Running Head: TREATMENT INTENSITY AND REGULARITY

Treatment Intensity and Regularity in Early Outpatient Psychotherapy and Its Relation to Outcome

Susanne Kraft[1]

Bernd Puschner[2]

Hans Kordy[1]

[1]Center for Psychotherapy Research, Heidelberg, Germany

[2]Ulm University, Department of Psychiatry II, Germany

We are grateful to "Deutsche Krankenversicherung" (DKV), Cologne, Germany, for funding the The TRANS-OP study.

Correspondence should be addressed to:

Dr. Hans Kordy

Center for Psychotherapy Research at the Institute for Psychosomatic Cooperative Research and Family Therapy

University Hospital Heidelberg

Bergheimer Str. 54, 69115 Heidelberg, Germany

Phone: ++49-6221-56- 7345; Fax: ++49-6221-56-7350

E-Mail: hans.kordy@med.uni-heidelberg.de

Abstract

The distribution of treatment sessions (number of interruptions, weeks without psychotherapy, and session number) during the first three months of psychodynamic psychotherapy (PD), cognitive behavioral therapy (CBT), and psychoanalytic psychotherapy (PA) was analyzed prospectively during two-years in a sample of 256 outpatients.

Number of weeks without psychotherapy in early treatment was predicted by initial helping alliance in PD and by quality of interpersonal relations in CBT. Level of initial psychological or physical impairment showed no effect on distribution of sessions during early treatment. In PD and CBT, session distribution early in treatment did not predict subsequent course of improvement. Only in PA, weeks without psychotherapy and session number affected rate of symptom change in that participants showed better outcome when treatment started continuously at a rather slow pace.

Implications for psychotherapy practice and research are discussed.

Keywords:

Outpatient psychotherapy, mid- and long-term psychotherapy, treatment interruptions, early treatment phase, course of improvement.

Treatment Intensity and Regularity in Early Outpatient Psychotherapy and Its Relation to Outcome

The handling of time, i.e. the number of sessions, their frequency and regularity, is a central aspect of psychotherapeutic treatment (Kordy, Rad, & Senf, 1988; Kordy & Kächele, 1995). The amount and spacing of sessions during a given treatment period could be influenced by several factors including therapist's theoretical orientation, third party payors' reimbursement regulations, time management of the therapist or the patient, patient's treatment motivation and symptom distress, and/or the quality of the patient-therapist-relationship. Empirical studies suggest a relationship of symptom distress and treatment intensity (Beutler et al., 2004). Thus, in times when the patient is in a crisis and plagued by high symptom distress, sessions are possibly applied more frequently: "Often, the more intense the symptoms, the greater the need for support during the early phases of treatment and until symptom intensity abates" (Beutler & Clarkin, 1990, p. 152).

In turn, the handling of time can be important for treatment outcome. In general, a positive relationship was reported between session number and outcome (Howard, Kopta, Krause, & Orlinsky, 1986; Seligman, 1995; Lambert & Ogles, 2004). A few studies dealt with frequency or treatment intensity, but yielded mixed results. While Kordy et al.

(1988), using the dominant number of weekly sessions as intensity parameter, did not find an advantage for more intensive therapies, Freedman, Hoffenberg, Vorus, and Frosch (1999) and Fettes & Peters (1992) found that higher session frequency was associated with better outcome.

Analyzing the interaction between duration and frequency in long-term psychoanalysis and (psychoanalytic) psychotherapy, Sandell, Blomberg, and Lazar (2002) observed that long, high-frequency as well as short, low-frequency treatments showed the best post-treatment outcome. Investigating the interaction of treatment duration and session number, Reardon, Cukrowicz, Reeves, and Joiner (2002) found that for patients with up to 11 sessions, more months in therapy were associated with worse outcome. This finding implies an unfavorable influence of long inter-session-intervals or interruptions.

It could be assumed that the beginning of psychotherapy is a critical phase because symptom distress is high, and a stable therapeutic alliance, which is generally emphasized as crucial for treatment success (Orlinsky, Rønnestad, and Willutzki (2003), has not yet been established. In this phase, long treatment interruptions might have an unfavorable impact on the therapeutic process and outcome. However, empirical evidence regarding this question is scarce. The only study on this issue known to the authors yielded that interruptions

during the first three months of psychoanalytic treatment had no impact on different outcome variables (Kordy et al., 1988).

In a prospective naturalistic longitudinal study, we will analyze for psychodynamic psychotherapy, cognitive behavioral therapy and psychoanalytic psychotherapy, (a) the handling of time during early treatment, (b) whether and how interruptions and session number during early treatment are affected by initial impairment (psychological, physical, and social) and the quality of the helping alliance, and (c) whether and how interruptions and session number early in treatment affect the subsequent course of symptomatic improvement.

Method

Design

Participants were recruited in co-operation with a major German health insurance company ("Deutsche Krankenversicherung", *DKV*). All insurees (*N* = 3804) who requested reimbursement of outpatient psychotherapy (psychodynamic psychotherapy--PD, cognitive behavior therapy--CBT, or analytic psychotherapy--PA) between fall 1998 and spring 2000 (a formal application for reimbursement is required if psychotherapy of more than 25 sessions is taken into consideration) were asked to participate in the study "Transparency and Outcome Orientation in Outpatient Psychotherapy" (TRANS-OP).

All insurees who considered participation (*N* = 939) received a questionnaire for themselves and another one for their therapist. Since gathering of complete service utilization data proved to be extremely laborious, of the participants who were recruited before December 1999 (PD: *N* = 402; CBT; *N* = 236; PA: *N* = 123), 100 of each form of psychotherapy were randomly selected. Of these, 259 sent back the first questionnaire (T1) and gave their written consent to participate. Participants received further questionnaires 1.5 years (T4) and two years thereafter (T5). Intermediate measurement points (T2 and T3) were administered randomly at two out of seven (4, 8, 16, 28, 40, 52, and 64 weeks after intake) points in time. This design--optimized for the application of Hierarchical Linear Models--allows for a large number of measurements (total of 10 for the sample) while participants were asked to provide data at only five times. Response rates for the second to fifth questionnaires were 93% (*N* = 240), 88% (*N* = 229), 82% (*N* = 211), and 78% (*N* = 203). For further analysis, only participants with a treatment duration of more than three months (*N* = 256) were included.

Measures

Psychological symptomatic impairment was measured via the German version (Franke, 1995) of Derogatis' (1986) "Symptom-Check-List" (SCL-90-R), a widely used self-report scale comprising 90 items, each rated on a five-point Likert scale

("not at all" ... "very much"). In this paper, the Global Severity Index (GSI) indicating a participant's mean impairment over all 90 items was used. The SCL-90-R was assessed at all measurement points.

The "Giessener Beschwerdebogen" (GBB-24;Brähler & Scheer, 1995) was used to assess the patient's view of his or her *physical impairment* (headache, dizziness, etc.) at T1. Of the 24 items, each rated on a 5-point-Likert scale ("not impaired" ... "very much impaired"), a sum score was calculated.

Quality of *interpersonal relations* at T1 was measured via the subscale "interpersonal relations" (OQ-IR) of the German version of the "Outcome Questionnaire" (OQ-45.2; Lambert, Hannöver, Nisslmüller, Richard, & Kordy, 2002)), consisting of 11 items. Higher scores on this scale represent a lower quality of interpersonal relations.

The patients' view of the quality of the *helping alliance* was measured via the German adaptation (Bassler, Potratz, & Krauthauser, 1995) of Alexander and Luborsky's (1986) "Helping Alliance Questionnaire" (HAQ). This inventory consists of 11 items of which a sum score was calculated.

Information on *SES* was provided in the first patient questionnaire.

Sample

Of the 256 participants, 47.7% were male. At study entry, participants' mean age was 42.8 ± 11.4 years, 42.7% were

married, 74.5% held a high track degree of education ("Abitur"), and 58.7% were university graduates.

For 209 participants, therapists provided main diagnoses coded according to ICD-10 (WHO, 1993) in their intake questionnaires and/or application for reimbursement to the *DKV*. These comprised mainly neurotic, stress-related and somatoform disorders (F4: 41.1%) and affective disorders (F3: 47.8%), while behavioral syndromes (F5: 4.3%) and personality disorders (F6: 6.2%) were rarely diagnosed.

Mean scores at intake were 1.02 ± 0.54 for SCL-90-R GSI, 1.73 ± 0.66 for HAQ total score, 26.56 ± 15.14 for GBB-24 total score, and 16.33 ± 6.91 for OQ-IR. Quality of interpersonal relations at T1 was significantly lower in PA than in CBT (two-sample t-test: t = -2.60; df = 160; p = 0.01). No further differences on intake measures between forms of treatment were observed.

Information about total number of sessions during the two-year observation period and date of each number were provided by the *DKV*. Treatments of 146 (57.0%) subjects (PD: 51.1%; CBT: 81.0%; PA: 39.0%) were terminated within the two-year observation time; these had a mean duration of 14.2 ± 5.9[1] (PD: 15.5 ± 4.7; CBT: 13.8 ± 6.4; PA: 13.4 ± 6.4) months, the mean number of sessions was 35.6 ± 22.5 (PD: 37.5 ± 20.9; CBT: 29.6 ± 14.9; PA: 45.5 ± 32.7).

Procedure

Three indicators of organization of treatment time during the first three months of therapy were applied: (a) number of treatment interruptions (TI) of at least three weeks; (b) number of weeks without treatment (WWT); and (c) session number (SN) during that time. Since none of these indicators was normally distributed in the total sample, Median-Tests were applied in order to scrutinize differences between forms of treatment.

In contrast to WWT and SN, the distribution of TI was also skewed within treatment groups. Thus, for further analyses within groups, a dichotomous variable (0 = no interruption, 1 = one or more interruptions) was created.

The impact of therapeutic alliance, of psychological and physical impairment as well as of the quality of interpersonal relations at T1 on TI, WWT, and SN was analyzed separately for the three forms of treatment. For the prediction of TI, logistic regression analyses were applied, while for WWT and SN, linear multiple regression analyses were carried out.

The influence of TI, WWT, and SN early in treatment on subsequent course of improvement was analyzed via Hierarchical Linear Modeling (HLM; e.g. Raudenbush & Bryk, 2001). Given unbalanced longitudinal data, HLM allows to use all available data from all participants, even if they missed a number of

measurement points and/or took part at differently spaced assessment points.

Results

Organization of Treatment Time during the Early Phase of Treatment

Features of TI, WWT and SN during the first three months of PD, CBT or PA are displayed in Table 1. No significant differences between forms of treatment were observed regarding TI (Median-Test: $X^2 = 2.02$; $df = 2$; $p > .05$) and WWT ($X^2 = 2.32$; $df = 2$; $p > .05$). Although in PA, SN was somewhat higher than in the other forms of therapy, differences were not significant ($X^2 = 1.08$; $df = 2$; $p > .05$).

Table 1

Effects of Patient Pre-Treatment Characteristics on Organization of Treatment Time during the Early Phase of Treatment

In neither form of treatment, TI or SN during the first three months of treatment could be predicted by psychological or physical impairment, quality of interpersonal relations, or the helping alliance at T1. However, in PD, number of WWT was higher when the patients' initial appraisal of the quality of the therapeutic alliance was low. Furthermore, in CBT, number of WWT was higher in patients with a higher initial (self-reported) quality of interpersonal relations. The parameters of the multiple regression models for the prediction of the

number of WWT for the three forms of treatment are displayed in Table 2.

Table 2

Organization of Treatment Time during the Early Treatment Phase and Subsequent Course of Improvement

The course of psychological impairment after three months of treatment and its prediction by TI, WWT, and SN during early treatment was analyzed separately for each form of treatment via HLM.

In Table 3 it can be seen that in all three forms of treatment, from the end of the third month after start of treatment until the end of the two-year assessment period, patients on average improved significantly.

Intercept indicates the mean level of impairment three months after the start of treatment, while slope denotes the average monthly rate of symptom change during the subsequent study period. E.g. patients in PD on average started off with 0.735 GSI-points and improved by 0.015 GSI-points per month. "Value" indicates the HLM fixed effect coefficients, i. e. for predictors the deviation in the criterion variables (intercept or slope) from their mean values.

HLM yielded that for patients in PD and CBT, neither intercept nor slope could be predicted by any of the three indicators of organization of treatment time. However, participants in PA with more WWT and higher SN subsequently

improved at a lower rate of change. To be more specific: with one more week without treatment, slope increased (i. e. improvement decelerated) by 0.003 GSI-points per month, with an additional session this rise was 0.001 GSI-points per month. Including the interaction of these two variables in the model yielded no additional effects.

Table 3

Discussion

Organization of treatment time - number of treatment interruptions of at least three weeks (TI), number of weeks without treatment (WWT), and session number (SN) - during the first three months in outpatient treatment and its effect on subsequent course of symptom distress was analyzed in a two-year prosepective study for three forms of subsidized outpatient psychotherapy (psychodynamic psychotherapy - PD, cognitive behavioral treatment - CBT, and psychoanalytic psychotherapy - PA) widely practiced in German routine specialist care.

It was found that the distribution of sessions during the initial phase of therapy was dealt with very similarly in the three forms of treatment. During the first three months, about eight sessions took place, i. e. average session frequency was less than one session per week. This finding surprises since one might assume that psychoanalytic treatments start (and continue) with higher treatment intensity.

In the whole sample, neither participants' baseline psychological, physical, or interpersonal impairment nor self-rated quality of the helping alliance predicted session number or number of interruptions during this early phase. However, for participants in PD it was found that more weeks without therapy were related to a lower initial quality of the helping alliance. This finding indicates that patients or therapists in PD might hesitate to engage in therapy too intensely if formation of the helping alliance is flawed, for instance because they are not sure if they really want to work together.

In CBT, patients who reported more serious interpersonal problems had fewer weeks without therapy in early treatment, i.e. they tended to see their therapist more often than patients with fewer interpersonal problems. As they had a lack of good relationships, these patients were probably very much in need for someone to talk to. Compared to the analytically oriented treatment forms (PD or PA), in CBT this perhaps makes more of a difference since the earlier traditionally lend more weight on talking ("talking cure") than CBT which rather stresses the "action" side. Contrary to expectations and previous research (Beutler et al., 2004), initial psychological and physical impairment had no influence on the handling of time in early treatment. It seems that

interpersonal factors, such as the relationship to significant others or to the therapist, play a more important role.

Hierarchical linear models yielded that in the three forms of therapy, early symptom improvement did not predict state (intercept) of symptomatic impairment after three months of treatment. More importantly, none of the three measures of organization of early treatment time predicted subsequent outcome in PD and CBT.

However, in PA, patients with more weeks without psychotherapy in early treatment subsequently improved at a slower rate. This is in line with the assumption that a regular treatment has a favourable impact on the success especially of psychoanalytic treatment. As in the Kordy et al. (1988) study, patients without "long" treatment interruptions of more than three weeks had no worse outcome than patients with at least one interruption. However, this result contradicts that of Reardon et al. (2002) who found that higher density of treatment dose was associated with better outcome. It should be noted, though, that our study differs to that of Reardon et al. (2002) in a number of aspects which might limit comparability. Different from the TRANS-OP study, Reardon et al. (2002) used an archival outpatient clinic data set of self-pay-patients, mean session number was much lower (17.97), outcome assessment was carried out via a

retrospective and rather crude (CGI) rating, and type of outpatient psychotherapy has not been specified.

A second predictor in PA was session number: patients with fewer sessions in early treatment showed somewhat better outcome. This result is surprising as it contradicts the general finding that higher session number is associated with better outcome (Freedman et al., 1999; Lambert & Ogles, 2004). Again, comparison between studies is not straightforward since e.g. Freedman et al. (1999) colleceted outcome data retrospectively via an "Effectiveness Questionnaire" derived from the Consumer Reports study (Seligman, 1995). Furthermore, results only pertain to the early phase of treatment in psychoanalytic psychotherapy, and not to psychotherapy in general.

Bearing in mind these limitations - but also advantages of the TRANS-OP study, above all prospective multi-wave assessment of rather comprehensive patient-rated indicators of outcome - these findings indicate that too intense treatment in the beginning phase of psychoanalytic psychotherapy might not be advantageous for most patients. Thus, starting treatment continuously at a slow pace seems to be beneficial for patients in PA. However, the interaction of these two predictors was not significant, i.e. treatments with both low session number and few weeks without psychotherapy were not found to be especially effective.

Some limitations of this study should be mentioned. Besides the possibility that results may differ for other outcome measures or subgroups of patients, it must be taken into account that our sample consisted of privately insured patients--a usually rather privileged group concerning their social class and the treatment in the health care system. Furthermore, there was no random assignment to the three forms of outpatient treatment. On the other hand, at intake, differences on outcome measures between treatment groups were marginal.

In conclusion, in the two shorter forms of treatment, PD and CBT, although interruptions (weeks without psychotherapy) in early treatment were affected by interpersonal factors, these do not seem to play a role for subsequent outcome. In contrast, in PA, where the handling of time was independent of patient characteristics at the start of treatment, interruptions negatively affected later outcome to some extent.

As strict regularity can also be a sign of inflexibility and constraint, treatment interruptions must not necessarily have negative implications. Unfortunately, we do not know how treatment interruptions were initiated, nor do we have information about either the patients' or the therapists' motives to interrupt treatment. Further research should go

beyond description of temporal patterns in psychotherapy and focus on the underlying motives of handling of time.

Footnotes

[1]Mean ± Standard Deviation

Acknowledgements

We wish to thank Adelheid Kühn and Jung Ah Choi at the Center for Psychotherapy Research and Helmut Hiller and Birgit Homann at DKV.

References

Alexander, L. B. & Luborsky, L. (1986). The Penn Helping Alliance Scales. In L.S.Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 325-366). New York: Guilford Press.

Bassler, M., Potratz, B., & Krauthauser, H. (1995). Der "Helping Alliance Questionnaire" (HAQ) von Luborsky: Möglichkeiten zur Evaluation des therapeutischen Prozesses von stationärer Psychotherapie [Luborsky's HAQ: Possibilities to evaluate the therapeutic process in inpatient psychotherapy]. *Psychotherapeut, 40,* 23-32.

Beutler, L. E., Malik, M., Alimohamed, S., Harwood, T. M., Talebi, H., Noble, S. et al. (2004). Therapist variables. In M.J.Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (pp. 227-306). New York: Wiley.

Beutler, L. E. & Clarkin, J. F. (1990). *Systematic Treatment Selection: Toward targeted therapeutic interventions*. New York City: Brunner/Mazel.

Brähler, E. & Scheer, J. W. (1995). *Der Gießener Beschwerdebogen (GBB) (Testmappe mit 2., ergänzter und revidierter Auflage des Handbuchs) [The Gießen complaints questionnaire]*. Bern: Huber.

Derogatis, L. R. (1986). SCL-90-R: Self Report Symptom Inventory. In Collegium Internationale Psychiatriae Scalarum (Ed.), *Internationale Skalen für Psychiatrie.* Weinheim: Beltz.

Fettes, P. A. & Peters, J. M. (1992). A meta-analysis of group treatments for bulimia nervosa. *International Journal of Eating Disorders, 11,* 97-110.

Franke, G. H. (1995). *Die Symptom-Checkliste von Derogatis - Deutsche Version [Derogatis' Symptom Checklist - German version]*. Göttingen: Beltz Test.

Freedman, N., Hoffenberg, J. D., Vorus, N., & Frosch, A. (1999). The effectiveness of psychoanalytic psychotherapy: The role of treatment duration, frequency of sessions, and the therapeutic relationship. *Journal of the American Psychoanalytic Association, 47,* 741-772.

Howard, K. I., Kopta, S., Krause, M., & Orlinsky, D. (1986). The dose-effect relationship in psychotherapy. *American Psychologist, 41,* 159-164.

Kordy, H. & Kächele, H. (1995). Der Einsatz von Zeit in der Psychotherapie [The handling of time in psychotherapy]. *Psychotherapeut, 40,* 195-209.

Kordy, H., Rad, M. v., & Senf, W. (1988). Time and its relevance for a successful psychotherapy. *Psychotherapy and Psychosomatics, 49,* 212-222.

Lambert, M. J., Hannöver, W., Nisslmüller, K., Richard, M., & Kordy, H. (2002). Fragebogen zum Ergebnis von Psychotherapie: Zur Reliabilität und Validität der deutschen Übersetzung des Outcome Questionnaire 45.2 (OQ-45.2) [Questionnaire on the results of psychotherapy: Reliability and validity of the German translation of the Outcome Questionnaire 45.2 (OQ-45.2)]. *Zeitschrift für Klinische Psychologie, 1,* 40-47.

Lambert, M. J. & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M.J.Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (5 ed., pp. 139-193). New York City: Wiley.

Orlinsky, D., Rønnestad, M. H., & Willutzki, U. (2003). Fifty years of psychotherapy process-outcome research: Continuity and change. In M.J.Lambert (Ed.), *Handbook of Psychotherapy and Behavior Change* (pp. 307-389). New York: Wiley.

Raudenbush, S. W. & Bryk, A. S. (2001). *Hierarchical linear models: Applications and data analysis methods*. (2 ed.) Newbury Park, CA: Sage.

Reardon, M. L., Cukrowicz, K. C., Reeves, M. D., & Joiner, T. E. J. (2002). Duration and regularity of therapy attendance as predictors of treatment outcome in an adult outpatient population. *Psychotherapy Research, 12,* 273-285.

Sandell, R., Blomberg, J., & Lazar, A. (2002). Time matters: On the temporal interactions in long-term follow-up of long-term psychotherapies. *Psychotherapy Research, 12,* 39-59.

Seligman, M. E. P. (1995). The effectiveness of psychotherapy: The Consumer Reports study. *American Psychologist, 50,* 965-974.

WHO (1993). *Internationale Klassifikation psychischer Störungen: ICD-10, Kapitel V (F) [International classification of mental disorders: ICD-10, chapter V (F)]*. (2nd ed.) Bern, Göttingen, Toronto, Seattle: Huber.

Table 1

Number of Interruptions, Number of Weeks without Psychotherapy, and Session Number During the first Three Months of PD, CBT or PA

		Number of Interruptions	Number of Weeks without Psychotherapy	Number of Sessions
PD	Mean	0.79	6.29	7.47
(*N* = 90)	*Md*	1.00	7.00	6.00
	SD	0.73	3.00	4.40
CBT	Mean	0.85	6.30	7.83
(*N* = 84)	*Md*	1.00	7.00	7.00
	SD	0.77	2.91	4.14
PA	Mean	0.78	5.94	9.45
(*N* = 82)	*Md*	1.00	7.00	8.00
	SD	0.65	2.92	6.23

Note: PD: psychodynamic psychotherapy; CBT: cognitive behavioral therapy; PA: psychoanalytic psychotherapy

Table 2

Number of Weeks without Psychotherapy During the Early Phase of PD, CBT, or PA as Predicted by Patient-Rated Intake Characteristics

	Variables in Equation	*B*	*SE*	*Beta*	*T*	*p*
PD	(Constant)	8.883	1.357		6.545	.000
	HAQ	-1.532	0.557	-.298	-2.752	.007
	SCL-GSI	-1.608	0.955	-.252	-1.684	.096
	GBB	0.043	0.029	.203	1.480	.143
	OQ-IR	0.035	0.053	.079	0.667	.506
CBT	(Constant)	8.634	1.371		6.298	.000
	HAQ	-0.295	0.474	-.071	-0.622	.536
	SCL-GSI	-0.303	0.807	-.060	-0.375	.709
	GBB	0.012	0.027	.063	0.450	.654
	OQ-IR	-0.119	0.059	-.262	-2.024	.047
PA	(Constant)	4.236	1.475		2.871	.005
	HAQ	0.405	0.538	.089	0.753	.454
	SCL-GSI	-0.609	0.863	-.115	-0.706	.482
	GBB	0.045	0.027	.245	1.649	.103
	OQ-IR	0.033	0.054	.083	0.614	.541

Note: PD: psychodynamic psychotherapy; CBT: cognitive behavioral therapy; PA: psychoanalytic psychotherapy; HAQ: Helping Alliance; SCL-GSI: Symptomatic Impairment; GBB: Physical Impairment; OQ-IR: Interpersonal Problems.

Table 3

Hierarchical Linear Models for the Prediction of Course of Symptom Distress (SCL-90-R, GSI) in the Different Forms of Treatment by Number of Interruptions, Number of Weeks without Psychotherapy (PT) and Session Number During Early Treatment

	Variables in Equation	*Value*	*SD*	*DF*	*t*	*p*
PD	*Intercept*	0.735	0.376	261	1.956	0.0515
	Interruptions	-0.104	0.061	84	-1.706	0.0918
	Weeks w/o PT	0.027	0.034	84	0.772	0.4421
	Session Number	0.007	0.023	84	0.297	0.7670
	Slope	-0.015	0.016	261	-0.949	0.3433
	Interruptions	0.002	0.003	261	0.981	0.3274
	Weeks w/o PT	0.000	0.001	261	0.055	0.9563
	Session Number	0.000	0.001	261	-0.027	0.9783
CBT	*Intercept*	*0.603*	*0.471*	*207*	*1.281*	*0.2015*
	Interruptions	-0.039	0.073	77	-0.533	0.5953
	Weeks w/o PT	0.013	0.042	77	0.320	0.7499
	Session Number	0.023	0.029	77	0.800	0.4264
	Slope	*-0.033*	*0.019*	*207*	*-1.769*	*0.0784*
	Interruptions	0.000	0.003	207	-0.160	0.8732
	Weeks w/o PT	0.002	0.002	207	1.432	0.1538
	Session Number	0.002	0.001	207	1.299	0.1953

table continues

Table 3 continued:

	Variables in Equation	*Value*	*SD*	*DF*	*t*	*p*
PA	*Intercept*	*0.943*	*0.328*	*223*	*2.874*	*0.0044*
	Interruptions	-0.043	0.066	75	-0.652	0.5166
	Weeks w/o PT	0.015	0.033	75	0.445	0.6576
	Session Number	-0.003	0.016	75	-0.199	0.8431
	Slope	*-0.044*	*0.013*	*223*	*-3.378*	*0.0009*
	Interruptions	-0.002	0.003	223	-0.612	0.5409
	Weeks w/o PT	0.003	0.001	223	2.465	0.0144
	Session Number	0.001	0.001	223	2.168	0.0312

Note: PD: psychodynamic psychotherapy; CBT: cognitive behavioral therapy; PA: psychoanalytic psychotherapy