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Clinician reports of personality pathology of patients beginning and patients ending psychoanalysis

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Objectives. The purpose of this work was to use a clinician Q-sort procedure to describe the personality pathology and adaptive functioning of patients beginning and ending psychoanalysis.

Design. With a cross-sectional design, we compared a group of patients beginning and a group of patients ending psychoanalysis.

Methods. Twenty-six psychoanalysts described a patient beginning psychoanalysis and 26 described a patient ending psychoanalysis using the Shedler–Westen Assessment Procedure 200 (SWAP-200). Each clinician also completed questions about themselves, the patient, and the treatment. The most characteristic SWAP-200 items describing patients beginning and patients ending psychoanalysis provide a meaningful picture of the two groups.

Results. Among patients at the end of psychoanalysis, scores were significantly lower on the SWAP-200 Paranoid, Schizotypal, Borderline, Histrionic, and Dependent scales and scores were significantly higher on the SWAP-200 High functioning scale and the DSM-IV GAF scale. Common characteristics of patients beginning psychoanalysis were anxiety, guilt, and shame. Common characteristics of patients ending psychoanalysis were conscientiousness and responsibility, striving to live up to moral and ethical standards, and enjoyment of challenges.

Conclusions. The findings demonstrate the usefulness of a clinician report measure for the study of psychoanalytic psychotherapy and psychoanalysis.

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Our goal is to assess the viability of using a clinician-report methodology to study changes in personality pathology in long-term psychotherapeutic treatments as they are carried out in the community. The present work is a descriptive cross-sectional study of a group of patients at the beginning of psychoanalysis and a different group of patients at the end of psychoanalysis. If this method is sensitive to differences between these two groups, then the method can be used later in a longitudinal study, following change in a group of patients over the course of long treatments such as psychoanalysis or psychoanalytic psychotherapy.

Although there are several clinically relevant self-report (e.g. MMPI-2, Hathaway & McKinley, 1989) and interview (e.g. Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II), First, Spitzer, Gibbon, Williams, & Benjamin, 1996) measures of personality pathology, these measures are less than ideal for studying personality pathology in everyday clinical practice in the community. A reliable, valid, and standardized clinician-report measure has several potential advantages. Clinicians are sophisticated observers of behavior (Shedler & Westen, 1998), who consider patients' explicit reports about their symptoms, histories, and relationships, and also consider patterns of relating that occur between therapist and patient within the consulting room. Although clinicians can and do have biases, multiple contacts with patients and the use of psychometrically sound instruments can provide a comprehensive description of personality characteristics and disorders. A clinician-report measure also does not raise the formidable problem of obtaining confidential patient information from clinicians practicing in the community, since clinicians can describe their patients anonymously.

Studies of the outcome of psychoanalysis have been reported since 1917 (Coriat, 1917). However, the majority of studies of the outcome of psychoanalysis and psychoanalytic psychotherapy have had methodological problems, and questions remain about the effectiveness of these treatments. Roth and Fonagy (1996) have noted that the relative absence of evidence for psychodynamic therapies is sometimes misunderstood as an absence of the efficacy of these therapies.

There have been several relatively recent large-scale effectiveness studies of psychoanalysis. A major outcome study was The Menninger Foundation Psychotherapy Research Project (Kernberg, Burstein, Coyne, Applebaum, & Horowitz, 1972; Wallerstein, 1986), a prospective longitudinal study of psychoanalytic outcome. The Menninger project compared patients in psychoanalysis and psychoanalytic psychotherapy, with follow-ups 2–3 years after the end of treatment. Patients in the Menninger project were more disturbed than most patients entering psychoanalysis. Half of the patients in psychoanalysis had borderline functioning, 35% had problems with drugs and/or alcohol, and 33% had paranoid features. On the Health-Sickness Rating Scale (HSRS; Luborsky *et al.*, 1993), a precursor to the DSM Global Assessment of Functioning (GAF) scale (American Psychiatric Association, 1994), patients began with average ratings of 45.6. Like the GAF, the HSRS ranges from 0 to 100 and the average initial rating of 45.6 indicate serious impairment in functioning. Among 22 patients in

psychoanalysis and 20 in psychoanalytic psychotherapy, the average HSRS scores increased with treatment. At 2-year follow-up, HSRS scores were 61.7, indicating some mild symptoms. Although the assessment of patients before and after treatment was sophisticated and complex, the Menninger study was carried out before the adoption of standardized criteria for personality disorders.

Since the Menninger study, several studies of psychoanalytic outcome have been reported. Bachrach, Galatzer-Levy, Skolnikoff, and Waldron (1991) summarized the results of six studies of terminated analyses involving 550 patients and concluded that 60–90% of patients selected as being suitable for psychoanalysis showed substantial therapeutic benefit as evaluated by the treating analysts. Doidge *et al.* (2002) reported on the survey responses of 510 psychoanalysts in the US, Canada, and Australia who described the psychopathology and trauma histories of 1,718 patients in psychoanalysis. These patients had substantial psychopathology and histories of trauma. Before beginning psychoanalysis, 82% of the patients had tried other treatments or medications. At the beginning of psychoanalysis, 71% had one or more DSM-III-*R* Axis II disorders. These data indicate that the patients began psychoanalysis with significant psychopathology. The results of the survey showed that psychoanalysis lasted an average of 5–6 years and that more patients were employed as psychoanalysis progressed. No data were reported as to changes in psychopathology as a function of treatment.

In Germany, Leuzinger-Bohleber (2002) reported on a 6-year effectiveness follow-up of the outcome of psychoanalysis among 401 patients. Half were followed up with questionnaire measures and half with interviews by an independent analyst, audio tape-recorded, and reviewed by a research team. The research team found that patients were more satisfied with the treatment outcomes than psychoanalysts, who were more cautious in estimating therapy outcomes. Keller, Westhoff, Dilg, Rohner, and Studt (2002) reported on the outcomes of psychoanalysis among 111 patients who had completed at least 100 sessions of psychoanalysis. The severity of symptoms reported by patients on the Symptom Checklist-90 (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974), a self-report measure of psychiatric symptoms, was reduced after psychoanalysis. Significant reductions in symptoms reported on the SCL-90 after psychoanalysis have also been reported by Sandell *et al.* (2000) in a longitudinal study which involved several hundred patients in Stockholm before, during, and after psychoanalysis or psychotherapy. Significant reductions in work absenteeism and in health care costs after psychoanalysis or long term psychoanalytic psychotherapy have been reported recently by Beutel, Rasting, Stuhr, Ruger, and Leuzinger-Bohelber (2004). More than 80 completed and ongoing studies of psychoanalytic outcome are summarized in Fonagy *et al.* (2002).

Psychoanalysis has always concerned itself with personality change, also referred to as *structural change*. However, standardized measures of personality disorders have not been included as outcome measures in studies of psychoanalysis. Shedler and Westen (1998), Westen and Shedler (1999a, 1999b) have recently developed a clinically sensitive, reliable, and valid measure of personality disorders, traits, and strengths which harnesses clinician judgments about patients and is consistent with DSM-IV personality

disorder categories. The Shedler–Westen Assessment Procedure-200 (SWAP-200) is a Q-sort measure of personality. Clinicians describe their patients by sorting (rank ordering) 200 statements into eight categories ranging from 'inapplicable or not descriptive' to 'highly descriptive'. Westen and others have demonstrated the validity of the SWAP-200 in studying personality and personality pathology (e.g. Porcerelli, Cogan, & Hibbard, 2004; Westen & Muderrisoglu, 2003; Westen & Harnden-Fischer, 2001; Westen & Shedler, 1999a, 1999b).

The present study is the first comprehensive assessment of the personality of patients beginning and patients ending psychoanalysis with a measure that (a) is consistent with Axis II of DSM-IV, (b) includes commonly observed Axis I symptoms which often co-occur with Axis II psychopathology, (c) draws on the expertise of clinicians; and (d) has been psychometrically evaluated in published studies of reliability and validity.

In this cross-sectional descriptive study, psychoanalysts described patients beginning and patients ending psychoanalysis using the SWAP-200. One concern about a cross-sectional study of psychoanalysis would be that patients with more psychopathology might be more apt to drop out of treatment and thus the sample at the end of treatment would be composed of patients who were higher functioning at the onset of treatment. To deal with this possible problem, we asked clinicians to provide the patients' DSM-IV Axis I and Axis II diagnoses at the beginning of treatment. Another possible problem is that psychoanalysts reporting on patients ending psychoanalysis may be overly optimistic and their SWAP-200 reports could reflect the psychoanalysts' ideal of what patients should look like at the end of psychoanalysis. However, previous investigators have found that psychodynamic therapists do not differ in outcome assessments as compared with the assessments of patients and/or independent observers (Hilsenroth, Ackerman, Belays, Bait, & Mooney, 2003; Horowitz, Marmar, Weiss, Kaltreider, & Wilner, 1986). Several studies have found that psychodynamic therapists (Leichsenring & Leibing, 2003) and psychoanalysts (Leuzinger-Bohleber, 2002) underestimate rather than overestimate gains made by patients in treatment as reported by patients and independent observers. A cross-sectional study is a practical first step in applying the SWAP-200 clinician report methodology to the study of psychoanalytic outcome.

We hypothesize that patients ending psychoanalysis will have lower scores on SWAP-200 personality disorder scales than patients beginning psychoanalysis. We hypothesize that fewer patients at the end of psychoanalysis will meet criteria for personality disorders. Finally, we hypothesize that patients at the end of psychoanalysis will evidence higher levels of adaptive functioning than patients beginning psychoanalysis.

Method

Participants

The participants were 54 psychoanalysts who were members of the American Psychoanalytic Association. Twenty-six described a patient beginning psychoanalysis and 26 described a patient ending psychoanalysis with a mutually agreed upon

termination. Two additional descriptions of patients who terminated for reasons external to the treatment are not included here.

Measures

The clinicians completed a questionnaire that included questions about themselves, their clinical practices, and their anonymous patients. Questions concerned the clinician's age, gender, ethnicity, length of clinical practice, and profession. Questions about their patients included demographic information, the clinicians' DSM-IV Axis I and Axis II diagnoses of their patients at the beginning of psychoanalysis, current psychiatric medications, and previous psychotherapeutic treatments. Each clinician also answered a question about the length of the patient's treatment and completed the DSM-IV Global assessment of functioning scale (American Psychiatric Association, 1994).

The clinicians completed the SWAP-200. The SWAP includes 200 descriptive statements describing both pathological and health aspects of personality. The statements are sorted into eight categories, ranging from 0 (*irrelevant to the patient being described*) to 7 (*highly descriptive of the patient being described*). Westen and Shedler (1999a) note that 'SWAP-200 statements are written in a manner close to the data (e.g. 'Tends to be passive and unassertive' or 'Living arrangements are chaotic and unstable') and statements that require inference about internal processes are written in clear and unambiguous language (e.g. 'Is unable to describe important others in a way that conveys a sense of who they are as people; descriptions lack fullness and color' or 'Tends to blame others for own failures or shortcomings; tends to believe his or her problems are caused by external factors').' (pg. 261). Reliable descriptions with the SWAP-200 have been obtained from clinicians from a variety of theoretical orientations (Westen & Shedler, 1999a, 1999b).

The SWAP-200 Personality Disorder scores can be used both categorically and dimensionally. A diagnosis can be derived by correlating the patient's SWAP-200 profile with an empirically derived profile for each of the DSM-IV personality disorders. The SWAP-200 also includes a High functioning scale, a dimensional measure of psychological strengths and adaptive functioning. *T*-scores for each of the personality disorders are calculated by correlating the SWAP profile for a patient with profiles developed by Westen and Shedler (1999a) for each of the DSM-IV personality disorders. A profile yields a categorical diagnosis if a subject's score on the relevant scale exceeds the cut-off *t*-score of 60 (i.e. one standard deviation above a mean of 50; J. Shedler, personal communication, January 20, 2003). *T*-scores for each personality disorder scale can also be used dimensionally, with higher scores indicating more characteristics of the personality disorder.

With respect to the reliability of the SWAP-200, internal consistencies equal to or greater than .90 have been reported (Westen & Shedler, 1999a), with interrater reliability coefficients greater than .80 for each scale (Westen & Muderrisoglu, 2003). Convergent validity has been assessed through correlations between actual patient profiles and

prototypic profiles (Westen & Shedler, 1999a). Validity coefficients for similar diagnostic categories ranged from .79 to .93 (Westen & Shedler, 1999a). Convergent validity was also supported through correlations between SWAP Personality Disorder *t*-scores and clinicians' ratings of personality disorders. Validity coefficients ranged from .49 to .70. With regard to the validity of the SWAP-200 High functioning scale, a significant correlation (.48) was obtained between GAF ratings and the SWAP-200 Healthy functioning scale. Incremental validity of the SWAP-200 was demonstrated when SWAP-200 scores accounted for variance above and beyond Axis I diagnosis in predicting eating disorder symptoms and adaptive functioning (Westen & Harnden-Fischer, 2001). With regard to known groups validity, SWAP-200 Personality Disorder scores differentiated partner-violent and non-violent men in psychotherapy (Porcerelli *et al.*, 2004).

Procedure

Letters inviting participation were sent to a random selection of approximately 1,200 psychoanalysts who were members of the American Psychoanalytic Association. After a complete description of the study was provided to the responding clinicians, written informed consent was obtained. A packet of research materials was sent to 66 volunteers. We have no way of knowing how many potential participants had a patient at the beginning or at the end of psychoanalysis and thus cannot assess any possible analyst–patient selection biases. However, Doidge *et al.* (2002) reported that 342 US psychoanalysts who responded to a survey had an average of 2.7 psychoanalytic patients in their practice. Since Doidge *et al.* (2002) also reported that the psychoanalysts' five most recently terminated analyses lasted an average of 5.7 years, the likelihood of any individual psychoanalyst having a patient at any given time at either the beginning or the end of psychoanalysis would be quite low. Twelve participants did not return, or returned but did not complete packets. Each responding clinician was free to choose to describe a patient either at the beginning or at the end of psychoanalysis. Completed materials were received from 54 psychoanalysts who met inclusion criteria of having a patient within 2 months of the beginning ($N = 26$) or 2 months of the end psychoanalysis ($N = 28$). Twenty-six of the materials describing a patient at the end of psychoanalysis concerned an analysis that ended by mutual agreement between the patient and the psychoanalyst. Two participants completed materials describing a patient at the end of psychoanalysis which had been interrupted for external reasons (the patients relocated). Data from these two participants were not included. Participants were not reimbursed for their time.

The SWAP-200 Q-sorts were scored for (a) DSM-IV personality disorders, (b) psychological strengths (the High functioning scale) and, (c) the most characteristic items. Personality disorder scores are converted into *t*-scores ($M = 50$, $SD = 10$) for each of the DSM-IV personality disorders. The standardization sample for the SWAP-200 at this time is solely comprised patients with personality disorders, and a *t*-score at or above 60 (1 *SD* or more above the mean) is the cut-off for a DSM-IV personality disorder. We used

t-scores between 55 and 60 (0.5 *SD* above the mean) as indicative of personality disorder features. Differences between the SWAP-200 personality disorder scores of patients beginning and patients ending psychoanalysis, shown in Table 2, were evaluated with Wilcoxon (Mann–Whitney *U*) tests with a Bonferroni–Holm adjustment so that a p value of .004 was required for statistical significance.

Results

Characteristics of the groups

The demographic characteristics of patients beginning and patients ending psychoanalysis did not differ, nor did the clinical Axis I or II diagnoses at the beginning of psychoanalysis, as can be seen in Table 1. The characteristics of psychoanalysts describing a patient beginning and those describing a patient ending psychoanalysis did not differ, as can be seen in Table 1. The frequency of sessions and use of the couch also did not differ for patients beginning and patients ending psychoanalysis, also shown in Table 1.

SWAP-200 personality disorders

SWAP-200 personality disorders were markedly less prevalent among patients ending as compared with patients beginning psychoanalysis. Of the 26 patients beginning psychoanalysis, 11 met SWAP-200 criteria for one or more personality disorders, most often Cluster B or C. Ten additional patients beginning psychoanalysis had SWAP-200 personality disorder features, most often Cluster C. None of the 26 patients ending psychoanalysis met SWAP-200 criteria for a personality disorder and only eight had personality disorder features, indicating some degree of residual personality pathology. With the Bonferroni–Holm adjustment, the groups differed on five of the SWAP-200 Personality disorder scale scores, as can be seen in Table 2: paranoid, schizotypal, borderline, histrionic, and dependent.

Adaptive functioning

Scores on the SWAP-200 High functioning scale, a measure of psychological strengths, were higher for the patients at the end than the patients at the beginning of psychoanalysis, shown in Table 2. Scores on the DSM-IV GAF scale, a measure of adaptive functioning, were also higher among patient at the end than among patients at the beginning of psychoanalysis, shown in Table 2. The SWAP-200 High functioning and the GAF scores were correlated $+.55$ among patients beginning and $+.37$ among patients ending psychoanalysis, large and medium effect sizes respectively, suggesting a moderate amount of shared variance. Neither the SWAP-200 High functioning scale nor GAF scores correlated significantly with the number of months in treatment among patients at the end of psychoanalysis, $r = .08$ ($p = .71$) and $r = -.07$ ($p = .75$), respectively.

Table 1. Demographics of analysts and patients, and characteristics of the analyses of patients beginning and patients ending psychoanalysis

	Beginning analysis ($N = 26$) frequency (%) or mean (*SD*)	Ending analysis ($N = 26$) frequency (%) or mean (*SD*)	Tests of differences[a]	*p*
Psychoanalysts				
Sex			χ^2	.10
Male	11 (42.3%)	17 (65.4%)		
Female	15 (57.7%)	9 (34.6%)		
Discipline			*F*	.13
Psychiatrists	12 (46.2%)	18 (69.2%)		
Psychologists	12 (46.2%)	7 (26.9%)		
Other	2 (7.7%)	1 (3.8%)		
Race			χ^2	.15
White	26 (100%)	24 (92.3%)		
Other	0 (0%)	2 (7.7%)		
Years of professional experience	17.7 (9.9)	28.7 (11.7)	*W*	.0006
Years of psychoanalytic experience	8.0 (8.9)	20.8 (14.5)		.0004
Patients				
Sex			χ^2	.26
Male	13 (50%)	9 (34.6%)		
Female	13 (50%)	17 (65.4%)		
Age	40.7 (12.4)	46.5 (7.9)	*t*	.05
Race			χ^2	.49
White	26 (100%)	25 (96.2%)		
Other	0 (0%)	1 (3.8%)		
Education			*W*	.17
Less than high school	1 (3.8%)	0 (0%)		
High school	1 (3.8%)	0 (0%)		
Some college	1 (3.8%)	0 (0%)		
College	6 (23.1%)	5 (19.2%)		
Graduate/professional	17 (65.4%)	21 (80.8%)		
Axis I Disorders at the beginning of analysis	25 (96%)	25 (96%)		
Axis II disorders at the beginning of analysis (yes vs. no)			χ^2	.55
Yes	17 (65%)	19 (71%)		
Cluster A	0 (0%)	4 (14%)		
Cluster B	6 (23%)	7 (29%)		
Cluster C	5 (19%)	3 (10%)		

Table 1. (*Continued*)

	Beginning analysis ($N = 26$) frequency (%) or mean (*SD*)	Ending analysis ($N = 26$) frequency (%) or mean (*SD*)	Tests of differences[a]	*p*
Personality disorder not otherwise specified	6 (23%)	5 (19%)		
No	9 (35%)	7 (29%)		
Psychotropic medication			χ^2	.02
Yes	15 (68.2%)	7 (31.8%)		
No	11 (42.3%)	19 (63.3%)		
Analyses				
Frequency of sessions			*W*	.59
Three/week	4 (15.4%)	4 (15.4%)		
Four/week	21 (80.8%)	19 (73.1%)		
Five/week	1 (3.8%)	3 (11.5%)		
Use of the couch			*F*	.67
Yes	23 (92.0%)	22 (84.6%)		
No	2 (8.0%)	4 (15.4%)		
Months of analysis	1.7 (.5)	71.0 (30.2)		

[a] χ^2, chi-squared; *F*, Fisher's exact text; *W*, Wilcoxon (Mann–Whitney *U*) Test; *t*, *t*-test.

SWAP-200 composite descriptions of patient groups

A clinically useful feature of the SWAP-200 is that it allows clinicians to identify in rank order the most salient characteristics of a patient. The 15 items most characteristic of patients beginning and patients ending psychoanalysis provide a meaningful picture of the two groups of patients and are shown in Tables 3 and 4. Patients at the both the beginning and end of psychoanalysis were described as having important strengths (articulate, conscientious, and insightful, with a sense of humour and with moral and ethical standards). At the beginning of psychoanalysis, of the 15 most descriptive items, 10 items concerned internal struggles (afraid of rejection or abandonment, guilty, feels inadequate, unhappy, self critical, anxious, competitive, ashamed, submissive, and creates situations that lead to unhappiness). In contrast, at the end of psychoanalysis, of the 15 most descriptive items, four concerned positive aspects of work (satisfaction in pursuing long-term goals, pleasure in accomplishing things, able to use talents effectively, and contentment in life's activities), three concerned positive relationships with others (fulfilment in mentoring, empathic, able to assert appropriately), and three concerned resilience (resolution of painful experiences from the past; can hear and benefit from hearing emotionally threatening information, and able to recognize alternative viewpoints even when strong feelings are involved).

Table 2. *T*-scores of SWAP-200 personality disorder scales, the SWAP-200 High functioning scale, and global assessment of functioning (GAF) scale of patients beginning and patients ending psychoanalysis

Scale	Beginning analysis ($N = 26$) Mean (*SD*)	Ending analysis ($N = 26$) Mean (*SD*)	Wilcoxon exact test[a]
Personality disorders[a]			
Paranoid	43.22 (7.36)	37.29 (5.96)	.001[b]
Schizoid	44.81 (7.94)	40.13 (5.26)	.009
Schizotypal	42.82 (6.87)	35.49 (4.80)	.0001[b]
Antisocial	46.31 (6.41)	42.65 (3.86)	.002
Borderline	46.40 (9.72)	34.89 (5.36)	.0001[b]
Histrionic	47.79 (9.27)	39.67 (4.97)	.0005[b]
Narcissistic	46.93 (7.68)	43.03 (5.46)	.05
Avoidant	48.92 (6.96)	44.31 (4.82)	.009
Dependent	50.87 (6.50)	43.92 (4.85)	.0001[b]
Obsessive	49.15 (7.91)	50.17 (5.06)	.30
High functioning	59.24 (9.07)	71.54 (6.14)	.0001[b]
DSM-IV GAF Scale	59.81 (19.79)	86.96 (8.38)	.0001[b]

Note. The standardization sample (Westen and Shedler, 1999a) consisted of patients with personality disorders.

[a] One-sided probability.

[b] Significant with a Bonferroni–Holm adjustment (.05/12) requiring .004 for significance.

Discussion

To the best of our knowledge, this is the first study assessing the SWAP-200 clinician report methodology to compare personality pathology and adaptive functioning in patients at the beginning and patients at the end of psychoanalysis and/or psychotherapy. An important finding is that the measure shows that most patients beginning psychoanalysis had some degree of personality pathology and difficulties in functioning (with an average GAF score of 63) but these patients also had psychological strengths. Data from the SWAP-200 show that patients beginning psychoanalysis are articulate, thoughtful, and have a sense of humour, considered by Freud (Freud, 1960/1905) and by Vaillant (2003) to be a high level mechanism of defence. Gabbard (2000), among others, has noted the importance of personality (ego) strengths as important prerequisites for the psychoanalytic psychotherapies.

Using the SWAP-200 clinician report methodology, we have shown that personality disorder scale scores are lower among patients ending psychoanalysis, as compared with patients beginning psychoanalysis. Essentially, SWAP-200 personality disorder scales scores suggest a higher level of object relatedness and a better capacity to modulate affect among patients at the end of psychoanalysis. Individual SWAP-200 items characteristic of patients beginning psychoanalysis show that these patients have symptoms of anxiety,

Table 3. Composite description of 26 patients at the beginning of psychoanalysis

Item	Mean[a]
Is articulate; can express self well in words	5.77
Tends to fear s/he will be rejected or abandoned by those who are emotionally significant	4.42
Tends to feel guilty	4.38
Appreciates and responds to humour	4.31
Tends to feel s/he is inadequate, inferior, or a failure	4.31
Tends to feel unhappy, depressed, or despondent	4.27
Tends to be self-critical; sets unrealistically high standards for self and is intolerant of own human defects	4.23
Tends to be anxious	4.12
Tends to be competitive with others (whether consciously or unconsciously)	4.04
Tends to feel ashamed or embarrassed	4.00
Tends to be ingratiating or submissive (e.g. may consent to things s/he does not agree with or does not want to do, in the hope of getting support or approval)	3.77
Has moral and ethical standards and strives to live up to them	3.77
Is psychologically insightful; is able to understand self and others in subtle and sophisticated ways	3.73
Tends to be conscientious and responsible actively avoids opportunities for pleasure and gratification	3.73
Appears to want to 'punish' self; creates situations that lead to unhappiness, or actively avoids opportunities for pleasure and gratification	3.54

[a] Highest means are most representative of the group.

guilt, and shame. Individual SWAP-200 items characteristic of patients ending psychoanalysis show these patients to be more insightful and better able to experience pleasure in life's challenges. The composite descriptions and GAF scores show that patients ending psychoanalysis show good functioning in all areas, with few symptoms or none at all.

This study has several methodological limitations. First, the study is cross-sectional and thus we are able to talk only of group differences and not of changes in patients over time. Second, there may have been selective responding by the analysts, which calls into question the representativeness of the samples. Third, there may have been self-serving response biases by the analysts with respect to both the choice of patients and responses to the SWAP-200. That is, analysts might have chosen to describe only patients having a more positive response to psychoanalysis and/or may have had a positive response bias in describing patients at the end of psychoanalysis. Some of the present data bears on the limitations of the study. At least in this study, those patients who completed psychoanalysis began analysis with a similar level of both Axis I and Axis II pathology as compared with the patients beginning psychoanalysis. In terms of a possible self-serving bias by the clinicians, the correlations between the months of treatment, which

Table 4. Composite description of 26 patients at the end of psychoanalysis

Item	Mean[a]
Tends to be conscientious and responsible	5.96
Is articulate; can express self well in words	5.88
Has moral and ethical standards and strives to live up to them	5.77
Is psychologically insightful; is able to understand self and others in subtle and sophisticated ways	5.69
Is able to find meaning and satisfaction in the pursuit of long-term goals and ambitions	5.65
Enjoys challenges; takes pleasure in accomplishing things	5.58
Appreciates and responds to humour	5.50
Appears to have come to terms with painful experiences from the past; has found meaning in, and grown from such experiences	5.38
Is able to use his/her talents, abilities, and energy effectively and productively	5.27
Is able to find meaning and fulfilment in guiding, mentoring, or nurturing others	5.23
Is empathic; is sensitive and responsive to other people's needs and feelings	5.15
Is able to assert him/herself effectively and appropriately when necessary	5.15
Is capable of hearing information that is emotionally threatening (i.e. that challenges cherished beliefs, perceptions, and self-perceptions) and can use and benefit from it	5.15
Has the capacity to recognize alternative viewpoints, even in matters that stir up strong feelings	5.04
Generally finds contentment and happiness in life's activities	4.96

[a] Highest means are most representative of the group.

ranged from 6 to 171 months with skewness (1.57) and kurtosis (1.14), and the two measures of adaptive functioning were close to zero ($r = .08$ and $r = .07$, respectively). Thus, analysts who treated patients over a longer period of time did not rate those patients differently at the end of treatment from analysts who treated patients for shorter periods of time.

The goal of this study was to test the viability the SWAP-200 clinician report methodology for studying psychoanalysis. Psychoanalysts practicing in the community did respond to the SWAP-200 to describe patients at the beginning and end of psychoanalysis. There were marked differences between the two groups in the level of personality pathology, as would be expected, which suggests that the SWAP-200 is sensitive to change and provides support for the construct (known-groups) validity of the SWAP-200. The SWAP-200 allows for the assessment of personality pathology and strengths and also allows for a rank ordering of both pathological and adaptive characteristics and is a promising approach to the longitudinal study of changes in personality pathology during psychoanalysis and psychoanalytic psychotherapy. We are beginning longitudinal work studying changes in psychoanalytic treatment via clinicians' SWAP-200 descriptions of patients at the beginning of treatment and after every 6 months of treatment.

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