. There were also statistical differences between patients accepted and those rejected for analysis on the STIPO, in particular on the dimensional assessment of personality rigidity and primitive defenses and to a lesser degree outward aggression and moral functioning. It remains to be established whether the statistical differences in the STIPO ratings of patients accepted and rejected for analysis correspond with different clinical presentations or whether they are differences without meaning. It is nonetheless worth noting that the SNAP data on impulsivity, aggression, and sociopathy are consistent with the STIPO data. The SNAP and the STIPO ask different questions, and the SNAP is organized around assessment of personality traits and the STIPO around assessment of the clinical correlates of underlying psychological structures. Yet both instruments may be identifying a group of patients with more severe personality pathology, whom analysts may view as poorly suited for analytic treatment. Although the majority of the tests were not statistically significant, the overwhelming majority were in a direction that suggests that patients accepted for analysis are characterologically healthier than patients rejected. The

upper bound of the 95% confidence intervals (CIs) are consistent with this interpretation (CIs reflect the range of scores in which the mean difference between the accepted and rejected groups is likely to be found in the population). In this regard, the upper bounds of the CIs for these comparisons are of interest and suggest that there may be differences between the groups on a range of dimensions, but that would have to be tested on a different sample of patients.

We also found that subjective factors assessed on the clinician-rated CRF, in particular the personal appeal of the patient or the candidate's impression of the patient's intellectual capacity, were higher in patients accepted for analysis. It is unclear how to interpret this finding. It may mean that certain personal attributes that candidates and their supervisors view as positive can predispose a candidate to accept a patient for analysis; it is also possible that these findings represent a halo effect whereby patients who are accepted for treatment are then more likely to be seen in an overall positive light. This explanation is supported by the higher ratings of intelligence given to the accepted patients, even though the evaluation procedure included no measures of IQ. There remains the possibility that there are additional subjective factors that we did not identify, either because we did not ask about them or because the evaluating clinicians were not consciously aware of and/or able to report them, that are influencing decision making.

We end with a note of caution. Establishing the criteria used by analysts to recommend analysis does not address the question of whether these criteria are in fact useful or valid. The criteria used to recommend analysis may simply reflect the perpetuation of unfounded myths about who would and who would not benefit from analytic treatment. Given the overall similarities we found between the groups of patients accepted for analysis and those rejected, in conjunction with the difficulty of recruiting training cases, one could make an argument that after making the clinical decision about whether to recommend analysis or not, all patients should enter analytic treatment to test whether the criteria used for referral have any predictive validity with respect to therapeutic benefit. By evaluating patients applying for analysis using structured assessments and clinical evaluations, and then putting all patients into treatment (ideally with a candidate other than the evaluating candidate, so that treating analysts would not be asked to treat patients they had rejected), we would be able to address the question of whether there are patient-based moderators of analytic treatment that can be identified.

APPENDIX A: CLINICIAN RATING FORM ITEMS

Items often viewed as influential (> 75% of candidates)

- Quality of interpersonal relationships (90%)
- Structural diagnosis (83%)
- Psychological mindedness of patient (82%)
- Psychoanalytic character diagnosis (79%)
- Likelihood of patient to benefit from other form of treatment (76%)
- Level of motivation for analysis (76%)

Items sometimes viewed as influential (50–75% of candidates)

- Ability to tolerate anxiety (70%)
- Ability of use trial interpretations (68%)
- Personal appeal of patient (65%)
- DSM Diagnosis, Axis II (64%)
- Personal like of patient (64%)
- Character rigidity (64%)
- Quality level of superego functioning (63%)
- Level of impulse control (63%)
- Outcome of previous treatment (63%)
- Level of intelligence (60%)
- Level of professional or academic functioning (60%)

Items not often viewed as influential (< 50% of candidates)

- DSM Diagnosis, Axis I (48%)
- Level of pressure to take a case (47%)
- Level of anxiety (43%)
- Possibility of life events interrupting treatment (40%)
- Level of sadism (39%)
- Level of sexual inhibition (35%)
- Scheduling issues (30%)
- Finances (20%)

Items with insufficient data (< 75% response rate)

- Presence/absence of thought disorder or psychotic/idiosyncratic thinking
- History of psychotic episode
- Sociopathy
- Presence of early trauma (sexual/physical)
- Sexual perversion
- Current substance abuse
- History of substance abuse
- Patient is a mental health provider

APPENDIX B: ASSESSMENT BATTERY

Instrument	Goals	Description	Practical Issues
Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I)	To provide broad coverage of DSM-IV Axis I diagnoses.	Observer-administered, semistructured interview with required "probe" questions and option of follow-up questions. Nine diagnostic modules (e.g., "Eating Disorders"). Collateral sources are encouraged.	Approx. 90 min. Interviewer must be trained in DSM-IV diagnoses and SCID administration.
Hamilton Rating Scale for Depression (Ham-D)	To measure the severity of depressive symptoms.	Developed in 1960s. Now the most commonly used observer-rated depressive symptom rating scale. Checklist of ≥ 17 items, ranked 0-2 or 0-4. Anchor points often used. Total score ≥27 = severe, 18-26 = moderate, 12-17 = mild.	15-20 min. Interviewer should be trained in Ham-D use.
Hamilton Anxiety Rating Scale (Ham-A)	To provide an overall measure of global anxiety, including psychic and cognitive symptoms.	Developed in 1959. Most widely used anxiety measure in drug trials. Clinician-administered. 14 items, ranked 0-4. No anchor points. Total score ≥14 = clinically significant anxiety, ≤5 = normal. Somatic symptoms feature prominently.	15-30 min. Clinicians can use scale w/out training.
Structured Interview for Personality Organization (STIPO)	To assess personality organization.	Structured interview designed to operationalize Kernberg's theory of personality organization. Level of organization (neurotic, borderline, or psychotic) is determined based on reality testing, sense of identity, defensive style, and other ego functions.	90-120 min. Interviewer must be trained in STIPO use.
Social Adjustment Scale–Self Report (SAS-SR)	To assess social functioning.	Self-administered. Assesses social functioning over 2-week period. Rates work, social/leisure activities, relationships w/ extended family, spousal role, parental role, and family member role according to behaviors and feelings. Items ranked 1 (better) to 5 (worse).	15-20 min. Ideally research assistant is present to instruct pt. Norms for various groups are available.

(continued)

APPENDIX B: (CONTINUED)

Instrument	Goals	Description	Practical Issues
Beck Depression Inventory (BDI)	To measure manifestations of depression in adults and adolescents.	Developed over last 40 yrs, based on work w/ depressed pts in psychoanalytic psychotherapy and CBT. Self-administered. Total score 30-63 = severe, 17-29 = moderate, 10-16 = mild, 6-9 = minimal.	5-10 min.
Self-Understanding of Interpersonal Patterns (SUIP)	To assess self-understanding of maladaptive interpersonal patterns.	Change in understanding maladaptive interpersonal patterns is considered an important mechanism of symptom change in dynamic psychotherapy. Ranks 19 potential core conflictual relationship themes on a 4-point scale.	5-10 min.
Schedule for Nonadaptive and Adaptive Personality (SNAP)	To assess adaptive and maladaptive traits and symptoms characteristic of personality disorders.	375-item (true/false) self-report inventory. Assesses 3 broad temperament and 12 specific personality trait dimensions. Also includes scales to assess each DSM-III personality disorder.	25-30 min.
Inventory of Personality Organization (IPO)	To assess personality organization.	Shorter (155-item), self-report version of STIPO (see above).	20 min.
Spielberger State Trait Anxiety Inventory (STAI)	To measure and differentiate between anxiety as a state and a trait.	Brief self-report instrument consisting of 20 trait and 20 state questions asking patients to rate anxiety on a 4-point intensity scale.	5 min.
Ego-Resiliency (ER)	To measure ego-resiliency (ER): the capacity for flexible and resourceful adaptation to external and internal stressors.	Self-report measure derived from more involved observer-rated measures of ER.	5 min.

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