PSYCHOANALYSIS WITH AVOIDANT PERSONALITY DISORDER: A SYSTEMATIC CASE STUDY

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This case study of process and outcome is based upon data obtained during a 5-year psychoanalysis of an adult male with avoidant personality disorder (AVPD). To date, no known systematic case studies, effectiveness studies, or randomized control trials exist for psychoanalysis in the treatment of AVPD. In this study, self-reported symptoms and observer-rated personality disorder (PD), global functioning, object relations, and psychological health were gathered at intake, after each year of treatment, and at 1-year follow-up.

Process data was gathered to determine the extent to which the treatment adhered to prototypes of psychodynamic, cognitive–behavioral, and interpersonal therapy. Results indicated that the patient achieved clinically significant reductions in PD, symptom severity, and relational pathology. Gains were maintained at 1-year follow-up. The treatment significantly adhered to psychodynamic principles throughout, with some use of cognitive–behavioral and interpersonal principles in the third year of treatment. These findings warrant further investigation of psychoanalysis for AVPD and demonstrate the usefulness of assessing multiple domains of patient functioning and treatment process.

Keywords: psychoanalysis, avoidant personality disorder, case study, treatment outcome

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Psychoanalytic clinicians have long been interested in and have treated individuals with avoidant personality pathology (one of the many forms of object relations pathology). Surprisingly, however, there are no known systematic case studies or effectiveness studies of psychoanalysis for avoidant personality disorder

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(AVPD). In fact, Fonagy (2002) has indicated that there are "no definitive studies that show psychoanalysis to be unequivocally effective relative to an active placebo or an alternative method of treatment" (p. 287) for any particular disorder. There are only five studies assessing the effectiveness of time-limited psychodynamic psychotherapy for Cluster C personality disorders (PD), which includes avoidant, obsessive–compulsive, and dependent PDs, or for AVPD itself (Barber, Morse, Krakauer, Chittams, and Crits-Christoph, 1997; Hardy et al., 1995; Hoglend, 1993; Svartberg, Stiles, & Seltzer, 2004; Winston et al., 1994), and only one study assessing the effectiveness Cluster C PDs with long-term psychodynamic therapy. This is somewhat surprising given that AVPD is one of the most prevalent of all PDs in the general population (Torgersen, Kringlen, & Cramer, 2001; Samuels et al., 2002; Coid, Yang, Tirer, Roberts, & Ullrich, 2006), is associated with disability (Grant et al., 2004), and impedes recovery from Axis I disorders (Hardy et al., 1995; Reich, 2003; Shea et al., 2004; Viinamaki et al., 2002; Viinamaki et al., 2003).

Barber and colleagues (1997) assessed the effectiveness of time-limited (52-session) supportive–expressive psychodynamic psychotherapy (Luborsky, 1984) in an open trial with patients diagnosed with *DSM–III–R* AVPD ($n = 24$) and obsessive–compulsive PD (OCPD) ($n = 14$). Patients also met criteria for at least one Axis I disorder (anxiety or depression). Although both treatment groups improved across time on symptom and personality measures, patients with OCPD lost their PD diagnosis more quickly, fewer met criteria for a PD at the end of treatment (15.4% vs. 38.5%), and OCPD patients had a significantly lower dropout rate (7% vs. 54%) than did patients with AVPD. Barber et al. (1997) concluded that supportive–expressive psychodynamic psychotherapy was more effective for patients with OCPD than for patients with AVPD.

Hardy and colleagues (1995) compared patients with Cluster C PDs ($n = 13$) and depression with patients absent a PD diagnosis ($n = 44$) for 8- or 16-week psychodynamic–interpersonal (PI) or cognitive–behavioral therapy (CBT). They found that PD patients had significantly poorer outcomes in PI therapy than in CBT, and that PD patients had significantly worse outcomes than no-PD for PI therapy but not for CBT. Depression severity appeared to interact with PD, resulting in poorer outcomes for PD than no-PD groups. They did not attempt to measure any therapeutic effects on PD symptoms per se. Effect sizes for symptoms and functioning measures were large for both treatments at termination. However, the effect sizes for CBT were larger than those for PI.

Hoglend (1993) studied short-term psychodynamic psychotherapy therapy (9 to 53 sessions) for patients without PDs ($n = 30$, 20 of whom had Axis I disorders) and with PDs ($n = 15$, 8 of whom had Cluster C PDs). Six of 15 PD patients no longer met criteria for PD at 4-year follow-up, and none of the 3 patients with AVPD showed significant intrapsychic improvement, whereas 2 showed significant Axis I symptom improvement.

Monsen and colleagues (1995) treated 25 patients with a PD and Axis I diagnosis with psychodynamic psychotherapy. Treatment length averaged 24 months, and the mean follow-up assessments occurred at 5.2 years. At the end of treatment, 75% and 72% of patients no longer met *DSM–III–R* criteria for Axis I and Axis II disorders, respectively. These findings essentially held up at follow-up. However, only 4 patients met Cluster C PD criteria, and the only patient who met AVPD criteria at intake still had the diagnosis at termination and follow-up.

Svartberg and colleagues (2004) conducted a randomized trial of 40-session psychodynamic ($n = 25$) and cognitive ($n = 25$) psychotherapy of patients with *DSM–III–R* Cluster C PDs, 31 of whom met criteria for AVPD. Most of the patients (94%) also met criteria for an Axis I disorder. Patients in both treatment groups exhibited significant changes in interpersonal problems and dimensional personality scales pre- and posttreatment. Patients in psychodynamic therapy showed significant decreases in symptom distress at the end of treatment, whereas the patients in cognitive therapy did not. However, scores on all measures decreased at the 2-year follow-up. Symptomatic recovery rates at follow-up were 54% and 42% for the psychodynamic and cognitive therapy groups, respectively. Recovery rates from interpersonal problems were approximately 40%. Svartberg and colleagues (2004) concluded that both forms of therapy were effective in the treatment of Cluster C PDs. Unfortunately, separate analyses were not conducted on patients with AVPD.

Winston and colleagues (1994) randomized 81 patients with a *DSM–III–R* PD to brief dynamic/

affective-focused or adaptive/cognitive-focused psychodynamic psychotherapy and a waiting-list control group. Patients were seen for an average of 40 sessions. Thirty-six (44.4%) of the patients had an AVPD. More than one half of patients met criteria for an Axis I disorder. Both treatments groups showed significant differences pre- and posttreatment on all of the outcome measures as compared to no differences in the waiting-list group. Thirty-eight (47%) of patients were available for follow-up (average of 1.5 years) for target complaint assessments. Target symptom ratings did not differ between the treatment groups, but both groups showed additional improvement from scores at the end of treatment. Thus, both treatments were effective for treating Cluster C PDs.

Each of these psychotherapy studies for AVPD included many patients with comorbid Axis I disorders. Thus the findings are likely to be more generalizable to real-world clinical practice than studies that attempt to isolate symptoms using stringent exclusion criteria. In sum, the findings from these six studies suggest that short-term psychodynamic psychotherapy may be a viable approach to treating AVPD. To the best of our knowledge, there are no studies supporting the effectiveness of long-term psychodynamic psychotherapy or psychoanalysis for AVPD.

Although short-term psychodynamic psychotherapy may be helpful for some patients with AVPD, clearly not all patients benefit from this approach. More intensive psychotherapies, including psychoanalysis, may have a place in the treatment of patients who do not improve in other treatments (Fonagy, Roth, & Higgitt, 2005; Gabbard, Gunderson, & Fonagy, 2002). Moreover, it is important to study patient change with more complexity because psychoanalysis emphasizes multiple layers of meaning to people's experiences (Blatt & Auerbach, 2003), information that is often lacking in many large outcome studies. In the present case study, the patient sought psychoanalysis because he had tried multiple therapies: crisis therapy plus medication in his late teens, psychodynamic and eclectic therapy in his 20s, behavior therapy in his 30s, and supportive psychotherapy in his early 40s. Symptom relief from these treatments was temporary at best, and the patient continued to have disabling symptoms (e.g., a phobia of driving on expressways) and major interpersonal problems. He resigned himself to the fact that he would have to live with his anxiety. At the age of 50, with the support of his wife, the patient sought psychoanalysis at four times per week.

The purpose of this systematic case study is to begin to assess the effectiveness of psychoanalysis for AVPD with comorbid Axis I pathology using a longitudinal design. Our methodology included yearly and follow-up assessments of Axis II pathology along with Axis I diagnosis, symptom severity, pathological and healthy aspects of functioning, and internalized object relations. In addition to a self-report measure of symptom severity, independent external raters completed all other outcome assessments.

Based upon the phase model of psychotherapy (Howard, Maling, & Martinovich, 1993; Howard, Moras, Brill, Martinovich, & Lutz, 1996; Kopta, Howard, Lowry, & Beutler, 1994; Lueger, Lutz, & Howard, 2000), we hypothesized that the patient would evidence clinically significant changes in symptom severity/global functioning, followed by clinically significant changes in personality pathology, including internalized object relations.

Method

The Patient

Mr. A, a computer technician, was 50 years old when he began treatment. His immediate impetus for being evaluated for psychoanalysis was his long-standing anxiety and fears about driving (especially on expressways). However, his wife (of 7 years) was also urging him to try psychoanalysis because she found living with him to be increasingly difficult. Problems that unfolded as a function of intensive treatment included: hostility toward his wife, who was disabled from a slowly but progressively deteriorating neuromuscular condition, inhibitions at work with regard to advancement, lifelong feelings of inadequacy, social inhibitions, sensitivity to criticism, and sexual conflicts.

The Therapist

The therapist (J. H. P.) was a middle-aged Caucasian male in independent practice in the midwestern United States. He holds a doctorate in clinical psychology from an American Psychological Association–accredited graduate program,

is board certified in clinical psychology by the American Board of Professional Psychology, and is a graduate of a psychoanalytic institute accredited by the American Psychoanalytic Association.

The Treatment

The treatment was psychoanalysis four times per week. After the evaluation sessions, the patient chose to use the analytic couch. During the last year of treatment, the patient reduced his sessions to three times per week. The patient negotiated a reduced fee (three fourths of the therapist's standard fee), which was paid for through a combination of private funds and health insurance.

Procedures

Mr. A. agreed to complete the Brief Symptom Inventory (BSI) at intake, after every year of therapy and at 1-year and 2-year follow-up. Results from the BSI were always discussed as part of the treatment. Mr. A gave his signed consent to the therapist's use of audiotaping for both clinical and research purposes. He declined the need to read any article that included any material about him and his treatment. He was assured that any presentation or article would omit identifying information. The patient agreed to the taping of 25 sessions, which included 4 intake sessions, 4 sessions at the end of each year, and 1 follow-up session. Three of the 4 sessions at the end of each year with the best audio quality were transcribed and used for the study. Therefore, 4 intake sessions, 15 therapy sessions, and 1 follow-up session were used to assess personality pathology, global functioning, and object relations by two independent raters (experienced clinical psychologists). The 15 therapy sessions were also used to assess psychotherapy process by two different raters (the therapist and an advanced doctoral student). All process and outcome data were double coded for interrater reliability. Raters used the entire session for rating all observer-based process and outcome measures. Raters' responses were averaged for all outcome measures for final data presentation.

Outcome Measure (Patient Self-Report)

Brief Symptom Inventory (BSI; Derogatis, 1993). The BSI is a 53-item self-report scale designed to assess recent psychiatric symptoms and includes nine symptom subscales and a measure of global symptom severity (Global Severity Index; GSI). Higher scores represent greater psychological distress. A t score of 65 or higher is considered positive for psychopathology. The mean GSI raw scores for a normal population ($N = 974$) is .30 ($SD = .31$) and test–retest reliability for a 2-week period utilizing a nonpatient sample was .90. The BSI is a reliable and valid measure of psychological distress for both research and clinical settings. For this study, only the GSI was used to track symptom severity.

Outcome Measures (External Raters)

Two experienced clinical psychologists (V. B. D. and S. L.) in independent practice independently rated all session transcripts using the Global Assessment of Functioning Scale (GAF; American Psychiatric Association, 1994), Social Cognition and Object Relations Scale—Global (SCORS-G; Westen, 1995), and the Shedler–Westen Assessment Procedure—200 (SWAP-200; Shedler & Westen, 1998). Both raters had experience in coding clinical data for research purposes. Prior to using these instruments, each rater read the relevant literature for each scale, studied each of the scales, and applied them to current cases in their practices. Raters were given the intake sessions first. Sessions from each year and follow-up were given in random order. Sessions were not disguised, and therefore it is likely that the raters were aware of coding sessions close to the termination of the treatment and the 1-year follow-up session. They were unaware of the details of the case at the time of coding. The means of the raters' scores were used for data presentation.

Global Assessment of Functioning Scale (GAF; American Psychiatric Association, 1994). The GAF (Axis V of *DSM–IV*) is a measure of overall functioning designed to track clinical progress. Clinicians are to take into account a patient's psychological, social, and occupational functioning at the time of the assessment and rate them on a scale from 0 to 100, with higher scores indicative of better functioning. Scores from 1 to 50 indicate severe psychopathology and severe impairment in social, occupational, or school functioning; 51 to 70 indicates moderate to mild symptom severity and moderate to mild functional impairment; 71 to 80 indicate transient

symptoms and slight impairment; 81 to 90 indicate absent or minimal symptoms and generally good functioning; 91 to 100 indicates an absence of symptoms and superior functioning. The GAF has demonstrated moderate to high interrater reliability and validity (Goldman, Skodol, & Lave, 1992; Hilsenroth et al., 2000).

Shedler–Westen Assessment Procedure—200 (SWAP-200; Shedler & Westen, 1998). This is a Q-sort instrument that 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*) to 7 (*highly descriptive of the patient*). 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 items 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"). Reliable descriptions with the SWAP-200 have been obtained from clinicians from a variety of theoretical orientations (Westen & Shedler, 1999a, 1999b). Clinician ratings are converted to *t* scores ($M = 50$; $SD = 10$) for each of the *DSM–IV* PDs. The SWAP-200 also includes a Healthy Functioning scale, a dimensional measure of psychological strengths and adaptive functioning. *T* scores from 55 to 59 indicate PD features, whereas a *t* score of 60 is the cutoff for PD (J. Shedler, personal communication, January 20, 2003). Thus the scale can be used categorically and/or dimensionally. The SWAP-200 scales have good internal consistency (Westen & Shedler, 1999b), interrater reliability (Marin-Avellan, McGauley, Campbell, & Fonagy, 2005; Westen & Muderrisoglu, 2003, 2006), and convergent/discriminant (Marin-Avellan et al., 2005; Westen & Shedler, 1999a), incremental (Westen & Harnden-Fischer, 2001), and known groups validity (Porcerelli, Cogan, & Hibbard, 2004). The SWAP-200 has demonstrated sensitivity to changes brought about in an intensive psychoanalytic psychotherapy of a patient with Axis I (substance abuse) and Axis II (borderline personality disorder) pathology (Lingiardi, Shedler, & Gazzillo, 2006). The mean SWAP-200 AVPD raw score in the standardization sample ($N = 530$) was .29

($SD = .25$), and interrater reliability was .85. For this study, only the AVPD and Health Functioning scales are reported.

Social Cognition and Object Relations Scale—Global (SCORS-G; Westen, 1995; Hilsenroth, Stein, & Pinsker, 2004). The SCORS-G is a measure of global dimensions of interpersonal representations for narrative data, including psychotherapy sessions. The scale integrates object relations, social–cognitive, and developmental theories. The SCORS-G comprises eight dimensions: Complexity of representations (Complexity) refers to the degree of self/other differentiation and degree of complexity in which others are experienced; Affect–tone of relationship paradigms (Affect–tone) refers to the overall affective quality of interpersonal representations from malevolent to benevolent; Capacity for emotional investment in relationships (Relationships) refers to the degree of mutuality (vs. ego-centricity) of relationships; Capacity for emotional investment in values and morals (Morals) refers to the degree to which moral issues are considered in relationships; Understanding social causality refers to the degree to which thought, feeling, and behavior is logical, accurate, and psychologically minded. Experience and management of aggression (Aggression) refers to the degree to which aggression is appropriately controlled and expressed. Self-esteem refers to degree to which the self is experienced as generally positive (vs. self-loathing); Identity and self-coherence (Identity) refers to the degree to which identity is stable, enduring, and purposeful (vs. fragmented, unstable, and inconsistent). Each dimension is rated on a 7-point scale where scores of 1 or 2 indicate immature/pathological object relations and scores of 6 and 7 indicate mature/healthy object relations. Each of the SCORS-G dimensions has demonstrated good interrater reliability and validity (Huprich & Greenberg, 2003; Stricker & Gooen-Piels, 2004). Peters, Hilsenroth, Eudell, Blagys, and Handler (2006) have reported the reliability and convergent validity of the SCORS, as rated through relational narrative and self-statements told during psychotherapy sessions, with *DSM–IV* Axis V measures of global functioning in outpatients undergoing short-term psychodynamic psychotherapy.

DSM–IV Axis I Diagnosis

The patient was diagnosed with *DSM–IV* specific phobia, situational type, by both the therapist (J. H. P.) following the four evaluation sessions and by an independent rater (V. B. D).

Process Measure

Two raters, an advanced psychology graduate student (M. B.) and the therapist (J. P.), independently rated each of 15 transcribed session for years 1 through 5 using the Psychotherapy Q-Set (PQS; Jones, 2000). The raters read the relevant PQS literature and coded five psychotherapy sessions from another psychotherapy case. Discrepancies in scoring were discussed. The average interrater reliability for the five practice cases was greater than .70. To eliminate therapist bias, only process ratings from the graduate student were used to assess treatment fidelity.

Psychotherapy Q-Set (PQS; Jones, 2000). The PSQ is a pantheoretical 100-item Q-sort rating scale designed to provide a comprehensive description of therapist–patient interactions (therapist interventions and attitudes, patient attitudes and behaviors, and therapist/patient interaction). The PQS can be used with videotaped or audiotaped psychotherapy sessions. Entire sessions are coded, not just a portion of the session, in order to capture the complexity of the treatment process. Coders sort the 100 items along a 9-point continuum. The most characteristic items are placed in Category 9, neutral (or irrelevant) items are placed in Category 5, and the least characteristic items are placed in Category 1. Items placed into the least characteristic category are important because they indicate what aspects of the treatment and interaction are not present in a given therapy session. The placement of the 100 items along the 9-point continuum is governed by a fixed distribution approximating a normal curve. Only 5 items can be placed at each end of the continuum (Categories 1 and 9), whereas 18 items can be placed in the center (Category 5). A fixed distribution is a hallmark of the Q-technique and requires coders to make multiple evaluations among items and therefore avoid response sets and halo effects. Interrater reliability is computed by correlating (intraclass correlation; ICC) PSQ ratings from two independent coders for the same psychotherapy session. The reliability and discriminant validity for the PQS has been demonstrated over several studies and treatment samples (Ablon & Jones, 2002). Ablon and Jones (1998, 1999, 2002) developed prototypes for psychodynamic, cognitive–behavioral, and interpersonal therapy by having experts in each of these theoretical orientations rate an "ideal" therapy process for their respective therapies. By correlating the 100 PQS items with PQS ratings from actual therapy sessions, it can be determined the degree to which a session adhered to a particular brand of therapy. Examples of the top four psychodynamic therapy prototype items are "Patient's dreams and fantasies are discussed" (Item 90); "Therapist is neutral" (Item 93); "Therapist points outpatient's use of defensive maneuvers" (Item 36); and "Therapist draws connections between therapeutic relationship and other relationships" (Item 100). Examples of the top four cognitive–behavioral therapy prototypes items are "There is discussion of specific activities or tasks for the patient to attempt outside of session" (Item 38); "Discussion centers on cognitive themes, that is, about ideas or belief systems" (Item 30); "Patient's treatment goals are discussed" (Item 4); and "Therapist encourages patient to try new ways of behaving with others" (Item 85). Examples of the top four interpersonal therapy prototypes are "Patient's interpersonal relationships are a major theme" (Item 63); "Love or romantic relationships are a topic of discussion" (Item 64); "Patient's current or recent life situation is emphasized in discussion" (Item 69); and "Therapist asks for more information or elaboration" (Item 31).

Determining Clinically Significant Change

We employed criteria established by Jacobson and Truax (1991), which include Reliable Change Index (RCI >1.96) and return to a functional distribution or out of a dysfunctional distribution ($SD >2.0$). An RCI was calculated for each of the outcome variables with a slight modification to the formula as suggested by Wise (2004). Because this is a case study, pretreatment mean scores and SDs were borrowed from other studies for the GAF and SCORS. Because there are no nonpatient norms for the GAF scale, the SD and mean from 41 patients beginning psychoanalysis for personality pathology (Cogan & Porcerelli, 2006) were used to calculate change in SD units. In that sample, the pretreatment mean was 67.80, and SD was 11.70. Nonpatient norms

do not exist for the SCORS-G. However, in a sample of 90 outpatients (all with Axis I diagnoses and 48 with comorbid Axis II diagnoses), Peters and colleagues (2006) reported means (3.12 for Self-Esteem to 4.02 for Complexity) and SDs (.81 for Self-Esteem to 1.17 for Aggression) for SCORS's dimensions from psychotherapy sessions. Thus, we set SDs for all SCORS dimensions at 1.00.

Results

Interrater Agreement for Outcome and Process Measures

Interrater agreements for the outcome and process measures were calculated using ICC (two-way random effects). The mean ICC for the SWAP-200 was .68 (.81 with Spearman–Brown correction for double coding). The ICC for the GAF scale was .67 (.80 corrected), and the ICC for the SCORS dimensions ranged from .54 to .97 (.70 to .98 corrected). The mean ICC for the process ratings for the PQS was .82 (.90 corrected; range .76 to .87).

Treatment Process: Did the Treatment Conform to the Psychoanalytic Prototype?

Correlations between the sessions of psychoanalysis and expert-developed psychodynamic, cognitive–behavioral, and interpersonal ideal prototypes are presented in Table 1. These results indicate that a strong psychodynamic process was demonstrated from three sessions at the end of each year of treatment. Significant correlations ($p < .001$) ranged from .49 to .62. At the end of the third year of treatment, correlations between

TABLE 1. Correlations Between Psychoanalytic Therapy Sessions and Psychodynamic, Cognitive-Behavioral, and Interpersonal Therapy Prototypes

| | Treatment prototypes | | |
| | | Cognitive- | |
Year	Psychodynamic	Behavioral	Interpersonal
1	49***	−.14	−.07
2	56***	−.04	−.01
3	62***	.23*	.24*
4	62***	.03	.01
5	.56***	.12	.06
Composite of Years 1–5	.64***	.04	.05

* $p < .05$.   *** $p < .001$.

the actual process ratings and the cognitive–behavioral and interpersonal therapy prototypes were statistically significant ($p < .05$), indicating that the process at that point in the treatment was not solely psychodynamic. A composite profile of the set of three yearly sessions across each of 5 years of treatment (15 total sessions) of the most characteristic and least characteristic processes is reported in Table 2.

Outcome

Table 3 displays the results of the outcome measures as rated by the patient and external observers at the end of each year of treatment and at follow-up.

Symptom Severity, Global Functioning, and Strengths

With regard to symptom severity, BSI Global Severity Index t scores were in the pathological range from intake through Year 3 of treatment. T scores were in the nonclinical range at Year 4 through 2 years posttreatment. Changes in raw BSI scores between intake, Years 4 and 5, and follow-up reached clinical significance. GAF scores changed from the "moderate" symptom severity range (51–60) to the "mild" range (61–70) at Year 2 and into the "transient" symptom range (71–80) at Year 5. They were maintained at the 1-year follow-up assessment. Changes in GAF scores from intake to Year 5 and 1-year follow-up were clinically significant. Psychological strengths, as indicated by SWAP-200 High Functioning scale scores, evidenced clinically significant changes by Year 4 through follow-up.

Personality Disorder

Mr. A met SWAP-200 criteria for AVPD with a t score of 60.50 at intake. At the end of Year 1 of treatment, he no longer met criteria for the disorder. However, in Years 3 and 4, he reached the "features" range with t scores of 55 and 59, respectively. At Year 5, he no longer exhibited AVPD features. Changes in Mr. A's SWAP-200 AVPD score at follow-up were clinically significant.

Specific Phobia

Mr. A reported having avoided driving expressways 18 times in the 2 weeks prior to be-

TABLE 2. Rank Ordering of PQS Process Means in Psychoanalysis for Avoidant Personality Disorder

Item no.	PQS items	*M*
	Most characteristic	
88	Patient brings up significant issues and material	8.13
73	Patient is committed to the work of therapy	8.10
90	Patient's dreams or fantasies are discussed	7.80
50	Therapist draws attention to feelings regarded by the patient as unacceptable (e.g., anger, envy, or excitement)	7.77
72	Patient understands the nature of therapy and what is expected	7.73
67	Therapist interprets warded-off or unconscious wishes, feelings, or ideas	7.40
81	Therapist emphasizes patient's feelings in order to help him or her experience them more deeply	7.27
49	Patient experiences ambivalent or conflicted feelings about the therapist	7.13
33	Patient talks of feelings about being close to or needing someone	7.00
53	Patient is concerned about what the therapist thinks of him	6.90
18	Therapist coveys a sense of nonjudgmental acceptance	6.87
28	Therapist accurately perceives the therapeutic process	6.83
98	Therapy relationship is focus of discussion	6.83
	Least characteristic	
38	There is a discussion of specific activities or tasks for the patient to attempt outside of sessions	1.23
77	Therapist is tactless	1.63
27	Therapist gives explicit advice and guidance (vs. defers even when pressed to do so)	1.77
37	Therapist behaves in a teacher-like (didactic) manner	1.90
51	Therapist condescends to or patronizes the patient	2.03
85	Therapist encourages patient to try new ways of behaving with others	2.07
57	Therapist explains rationale behind his or her technique or approach to treatment	2.13
21	Therapist self-discloses	2.13
17	Therapist actively exerts control over the interaction	2.30
89	Therapist acts to strengthen defenses	2.40
4	Patient's treatment goals are discussed	2.60
24	Therapist's own emotional conflicts intrude into the relationship	2.60

Note. PQS = Psychotherapy Q-Set. The mean score is the average score for each item across each of the 5 yearly sets of sessions (15 total sessions).

ginning his evaluation for treatment and reported six avoidances of expressway driving at 6 months into treatment. At Year 1, he was no longer avoided expressway driving and no longer met *DSM–IV* criteria for specific phobia, situational type, as reported by the therapist and an independent rater.

Object Relations

At intake, the majority of Mr. A's object relations ratings were around the midpoint of the 7-point scales (3.50–4.50), except for Complexity (3.00) and Self-esteem (2.50), which were clearly in the pathological range. Clinically significant changes were noted for four of eight dimensions at Year 4 and seven of eight by Year 5, with six of these seven dimensions remaining clinically significant at follow-up (Complexity, Affect–tone, Social causality, Aggression, Self-esteem, and Identity). Interestingly, the Self-esteem ratings were clinically significant at Year 2 through follow-up.

Discussion

Short-term psychodynamic therapies (9 to 53 sessions) show promise as interventions for AVPD. Treatment results reported by Barber et al. (1997), Hardy et al. (1995), Svartberg et al. (2004), and Winston et al. (1994) are likely generalizable to real-world clinical practice given that in all four studies most of the patients had a comorbid Axis I pathology. However, not all patients improved with short-term therapy, warranting an evaluation of the effectiveness of a

TABLE 3. Mean Scores of Symptom Severity, Global Functioning, Personality Disorder, and Object Relations by Year of Treatment

	Intake	Year 1	Year 2	Year 3	Year 4	Year 5	Follow-up		Effect size Cohen's d
							1 Year	2 Years	
Symptom severity/functioning									
GSI	72.00	76.00	67.00	67.00	63.00[*]	57.00[*]	58.00[*]	54.00[*]	1.80
GAF	54.00	58.00	64.00	63.50	63.00	78.50[*]	79.00[*]		2.50
High functioning	56.20	53.85	56.85	62.30	64.80[*]	74.75[*]	75.50[*]		1.93
Personality disorder									
Avoidant PD	60.50	50.75	53.90	57.30	55.50	48.20	37.45[*]		2.30
Object relations									
Complexity	3.00	4.00	4.50	5.00[*]	6.00[*]	6.00[*]	6.00[*]		3.00
Affect-tone	3.50	4.00	4.50	5.00[*]	5.00[*]	5.50[*]	6.50[*]		3.00
Investment/relations	4.50	4.00	5.50	5.00	5.50	5.50	5.50		1.00
Investment/morals	4.00	4.50	5.00	5.00	5.50[*]	6.00[*]	5.00		1.00
Social causality	4.00	4.00	4.00	4.50	5.00	6.50[*]	6.00[*]		2.00
Aggression	4.00	3.50	5.50	5.00	4.50	6.00[*]	6.50[*]		2.50
Self-esteem	2.50	3.50	4.50[*]	4.00[*]	4.50[*]	5.00[*]	6.00[*]		3.50
Identity	4.00	4.00	5.00	4.00	4.00	6.50[*]	6.50[*]		2.50

Note. GSI = Global Severity Index (Brief Symptom Inventory); Avoidant PD = SWAP-200 Avoidant Personality Disorder Scale; GAF = Global Assessment of Functioning Scale (*DSM-IV*); high functioning = SWAP-200 High Functioning Scale; object relations = Social Cognition and Object Relations Global Scale. Effect sizes were calculated between intake and at 1-year follow-up.
[*] Clinically significant change according to Jacobsen & Truax (1991): RCI > 1.96 and return to a functional distribution or out of a dysfunctional distribution.

more intensive psychodynamic therapy for treatment-resistant patients with AVPD with comorbid Axis I disorders. This naturalistic systematic case study was conducted to assess the effectiveness of psychoanalysis across multiple domains of patient functioning, including symptoms, global functioning, personality disorder, object relations, and psychological strengths. Assessments were conducted through both patient self-report and through ratings by independent raters, thus reducing therapist bias. And although process ratings were done by the therapist and an independent rater, interrater reliability coefficients were excellent, and final process ratings were based only upon ratings derived from the independent rater.

Findings from this case study warrant further investigation of psychoanalysis for patients with AVPD and comorbid Axis I conditions, especially those who have not benefited from other therapies. Mr. A reported reductions in symptoms during his prior treatments but was symptomatic shortly thereafter. Personality or character difficulties remained throughout his adult life and remitted only during psychoanalysis. In the present treatment, Mr. A needed an intensive, long-term treatment to allow the emergence of conflicts over aggression and sexual desires,

feelings of guilt associated with them, social and work inhibitions, and feelings of inadequacy. As indicated by the relationships between actual clinical processes, as rated with the Psychotherapy Q-Set, the treatment adhered to psychodynamic principles throughout with some use of cognitive–behavioral and interpersonal principles.

Psychodynamic processes included contributions from the patient, the therapist, and interactions between the two. Patient contributions included (in rank order) bringing up significant issues and material (Item 88), being committed to the work of therapy (Item 73), an understanding of the nature of therapy and what is expected (Item 72), experiencing ambivalent and conflicted feelings about the therapist (Item 49), being able to talk about feeling close to or needing others (Item 33), and being concerned about what the therapist thinks of him (Item 53). Therapist contributions to the process included (in rank order) the therapist drawing attention to feelings regarded by the patient as unacceptable (Item 50); interpreting warded off or unconscious wishes, feelings, or ideas (Item 67); emphasizing the patient's feelings in order to help him experience them more deeply (Item 81); conveying a sense of nonjudgmental acceptance (Item 18);

and accurately perceiving the therapeutic process (Item 28). Contribution of the patient/therapist interaction included (in rank order) dreams and fantasies are discussed (Item 90) and the therapy relationship is a focus of discussion (Item 98). These findings support the view of many psychotherapy researchers (e.g., Ablon & Jones, 1999; Blatt, Quinlan, Pilkonis, & Shea, 1995; Krupnick et al., 1996) who have reported that an analysis of patient characteristics in combination with therapist and relationship variables is crucial in understanding therapeutic outcome.

The CBT and IPT processes reported at the end of Year 3 deserve some explanation. Mr. A had extremely strong resistances to acknowledging and working with his conflicts over aggression toward his wife. Through the psychoanalytic method, the therapist and patient came to understand his intense and frightening unconscious rage toward his wife (and associated guilt), whose deteriorating physical health threatened to deplete his emotional and financial resources. It was during the third year that much work was accomplished in this area. During this time, detailed information was gathered about Mr. A's current thoughts, fantasies, feelings, and behaviors toward his wife. An emphasis on current relationships is a central focus of IPT, and thus it is not surprising that a significant correlation between session process at the end of Year 3 and the IPT ideal prototype emerged. During this same period, Mr. A often commented on his efforts to "behave differently" with his wife, and he and the therapist would at times talk about ways of improving his behavior toward her. These interactions could be construed as a type of homework and as advice-giving, which are common in CBT (for a review of the use of homework in psychodynamic psychotherapy, see Stricker, 2006).

Because of the limitations of effectiveness research, the investigators cannot say that the changes brought about during the course of the treatment were due to psychodynamic processes alone. Research by Ablon and Jones (1998) has demonstrated how therapists using relatively small amounts of technique from one brand of therapy can have significant effects on treatment outcome. Thus, without a larger sample of patients undergoing psychoanalysis for AVPD, we cannot at this point speak to the relative effect of psychodynamic, cognitive–behavioral, or interpersonal processes on treatment outcome. What can be said is that in this particular psychoanalytic treatment, which at times evidenced processes that could be classified as cognitive and interpersonal therapy techniques, was associated with recovery from Axis I and Axis II disorders, significant decreases in symptomatic distress and relational pathology, and an improvement in general functioning and psychological strengths.

Psychotherapy outcome research has consistently demonstrated that symptoms, functioning, and personality pathology respond at different rates during psychotherapy. Studies assessing the dose–effect relationship of psychotherapy have demonstrated that the most rapid changes occur in the areas of self-reported subjective well-being and Axis I symptoms (Howard et al., 1993, 1996; Kopta et al., 1994; Lueger et al., 2000). Changes in interpersonal and personality functioning tend to require longer interventions (Kopta et al., 1994; Perry, Banon, & Ianni, 1999) and thus change at a slower rate than Axis I symptoms— this three-phase sequence of recovery in known as the phase model (Howard et al., 1993, 1996). Our hypothesis regarding the phase model of change received partial support. Although the patient no longer met *DSM–IV* criteria for specific phobia, situational type, after Year 1, he did not evidence clinically significant change in symptom severity until Year 4. However, these clinically significant changes did occur prior to clinically significant changes in PD, thus supporting our hypothesis. The patient no longer met SWAP-200 criteria for AVPD at the end of the first year of treatment; he did, however, meet criteria for AVPD features at the end of the third and fourth years of treatment and did not evidence clinically significant change in AVPD SWAP-200 scores until 1-year follow-up. Object relations are considered to be enduring intrapsychic structures and thus are dimensions of personality. Inconsistent with the phase model, aspects of object relations showed clinically significant changes prior to clinically significant symptom changes. These dimensions included Self-esteem, Complexity, and Affect–tone. The change process for some patients may entail a greater degree of complexity than the current version of the phase model can account for. We speculate that changes in internal representations of self and other in treatment-resistant patients with AVPD may relate to trial behaviors and relationships in fantasy that prepare a patient for more enduring relational and personality changes.

We also speculate that Mr. A's anxiety/distress remained high for so long for several reasons. Mr. A was genetically predisposed to anxiety, lived with a highly anxious/phobic mother, had traumatic experiences both in childhood (i.e., hospitalization for a life-threatening illness, separation due to hospitalization in an isolation room for 2 weeks) and young adulthood (i.e., emergency landing of a plane), and sexual fantasies and conflicts that were met by an extremely harsh and punitive conscience that resulted in distress (in part as a punishment for his desires). In addition, he was the primary caretaker for his wife, who suffered from a deteriorating neuromuscular condition. He obsessively worried about her suffering an exacerbation of her condition that would warrant around-the-clock nursing care and deplete his emotional and financial resources. It took time to help him to become aware of, tolerate, and work through his enormous feelings of fear, guilt, anger, and sexual conflicts.

With regard to Mr. A's driving phobia, Fonagy, Roth, and Higgett (2005) indicate that there are no effectiveness or randomized control trials of short- or long-term psychoanalytic therapy for specific phobia in the literature, despite the fact that specific phobias are one of the most common anxiety disorders. However, there is data to suggest that short-term psychodynamic therapy is effective for a variety of other Axis I disorders (Leichsenring, Rabing, & Leibing, 2004), including panic disorder (e.g., Milrod et al., 2001). Given the fact that Mr. A's phobia remitted after 1 year of psychoanalysis (combined with behavioral technique) suggests that short-term therapy that integrates dynamic and behavioral technique may be useful in the treatment of specific phobia. It should be noted that Mr. A had a good working knowledge of behavioral treatment for phobias. It is beyond the scope of this article to discuss the details of the therapist's approach in working with Mr. A's phobic avoidance of driving on expressways. Suffice it to say, however, that the therapist did explore and interpret the dynamics of Mr. A's avoidance and helped him to make use of behavioral techniques while driving.

One of the major drawbacks of the present study was the limited number of sessions during each year that were audio recorded. Future systematic case studies of psychoanalysis should include assessments at 6 or even 3 months apart for outcome measures to gain a precise understanding of change processes. Likewise, a greater number of sessions available for process coding would allow for analyses of patient–therapist interaction processes as outlined by Jones (2000). We are in agreement with Jones (2000) that systematic case studies are key to understanding the mysteries of therapeutic action.

References

Ablon, J. S., & Jones, E. E. (1998). How expert clinicians' prototypes of an ideal treatment correlate with outcome in psychodynamic and cognitive–behavioral therapy. *Psychotherapy Research, 8*(1), 71–83.

Ablon, J. S., & Jones, E. E. (1999). Psychotherapy process in the NIMH Collaborative Research Program. *Journal of Consulting and Clinical Psychology, 67*(1), 64–75.

Ablon, J. S., & Jones, E. E. (2002). Validity of controlled clinical trials of psychotherapy: Findings from the NIMH treatment of depression collaborative research program. *American Journal of Psychiatry, 159*(5), 775–783.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Barber, J. P., Morse, J. Q., Krakauer, I. D., Chittams, J., & Crits-Christoph, K. (1997). Change in obsessive–compulsive and avoidant personality disorders following time-limited supportive–expressive therapy. *Psychotherapy, 34,* 133–143.

Blatt, S. J., & Auerbach, J. S. (2003). Psychodynamic measures of therapeutic change. *Psychoanalytic Inquiry, 23,* 268–307.

Blatt, S. J., Quinlan, D. M., Pilkonis, P. A., & Shea, T. M. (1995). Impact of perfectionism and need for approval on the brief treatment of depression: The National Institute of Mental Health Treatment of Depression Collaborative Program revisited. *Journal of Consulting and Clinical Psychology, 63,* 125–132.

Cogan, R., & Porcerelli, J. H. (2006). The longitudinal study of psychoanalysis for personality pathology. Unpublished raw data.

Coid, J., Yang, H., Tyrer, P., Roberts, A., & Ullrich, S. (2006). Prevalence and correlates of personality disorder in Great Britain. *British Journal of Psychiatry, 188,* 423–431.

Derogatis, L. R. (1993). *BSI: Administration, scoring, and procedures manual.* Minneapolis, MN: National Computer Systems.

Fonagy, P. (2002). *An open door review of outcome studies in psychoanalysis* (2nd ed.). London: International Psychoanalytic Association.

Fonagy, P., Roth, A., & Higgitt, A. (2005). Psychodynamic psychotherapies: Evidence- based practice and clinical wisdom. *Bulletin of the Menninger Clinic, 69,* 1–58.

Gabbard, G. O., Gunderson, J. G., & Fonagy, P. (2002). The place of psychoanalytic treatments within psychiatry. *Archives of General Psychiatry, 59,* 505–510.

Goldman, H. H., Skodol, A. E., & Lave, T. R. (1992). Revising Axis V for *DSM–IV*: A review of measures of social functioning. *American Journal of Psychiatry, 149,* 1148–1156.

GRANT, B. F., HASIN, D. S., STINSON, F. S., DAWSON, D. A., CHOU, S. P., RUAN, W. J., ET AL. (2004). Prevalence, correlates, and disability of personality disorder in the United States: Results from the national epidemiologic survey on alcohol and related conditions. *Journal of Clinical Psychiatry, 65,* 948–958.

HARDY, G. E., BARKHAM, M., SHAPIRO, D. A., STILES, W. B., REES, A., & REYNOLDS, S. (1995). Impact of cluster C personality disorders on outcomes of contrasting brief psychotherapies for depression. *Journal of Consulting and Clinical Psychology, 63,* 997–1004.

HILSENROTH, M. J., ACKERMAN, S. J., BLAGYS, M. D., BAUMANN, B. D., BAITY, M. R., SMITH, R., ET AL. (2000). Reliability and validity of *DSM–IV* Axis V. *American Journal of Psychiatry, 157,* 1858–1863.

HILSENROTH, M. J., STEIN, M., & PINSKER, J. (2004). *Social Cognition and Object Relations scale: Global rating method (SCORS-G).* Unpublished manuscript.

HOGLEND, P. (1993). Personality disorders and long-term outcome after brief psychodynamic therapy. *Journal of Personality Disorders, 7,* 168–181.

HOWARD, K. I., LUEGER, R. J., MALING, M. S., & MARTINOVICH, Z. (1993). A phase model of psychotherapy outcome: Causal mediation of change. *Journal of Consulting and Clinical Psychology, 61,* 678–685.

HOWARD, K. I., MORAS, K., BRILL, P. L., MARTINOVICH, Z., & LUTZ, W. (1996). Evaluation of psychotherapy: Efficacy, effectiveness, and patient progress. *American Psychologist, 51,* 1059–1064.

HUPRICH, S. K., & GREENBERG, R. P. (2003). Advances in the assessment of object relations in the 1990s. *Clinical Psychology Review, 23,* 665–698.

JACOBSON, N. S., & TRUAX, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59,* 12–19.

JONES, E. E. (2000). *Therapeutic Action.* Northvale, NJ: Jason Aronson.

KOPTA, S. M., HOWARD, K. I., LOWRY, J. L., & BEUTLER, L. E. (1994). Patterns of symptomatic recovery in time-limited psychotherapy. *Journal of Consulting and Clinical Psychology, 62,* 1009–1016.

KRUPNICK, J. H., SOTSKY, S. M., ELKIN, I., WATKINS, J., & PILKONIS, P. A. (1996). The role of therapeutic alliance in psychotherapy and pharmacotherapy outcome: Findings in the National Institute of Mental Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology, 64,* 532–539.

LEICHSENRING, F., RABING, S., & LEIBING, E. (2004). The efficacy of short-term psychodynamic psychotherapy in specific psychiatric disorders: A meta-analysis. *Archives of General Psychiatry, 61,* 1208–1216.

LINGIARDI, V., SHEDLER, J., & GAZZILLO, F. (2006). Assessing personality change in psychotherapy with the SWAP-200: A case study. *Journal of Personality Assessment, 86,* 23–32.

LUBORKSY, L. (1984). *Principles of psychoanalytic psychotherapy: A manual for supportive/expressive treatment.* New York: Basic Books.

LUEGER, R., LUTZ, W., & HOWARD, K. (2000). The predicted and observed course of psychotherapy for anxiety and mood disorders. *Journal of Nervous and Mental Disease, 188,* 127–134.

MARIN-AVELLAN, L. E., McGAULEY, G., CAMPBELL, C., & FONAGY, P. (2005). Using the SWAP-200 in a personality-disordered forensic population: Is it valid, reliable and useful? *Criminal Behaviour and Mental Health, 15,* 28–45.

MILROD, B., BUSCH, F., LEON, A. C., ARONSON, A., ROIPHE, J., RUDDEN, M., ET AL. (2001). A pilot open trial of brief psychodynamic psychotherapy for panic disorder. *Journal of Psychotherapy Practice and Research, 10,* 239–245.

MONSEN, J. T., ODLAND, T., FAUGLI, A., DAAE, E., & EILERTSEN, D. E. (1995). Personality disorders: Changes and stability after intensive psychotherapy focusing on affect consciousness. *Psychotherapy Research, 5,* 33–48.

PERRY, J. C., BANON, E., & IANNI, F. (1999). Effectiveness of psychotherapy for personality disorders. *American Journal of Psychiatry, 156,* 1312–1321.

PETERS, E. J., HILSENROTH, M. J., EUDELL, E. M., BLAGYS, M. D., & HANDLER, L. (2006). Reliability and validity of the Social Cognition and Object Relations Scale in clinical use. *Psychotherapy Research, 16,* 606–614.

PORCERELLI, J. H., COGAN, R., & HIBBARD, S. (2004). Personality characteristics of partner violent men: A Q-sort approach. *Journal of Personality Disorders, 18,* 151–162.

REICH, J. H. (2003). The effect of Axis II disorders on the outcome of treatment of anxiety and unipolar depressive disorders: A review. *Journal of Personality Disorders, 17,* 387–405.

SAMUELS, J., EATON, W. W., BIENVENU, J., BROWN, C. H., COSTA, P. T., & NESTADT, G. (2002). Prevalence and correlates of personality disorders in a community sample. *British Journal of Psychiatry, 180,* 536–542.

SHEA, M. T., STOUT, R. L., YEN, S., PAGANO, M. E., SKODAL, A. E., MOREY, L. C., ET AL. (2004). Associations in the course of personality disorders and Axis I disorders over time. *Journal of Abnormal Psychology, 113,* 499–508.

SHEDLER, J., & WESTEN, D. (1998). Refining the measurement of Axis II: A Q-sort procedure for assessing personality pathology. *Assessment, 5,* 333–353.

STRICKER, G. (2006). Using homework in psychodynamic psychotherapy. *Journal of Psychotherapy Integration, 16,* 219–237.

STRICKER, G., & GOOEN-PIELS, J. (2004). Projective assessment of object relations. In M. Hersen (Series Ed.) & M. J. Hilsenroth & D. L. Segal (Vol. Eds.), *Comprehensive Handbook of Psychological Assessment, Vol. 2: Personality Assessment* (pp. 449–465). Hoboken, NJ: Wiley.

SVARTBERG, M., STILES, T. C., & SELTZER, M. H. (2004). Randomized, controlled trial of the effectiveness of short-term dynamic therapy and cognitive therapy for cluster C personality disorders. *American Journal of Psychiatry, 161,* 810–817.

TORGERSEN, S., KRINGLEN, E., & CRAMER, V. (2001). The prevalence of personality disorders in a community sample. *Archives of General Psychiatry, 58,* 590–596.

VIINAMAKI, H., HINTIKKA, J., HONKALAMPI, K., KOIVUMAA-HONKANEN, H., KUISMA, S., ANTIKAINEN, R., ET AL. (2002). Cluster C personality disorder im-

pedes alleviation of symptoms in major depression. *Journal of Affective Disorders, 71,* 35–41.

VIINAMAKI, H., TANSKANEN, A., KOIVUMAA-HONKANEN, H., HAATAINEN, K., HONKALAMPI, K., ANTIKAINEN, R., ET AL. (2003). Cluster C personality disorder and recovery from major depression: 24-month prospective follow-up. *Journal of Personality Disorders, 17,* 341–350.

WESTEN, D. (1995). *Social Cognition and Object Relations Scale—Global ratings (SCORS-G).* Unpublished manuscript.

WESTEN, D., & HARNDEN-FISCHER, J. (2001). Profiles of eating disorders: Rethinking the distinction between Axis I and Axis II. *American Journal of Psychiatry, 158,* 547–562.

WESTEN, D., & MUDERRISOGLU, S. (2003). Assessing personality disorders using a systematic clinical interview: Evaluation of an alternative to structured interviews. *Journal of Personality Disorders, 17,* 350–368.

WESTEN, D., & MUDERRISOGLU, S. (2006). Clinical assessment of pathological personality traits. *American Journal of Psychiatry, 163,* 1285–1287.

WESTEN, D., & SHEDLER, J. (1999a). Revising and assessing Axis II, part I: Developing a clinically and empirically valid assessment method. *American Journal of Psychiatry, 156,* 258–272.

WESTEN, D., & SHEDLER, J. (1999b). Revising and assessing Axis II, part II: Toward an empirically based and clinically useful classification of personality disorders. *Journal of Psychiatry, 156,* 273–285.

WINSTON, A., LAIKIN, M., POLLACK, J., SAMSSTAG, L. W., MCCULLOUGH, L., & MURAN, J. C. (1994). Short-term psychotherapy for personality disorders. *American Journal of Psychiatry, 151,* 190–194.

WISE, E. A. (2004). Methods for analyzing psychotherapy outcomes: A review of clinical significance, reliable change, and recommendations for future directions. *Journal of Personality Assessment, 82,* 50–59.

Correction to Fuertes et al. (2006)

In the article "Therapist Multicultural Competency: A Study of Therapy Dyads" by Jairo N. Fuertes, Thomas I. Stracuzzi, Jennifer Bennett, Jennifer Scheinholz, A. Mislowack, Mindy Hersh, and David Cheng (*Psychotherapy: Theory, Research, Practice, Training,* 2006, Vol. 43, No. 4, pp. 480–490) the fifth author's name should be spelled as follows:

ALEXA MISLOWACK