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The outcome of inpatient psychotherapy and the duration of previous psychotherapy treatment

Witold Simon, Marek Gajowy, Daniel Mikułowicz, Paweł Sala

Summary

Aim. The duration of previous psychotherapy treatment was the main independent variable.
Material and method. Three hundred and one patients successively reporting for inpatient treatment in the Clinic of Neurotic Disorders received questionnaires. Two-hundred seventy-four patients who completed the treatment and returned all the tests were divided into three groups: a) those without any previous experience of psychotherapy, b) those with previous experience of short-term therapy, and c) those previously in long-term psychotherapy. The following tools were used: Hopkins Symptom Checklist, Sense of Coherence, Questionnaire of Motivation, and Adjective Checklist.
Result. The duration of previous psychotherapy influenced symptoms, coherence, motivational factors and personality aspects, both at the beginning of psychotherapy and at the time of discharge from the hospital.

duration of psychotherapy / previous psychotherapy / short-term psychotherapy / long-term psychotherapy / psychotherapy outcomes

INTRODUCTION

Thanks to many years of research into psychotherapy, we now have at our disposal quite a reasonable body of data that confirms psychotherapy to be an effective method of treatment. Many researchers who have repeatedly studied psychotherapy, using methodologically sound tools, have proven its' positive influence on patients' health. [1, 2, 3, 4]. The ambiguity of the outcomes of research into the effectiveness of psychotherapy is probably due to a multiplicity of variables, controlled for to various degrees. One of the factors, which is often omitted from the analysis of the effectiveness of psychotherapy, is the duration of previous psychotherapy. This research will therefore focus on that particular variable, hoping to reach a fuller understanding of the positive effects of psychotherapy treatment.

Witold Simon, Marek Gajowy, Daniel Mikułowicz, Paweł Sala: The Clinic of Neurotic Disorders, Warsaw Institute of Psychiatry and Neurology, Poland; Correspondence address: Witold Simon, Department of Neurotic Disorders and Psychotherapy, Institute of Psychiatry and Neurology, 9 Sobieskiego Str., 02-957 Warsaw, Poland, e-mail: wsimon@ipin.edu.pl

Review of literature

Patients often undergo a form of counselling or psychotherapy in out-patient conditions, prior to undertaking inpatient treatment [5, 6, 7]. It is highly probable that, even more often, they approach their GP's for help, or consult their families and friends. Kopta et al's. [8] research reveals that 14% of patients get better before the first psychotherapeutic session. The authors who analyse the phenomenon of spontaneous remission [9, 10] have concluded that patients awaiting psychotherapy may experience an improvement of their symptoms, even if assistance is given by someone other than a qualified therapist.

However, both the subjective and/or objective limitations of such forms of aid result in patients being directed to a specialist centre, for an intensive inpatient treatment of integrated psychotherapy. It is also worth noting that, according to Mc Neilly and Howard [11], 15 sessions of psychotherapy produce the same effect as 2 years of spontaneous remission. These authors conclude that psychotherapy only accelerates, and perhaps settles, the changes that would otherwise happen spontaneously, without any psychotherapeutic intervention.

Most of the researchers [3, 10, 12, 13, 14] who have looked into the reasons behind therapeutic success or the deterioration effect, take into account the variables relating to the therapist, patient, their relationship, the type and intensity of disorders, psychotherapeutic methods and applied techniques. What is often omitted from these analyses is the variable of the patient's previous participation in psychotherapy, especially the duration of the earlier treatment.

In the 1960's, a number of separate studies [15, 16, 17] proved that previous psychotherapy does not affect the current treatment in any statistically meaningful way. These research procedures were, however, conducted on a small group of patients, and did not take into account the duration of any earlier psychotherapy treatment.

AIM OF THE STUDY

The main objective of this research has been defined as identifying the correlation between the duration of the previous ambulatory psychotherapy, undertaken in a variety of centres, and the results of the inpatient therapy carried out in the Clinic of Neurotic Disorders of IPiN in Warsaw.

The outcome of psychotherapy was evaluated with the use of four types of variables: Symptom Checklist, Sense of Coherence, Questionnaire of Motivation and Adjective Checklist. The choice of such a spectrum of variables is reflected in the bibliography, referring to the research on the effectiveness of psychotherapy [1, 2, 3, 8, 10, 12, 18, 19, 20, 21].

The hypothesis is that the values for these groups of variables, measured at admission (beginning of treatment) and prior to discharge from the hospital (end of treatment) vary in statistically significant ways, dependent on the duration of previous psychotherapy treatment. The hypothesis was verified with the use of such research tools as HSCL, SOC, MQ and ACL, discussed in detail below.

MATERIAL AND METHODS

Symptom Checklist (HSCL) [22] (as adapted by Siwak-Kobayashi [23]) was used for researching the following groups of symptoms: aggression/hostility, depression with anxiety, depressive stupor, phobias, interpersonal hypersensitivity, compulsive disorders, and somatization. This tool is widely regarded as an adequate instrument for the measurement of the effects of psychotherapy, as it positively reveals the intensity of psycho-pathological symptoms, and is also sensitive to their changes. HSCL has been used in research into neurotic patients on many previous occasions [24, 25, 26, 27].

The results achieved by healthy persons may be considered here as normative research. The internal consistency for each subscale is between 0.82 and 0.90. The reliability of the test measured for repeatability of results has shown that the correlations for 7 subscales were within 0.7273 and 0.8711 at $p < 0.0001$ [22]. The reliability measured for the agreement of the evaluating judges shows a high degree of agreement in the evaluation of symptoms and patient's behaviour – the coefficient varies from 0.64 – 0.80 [22].

Sense of Coherence (SOC) [28] (as adapted by IPiN, UAM and IMP) is based on the concept of salutogenesis, which allows for research into the patient's functioning patterns along the continuum of sickness and health. The sense of coherence, which reflects the patient's position on the continuum, is the perception of the world as a comprehensible, manageable and meaningful place. The feeling of comprehensibility is related to perceiving the stimuli one is exposed to as foreseeable rather than random. The ability to manage, corresponding to the inner position of control [29], is related to perceiving one's own resources or the resources available as sufficient rather than insufficient. The perception of the world being meaningful expresses the emotional and motivational side of coherence, and fur-

ther determines the way that life's challenges are tackled. SOC is used with increasing frequency as a research tool into the effectiveness of psychotherapy [30, 31, 32, 34].

The Polish adaptation of SOC is of 0.83 stability and internal consistency of ($\alpha = 0.87$). The correlation between the SOC results in the test and retest was 0.83 at $p < 0.0001$. Items were significantly correlated with a general result in SOC scale (from 0.28 to 0.63, $p < 0.001$) [33]. No normative research has been conducted for the Polish adaptation of SOC to date, and as a result our research has been based on the values available from personal samples.

The Questionnaire of Motivation [35] enables the correlation of motivational factors with other data regarding the patient's personality and his or her treatment and its' outcomes [19, 20]. The Questionnaire is mostly based on Maslov's theory [36]. Its' authors have described four different motivational factors: activity level, feeling of being wronged, helplessness or feeling of danger. The activity factor is expressed in expectations – its' highest values indicate the prohealth activities, such as readiness to learn new behaviours, and the lowest value suggests the influence of external motives. The factor of being wronged achieves high values, for example, in patients who separate their symptoms from their sense of 'self'. The helplessness factor provides the strongest motivation to undertake treatment, and is usually high when the patient cannot cope with the discomfort or when patients are aware of the psychological and social context of their own condition. The danger factor is typical for people who feel danger in relation to their sickness, while disregarding its' psychological and interpersonal background.

QM was standardized on the basis of the results achieved from 488 patients of the IPiN Clinic of Neurotic Disorders. The standards were expressed in the so-called standard nine scale. For example, the interpretation of results equal to 9 stanine is high at a particular level: 84 for activity level, 66 for feeling of being wronged, 48 for helplessness, 36 for feeling of danger. The stability of the questionnaire is expressed by the average correlation 0.50. The reliability coefficient for individual factors – each from 0.87 for feeling of danger to 0.92 for helplessness. The span for possible results is 70 for activity level factor (14–84), feeling of being wronged (11–66), 40 for helplessness (8–48) and 30 for feeling of danger (6–36).

Adjective Checklist [37] (Pluzek's [38] adaptation has been used here) is a test that captures the changes in a patient's personality that take place during psychotherapy. In 60%, the test is specific for neurotic patients [39]. In this research, we have used the largest bundle of scales, including the adjectives chosen by Murray [40]. Many other publications on the effects of psychotherapy have used ACL as an evaluation tool, which is considered to be a good indicator of changes taking place within the aspects of personality [41, 42, 43, 44].

This research has taken into account the scales regarding needs (achievement, dominance, persistence, self-awareness and understanding of others, order, taking care of others, affiliation, heterosexuality, exhibition, autonomy, aggression, change, succourance, abasement, subordination), thematic scales (readiness for counselling, self-control, self-confidence, personal adaptation, ideal self, creative personality, military leadership, masculinity, femininity) and the modus operandi scales.

The inner consistency for individual subscales of the tests varies from 0.53 to 0.94. The average value of the α-Cronbach coefficient for all 37 scales is 0.75. It has been shown that the test-retest correlations for 37 subscales are enclosed within 0.45–0.86, with the average correlation value at 0.65. The reliability and stability of the scales are 0.6–0.77.

The test has been standardized by the authors, based on the results achieved by testing 5238 men and 4144 women. Average values between 41–59 have been considered to be typical results [37].

The patients filled in all the questionnaires twice: when they were being accepted to the clinic (stage 1) and at the end of their treatment (stage 2), approximately 4–7 days prior to being discharged from the hospital.

One factor variation analysis has been applied. The calculations have been carried out using the statistics software SPSS-PC 10. The few missing values have been automatically filled in with the average results. The research group met the criteria of normal (standard) spread.

Research group

The research group comprised the patients treated in the Clinic of Neurotic Disorders between 1999 and 2002. In order to keep a relative representative value of the researched group, and having realized that it is very difficult to meet the postulate of a randomized choice of patients, the authors handed out the questionnaires to the first 301 patients who reported for treatment. 274 of them completed the therapy and filled in all the tests at stage 1 and 2 of the research. 18 completed the treatment but returned incomplete forms, and 9 patients finished the therapy before its end, and filled in the forms only at stage 1. The data given in this paper was calculated at N=274.

The researched group consisted mostly of women (72.6% participated compared to 24.7% men), young persons under 24 (38.32%), and the 25–34 age group (31.75%), with the average age of the patients being 30.62. Neurotic disorders were among the most frequent diagnoses (51.5%), following by eating disorders (27.0%), and personality/behavioural disorders (15.7%).

37.9% of the patients had undergone previous psychotherapy as outpatients of other treatment centres, including 14.2% who used regular, short-term (up to 6 months) help, and 23.7% who used regular long-term (over 6 months) assistance. The majority of the group, i.e. 62.1% had not been in therapy previously.

Out of the 18 patients who completed the treatment but handed in incomplete questionnaires,

Table 1. Characteristics of the research group

	Number		Sex		Age				Diagnosis			
Previous psychotherapy	**N**	**%**	**K**	**M**	**< 24**	**25–34**	**35–44**	**45–55**	**F 34.1**	**F 40–48**	**F 50**	**F 60**
No previous experience of psychotherapy (none at all)	170	62.1%	127	43	69	53	24	24	10	97	49	14
Regular short-term psychotherapy (up to 6 months)	39	14.2%	23	16	16	12	5	6	1	22	13	3
Regular long-term psychotherapy (more than 6 months)	65	23.7%	49	16	20	22	10	13	5	22	12	26

9 patients had never been in psychotherapy previously, 6 used regular short-term therapy and 3 had been in long-term therapy.

Out of the 9 patients who finished therapy in the Clinic of Neurotic Disorders before its' formal end, 4 had never been in psychotherapy previously, 2 had been in regular short-term therapy and 3 in long-term therapy.

It is worth emphasizing that any short or long-term treatment, undertaken on an outpatient basis prior to the treatment in the Clinic of Neurotic Disorders, was beyond the responsibility of the clinic's personnel, and therefore it is outside the scope of this research to investigate the selection criteria for these other, prior forms of therapy. It is, however, assumed that the ambulatory therapists recommended the inpatient treatment only to those patients whose previous outpatient treatment brought no satisfactory results, most commonly when the patients approached the phase of insight. These remarks are particularly relevant in the case of those diagnosed with various neurotic, eating or personality disorders.

RESULTS

In the group of patients who had previously undergone more than 6 months of psychotherapy, the highest statistically significant level of symptoms at admission fell into the group

Tables 2. Average intensity of symptoms among group members, evaluated with the use of HSCL, depending on previous psychotherapy

	none	up to 6 m	> 6 m	p	F
N	170	39	65		
Symptoms – evaluated at admission					
Aggression - hostility (aver.) (SD)	21.6356 (± 6.9094)	22.7315 (± 5.8355)	21.3889 (± 5.5286)	0.752	0.290
depression with anxiety (aver.) (SD)	24.6193 (± 7.5987)	26.3580 (± 5.1245)	25.7407 (± 6.0003)	0.481	0.752
depressive stupor (aver.) (SD)	24.1382 (± 7.1758)	28.0342 (± 7.5471)	27.1314 (± 6.5112)	**0.013**	4.447
phobia (aver.) (SD)	20.1029 (± 7.8531)	21.7284 (± 7.9689)	20.9323 (± 7.8329)	0.191	1.673
interpersonal hypersensitivity (aver.) (SD)	21.8386 (± 7.5569)	25.1587 (± 6.5215)	26.2500 (± 7.3474)	**0.002**	6.468
compulsive behaviour (aver.) (SD)	22.1528 (± 6.7192)	24.5833 (± 6.5023)	25.1823 (± 6.7929)	**0.025**	3.780
somatization (aver.) (SD)	21.3558 (± 7.1321)	21.6270 (± 5.4718)	21.7708 (± 6.5249)	0.937	0.065
Symptoms – evaluated at discharge from hospital					
Aggression - hostility (aver.) (SD)	20.1698 (± 5.8470)	21.3426 (± 6.0238)	20.8507 (± 5.2914)	0.634	0.465
depression with anxiety (aver.) (SD)	22.1502 (± 6.1279)	22.2222 (± 6.3772)	23.4722 (± 6.3669)	0.462	0.774
depressive stupor (aver.) (SD)	21.7379 (± 6.3714)	23.6325 (± 7.1277)	25.5449 (± 7.0554)	**0.005**	5.552
phobia (aver.) (SD)	17.6955 (± 6.4605)	18.2716 (± 7.0399)	19.4676 (± 7.4834)	0.327	1.124
interpersonal hypersensitivity (aver.) (SD)	20.2116 (± 6.6544)	20.6349 (± 6.8288)	23.2738 (± 6.8920)	**0.033**	3.480
compulsive behaviour (aver.) (SD)	19.6991 (± 6.1851)	21.4583 (± 6.4205)	22.6042 (± 6.9470)	**0.031**	3.542
somatization (aver.) (SD)	18.3532 (± 5.7604)	18.8095 (± 5.9611)	20.3571 (± 7.4435)	0.187	1.693

(SD) – standard deviation; F – test value; p – refers to differences between all subgroups
Statistically significant values have been marked in bold.

of interpersonal hypersensitivity and compulsive disorders. Patients who had undergone prior short-term therapy were, at admission, characterised by the highest statistically significant level of symptoms typical for depressive stupor, whereas patients who didn't have any prior experience of psychotherapy had the lowest level of symptoms mentioned above at the stage of admission.

When discharged from the clinic, the long-term therapy patients were characterized by the highest statistically significant level of symptoms from the following groups: interpersonal hypersensitivity, compulsive behaviour and depressive stupor. The lowest level of these symptoms was observed in the case of patients with no prior experience of psychotherapy.

The level of intensity of the three groups of symptoms – interpersonal hypersensitivity, compulsive behaviour and depressive stupor – amongst the subgroups of patients, both treated previously and new to psychotherapy, was lowered to a statistically significant degree, as a result of inpatient treatment. It is in the case of patients who were previously in short-term therapy that the most considerable lowering of the level of symptoms was observed. The least significant changes were almost always, with the exception of depressive stupor, observed in patients who had no previous experience of psychotherapy treatment, whereas the biggest change was observed in the case of interpersonal sensitivity in short-term therapy patients. The results in the other groups of symptoms (aggression – hostility, depression with anxiety, phobias, somatization) were not statistically significant (Tab. 3).

Patients with no prior experience of psychotherapy, when examined at admission, were characterised by the highest statistically significant level of coherence, comprehensibility and meaningfulness, whereas long-term therapy patients had the lowest values of the components mentioned in the table.

The level of two coherence components – comprehensibility & meaningfulness and the global value of coherence for the subgroups of both treated patients and those who were new to psychotherapy – increased significantly as a result of inpatient treatment. It is in the case of the long-term therapy patients that the highest increase of individual values of coherence has been noted. The lowest changes have been observed in short-term therapy patients. The global coherence value was most increased in the case of the long-term patients. The results with regards to one component of manageability were not statistically significant (Tab. 4).

At admission, it was the patients who underwent short-term therapy who were characterised by the highest level of helplessness; on the other hand, the patients with no previous experience of psychotherapy had the lowest level of helplessness.

The motivational factors were not different in any statistically significant way at the time of discharge from the clinic, in reference to the duration of previous therapy.

As far as the motivation components are concerned, both in case of the subgroups of patients treated previously and those who were new to therapy, no statistically significant difference was noted for any of them as a result of the inpa-

Table 3. Average intensity of the components of coherence, evaluated with the use of HSCL, depending on previous psychotherapy

	none	up to 6 m	> 6 m	p	F
N	**170**	39	65		
Coherence – evaluated at admission					
comprehensibility (aver.) (SD)	36.9528 (± 9.8574)	36.4444 (± 7.4061)	31.9149 (± 10.2932)	**0.013**	4.428
manageability (aver.) (SD)	36.7830 (± 10.5596)	33.8889 (± 9.0871)	33.6383 (± 11.5051)	0.191	1.671
meaningfulness (aver.) (SD)	34.1981 (± 8.7825)	31.6111 (± 12.3914)	29.8723 (± 10.2121)	**0.034**	3.439

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coherence (aver.) (SD)	107.9340 (± 25.6271)	101.9444 (± 26.0395)	95.4255 (± 28.7135)	**0.028**	3.667
Coherence – evaluated at discharge					
comprehensibility (aver.) (SD)	39.6729 (± 8.4950)	37.8333 (± 7.8159)	35.7708 (± 9.3972)	**0.036**	3.383
manageability (aver.) (SD)	38.9252 (± 8.7175)	37.5000 (± 8.8733)	35.3958 (± 10.3466)	0.090	2.443
meaningfulness (aver.) (SD)	36.9813 (± 7.9775)	33.8333 (± 10.2340)	32.7292 (± 10.2495)	**0.018**	4.124
coherence (aver.) (SD)	115.5794 (± 21.9880)	109.1667 (± 24.2396)	103.8958 (± 27.1319)	**0.018**	4.124

(SD) – standard deviation; F – test value; p – refers to differences between all subgroups
Statistically significant values have been marked in bold

Table 4. Average intensity of motivational factors, evaluated with the use of HSCL, depending on previous psychotherapy

	none	**up to 6 m**	**> 6 m**	**p**	**F**
N	**170**	**39**	**65**		
Motivation – evaluated at admission					
active (aver.) (SD)	62.8350 (± 7.3366)	64.5556 (± 6.1090)	64.4783 (± 8.1887)	0.748	0.290
wronged (aver.) (SD)	38.9806 (± 8.1805)	38.4444 (± 7.3742)	37.5435 (± 8.1778)	0.607	0.502
helpless (aver.) (SD)	34.6796 (± 7.0422)	38.1667 (± 5.8536)	37.5652 (± 5.3982)	**0.014**	4.400
endangered (aver.) (SD)	27.4854 (± 4.4981)	27.5000 (± 4.1338)	26.9348 (± 4.6063)	0.777	0.252
Motivation – evaluated at discharge					
active (aver.) (SD)	62.9904 (± 8.9459)	66.7222 (± 8.8038)	64.5227 (± 8.2785)	0.629	0.465
Being wronged (aver.) (SD)	37.1442 (± 8.3112)	34.6667 (± 7.1373)	35.4773 (± 9.6436)	0.365	1.013
helpless (aver.) (SD)	34.0000 (± 6.2597)	35.1667 (± 5.2832)	35.5909 (± 6.2629)	0.325	1.131
endangered (aver.) (SD)	26.2308 (± 4.5480)	26.8889 (± 4.9692)	26.3133 (± 4.5325)	0.850	0.162

(SD) – standard deviation; F – test value; p – refers to differences between all subgroups
Statistically significant values have been marked in bold

tient treatment. Only helplessness was marked as a statistically significant value, but only when evaluated at admission. The results of the other three motivation items were not statistically significant (Tab. 5).

At admission, patients who had no previous experience of psychotherapy were characterized by the highest level of the following needs: succorance, counselling readiness, change and dom-

Table 5. Average intensity of personality aspects (ACL), evaluated with the use of HSCL, depending on previous psychotherapy

		none	up to 6 m	> 6 m	p	F
N		**170**	**39**	**65**		
Personality aspects – needs evaluated at admission						
Communality (Com)	(aver.)	32.95	27.17	30.87	0.396	0.932
	(SD)	(± 11.44)	(± 12.35)	(± 14.74)		
Total I. adjectives checked (*Nck*)	(aver.)	41.12	41.06	41.48	0.969	0.032
	(SD)	(± 8.39)	(± 7.35)	(± 8.99)		
I. favourable adjectives (*Fav*)	(aver.)	35.86	33.33	32.45	0.227	1.497
	(SD)	(± 11.54)	(± 9.62)	(± 12.50)		
I. unfavourable adjectives (*Ufv*)	(aver.)	61.06	64.28	65.32	0.255	1.376
	(SD)	(± 14.10)	(± 12.50)	(± 18.08)		
achievement (*Ach*)	(aver.)	40.86	36.17	36.94	0.052	3.005
	(SD)	(± 10.42)	(± 11.46)	(± 10.83)		
dominance (*Dom*)	(aver.)	41.91	34.94	35.64	**0.002**	6.394
	(SD)	(± 11.17)	(± 13.67)	(± 10.84)		
endurance (*End*)	(aver.)	40.72	38.33	37.09	0.235	1.426
	(SD)	(± 12.36)	(± 11.32)	(± 12.70)		
intraception (*Int*)	(aver.)	39.38	36.50	38.23	0.560	0.582
	(SD)	(± 11.21)	(± 9.32)	(± 11.46)		
order (*Ord*)	(aver.)	43.31	43.33	41.81	0.752	0.285
	(SD)	(± 11.84)	(± 10.26)	(± 11.37)		
nurturance (*Nur*)	(aver.)	42.08	43.61	39.15	0.310	1.178
	(SD)	(± 11.96)	(± 10.47)	(± 14.42)		
affiliation (*Aff*)	(aver.)	38.32	34.50	33.55	**0.041**	3.258
	(SD)	(± 11.15)	(± 10.41)	(± 11.44)		
heterosexuality (*Het*)	(aver.)	38.59	36.67	32.66	**0.006**	5.294
	(SD)	(± 9.70)	(± 9.62)	(± 11.72)		
exhibition (*Exh*)	(aver.)	47.95	44.00	44.28	0.068	2.739
	(SD)	(± 9.48)	(± 9.88)	(± 11.29)		
autonomy (*Aut*)	(aver.)	50.55	49.78	50.53	0.956	0.045
	(SD)	(± 10.65)	(± 11.24)	(± 9.05)		
aggression(*Agg*)	(aver.)	51.67	48.83	49.21	0.383	0.967
	(SD)	(± 11.20)	(± 10.93)	(± 12.66)		
change (*Cha*)	(aver.)	45.67	40.06	42.70	**0.023**	3.863
	(SD)	(± 8.97)	(± 7.56)	(± 9.65)		
succourance (*Suc*)	(aver.)	60.92	69.83	64.11	**0.005**	5.507
	(SD)	(± 10.66)	(± 12.03)	(± 11.20)		

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abasement (*Aba*)	(aver.) (SD)	60.01 (± 12.92)	64.44 (± 16.80)	65.57 (± 13.65)	0.053	2.989
deference (*Def*)	(aver.) (SD)	50.56 (± 10.19)	52.67 (± 9.98)	51.72 (± 10.72)	0.651	0.430
counselling readiness (*Crs*)	(śr) (SD)	52.75 (± 10.16)	59.72 (± 14.70)	56.15 (± 11.57)	**0.026**	3.735
self-control (*S-Cn*)	(aver.) (SD)	48.31 (± 9.41)	51.06 (± 8.65)	50.57 (± 11.49)	0.318	1.155
self-confidence (*S-Cfd*)	(aver.) (SD)	40.11 (± 11.87)	31.89 (± 12.28)	33.96 (± 12.27)	**0.002**	6.351
personal adjustment (*P-Adj*)	(aver.) (SD)	36.85 (± 9.84)	36.06 (± 7.88)	34.30 (± 9.76)	0.328	1.122
ideal self (*Iss*)	(aver.) (SD)	40.47 (± 10.55)	36.89 (± 10.21)	38.30 (± 12.56)	0.319	1.1149
creative personality (*Cps*)	(aver.) (SD)	44.78 (± 8.85)	39.83 (± 9.27)	43.32 (± 11.00)	0.121	2.136
military leadership (*Mls*)	(aver.) (SD)	39.49 (± 11.22)	37.44 (± 8.83)	34.32 (± 11.29)	**0.031**	3.535
Masculinity scale (*Mas*)	(aver.) (SD)	45.16 (± 9.59)	42.56 (± 9.95)	41.72 (± 9.41)	0.108	2.257
Feminity scale (*Fem*)	(aver.) (SD)	43.13 (± 8.58)	45.61 (± 8.60)	43.47 (± 10.13)	0.565	0.574
Personality aspects – needs evaluated at the time of discharge from the clinic						
Communality (Com)	(aver.) (SD)	33.47 (± 10.58)	29.71 (± 14.42)	28.73 (± 12.33)	0.059	2.880
Total l. adjectives checked (*Nck*)	(aver.) (SD)	41.76 (± 10.39)	42.76 (± 9.79)	43.38 (± 9.47)	0.663	0.413
l. favourable adjectives (*Fav*)	(aver.) (SD)	38.65 (± 10.03)	34.59 (± 14.08)	33.04 (± 11.04)	**0.013**	4.454
l. unfavourable adjectives (*Ufv*)	(aver.) (SD)	59.72 (± 13.91)	66.35 (± 17.26)	63.89 (± 15.53)	0.114	2.202
achievement (*Ach*)	(aver.) (SD)	43.09 (± 8.66)	38.59 (± 11.75)	39.76 (± 11.49)	0.073	2.666
dominance (*Dom*)	(aver.) (SD)	44.00 (± 9.97)	38.53 (± 14.76)	39.44 (± 11.34)	**0.028**	3.673
endurance (*End*)	(aver.) (SD)	43.59 (± 11.21)	38.71 (± 14.84)	40.40 (± 11.67)	0.146	1.949
intraception (*Int*)	(aver.) (SD)	40.59 (± 10.54)	36.53 (± 12.26)	37.56 (± 10.55)	0.159	1.859
order (*Ord*)	(aver.) (SD)	46.18 (± 10.28)	41.94 (± 11.08)	43.42 (± 9.77)	0.149	1.930
nurturance (*Nur*)	(aver.) (SD)	42.28 (± 10.71)	39.47 (± 11.74)	38.91 (± 12.68)	0.224	1.512
affiliation (*Aff*)	(aver.) (SD)	40.89 (± 10.94)	37.41 (± 16.14)	34.89 (± 11.94)	**0.019**	4.049

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heterosexuality (*Het*)	(aver.) (SD)	41.79 (± 10.31)	38.29 (± 10.66)	35.44 (± 12.55)	**0.006**	5.212
exhibition (*Exh*)	(aver.) (SD)	49.33 (± 9.94)	47.12 (± 9.78)	47.40 (± 10.99)	0.483	0.732
autonomy (*Aut*)	(aver.) (SD)	52.14 (± 9.53)	51.41 (± 7.98)	51.89 (± 9.47)	0.954	0.047
aggression(*Agg*)	(aver.) (SD)	52.38 (± 11.01)	51.00 (± 8.65)	51.51 (± 9.78)	0.828	0.189
change (*Cha*)	(aver.) (SD)	44.53 (± 7.84)	44.35 (± 9.25)	43.07 (± 8.37)	0.605	0.504
succourance (*Suc*)	(aver.) (SD)	58.38 (± 11.15)	65.59 (± 13.19)	61.11 (± 11.52)	**0.044**	3.185
abasement (*Aba*)	(aver.) (SD)	56.05 (± 11.46)	61.40 (± 14.08)	61.05 (± 13.30)	**0.039**	3.315
deference (*Def*)	(aver.) (SD)	48.52 (± 9.21)	50.41 (± 7.58)	49.51 (± 9.03)	0.659	0.417
counselling readiness (*Crs*)	(śr) (SD)	50.86 (± 10.83)	54.59 (± 10.83)	54.87 (± 12.98)	0.114	2.207
self-control (*S-Cn*)	(aver.) (SD)	48.53 (± 9.33)	51.65 (± 5.93)	49.78 (± 8.83)	0.367	1.009
self-confidence (*S-Cfd*)	(aver.) (SD)	41.40 (± 10.76)	35.76 (± 16.94)	37.84 (± 13.18)	0.102	2.312
personal adjustment (*P-Adj*)	(aver.) (SD)	39.54 (± 9.81)	36.76 (± 11.03)	35.29 (± 9.02)	**0.048**	3.089
ideal self (*Iss*)	(aver.) (SD)	44.61 (± 10.59)	41.35 (± 12.00)	41.93 (± 11.13)	0.276	1.297
creative personality (*Cps*)	(aver.) (SD)	47.47 (± 9.36)	43.88 (± 9.92)	45.20 (± 10.98)	0.241	1.438
military leadership (*Mls*)	(aver.) (SD)	40.55 (± 8.79)	37.18 (± 11.49)	35.87 (± 9.19)	**0.016**	4.276
Masculinity scale (*Mas*)	(aver.) (SD)	46.04 (± 8.33)	43.00 (± 10.06)	43.38 (± 9.87)	0.169	1.799
Feminity scale (*Fem*)	(aver.) (SD)	44.55 (± 8.82)	42.94 (± 9.32)	41.60 (± 11.16)	0.229	1.487

(SD) – standard deviation; F – test value; p – refers to differences between all subgroups
Statistically significant values have been marked in bold.

inance. The group of short-term therapy patients was characterized by the highest value of succourance, counselling and change. The patients who underwent long-term therapy had analogous results.

When examined at discharge from the clinic, patients from all three subgroups (no previous psychotherapy, short-term therapy, long-term therapy) were characterised by a high level of succorance, abasement and dominance.

Regarding the personality aspects evaluated with the ACL test at admission and immediately prior to discharge from the clinic, five reached statistically significant values in the case of patients treated previously and those new to psychotherapy: dominance, affiliation, succorance, military leadership and heterosexuality. The

sixth need, which was considerably higher at discharge than at admission, was abasement, as it was very close to the level of statistical relevance (0.053).

The patients with no previous experience of psychotherapy were characterized by the highest increase in the need for heterosexual contacts and affiliation, and the biggest decrease in abasement.

The short-term therapy patients were characterized by the highest increase in the need to dominate and affiliate and the biggest decrease in succorance, whereas in case of the group of patients who previously used long-term therapy, the highest increase was observed in dominance and the lowest drop was in abasement.

The largest difference between the admission and discharge values was noted in case of succorance in the short-term therapy patients and the drop in the need for abasement in the group of long-term therapy patients.

DISCUSSION AND CONCLUSIONS

The duration of previous psychotherapy differentiates the values of individual variables (groups of symptoms, components of coherence, motivation factors, personality aspects), both at the time of admission to inpatient psychotherapy treatment and at the time of discharge from the clinic. These results point out the fact that undergoing intensive inpatient treatment does not interfere with the effect of the duration of previous psychotherapy on the end results of inpatient treatment. The only variable independent of the duration of previous psychotherapy at the time of discharge from the clinic was the motivation to undertake psychotherapy; this result is also reflected in other research, which shows a much higher role of motivation at the beginning of treatment than at the end of it [45, 46, 47].

The group of patients who had no previous experience of psychotherapy is characterized by surprisingly high values of coherence and low levels of symptoms. The relatively high level of coherence components means that these persons cope better in stressful situations, perceiving any stimuli as motivating for action instead of as destructive stressors [33]. Such results were expected in case of the patients who had used psychotherapy previously, especially long-term patients. Perhaps the treatment in the clinic is mostly undertaken by patients who had tried long-term outpatient treatment, had experienced pressure from symptoms and had an unfavourable combination of personality traits, and finally decided to take things further when no satisfactory results were obtained in ambulatory therapy. If so, than the persons with no previous experience of therapy were sure to perceive the world as comprehensible, controllable and meaningful and so needed no treatment.

Patients who used short-term therapy prior to the admission to the Clinic of Neurotic Disorders were characterized by the highest value of helplessness, which was regarded as a predictor of considerable change in symptoms [35]. It is worth remembering that chronic neurotic disorders are understood as reactions to helplessness towards the requirements imposed by circumstances [48]. The helplessness factor seems to play a particularly significant role in making a decision about treatment; patients often feel that they are caught in a vicious circle of growing and overlapping problems and symptoms, which they cannot escape or cope with [20]. The feeling of helplessness is also closely related to the level of symptoms at various stages of treatment [49]. It is the dysthymic patients with neurotic personalities, long-term situational anxiety and very high emotional hypersensitivity who usually decide to commence treatment in the Clinic of Neurotic Disorders. [35]. Such patients are usually distinguished by high levels of helplessness. The strong impact of the helplessness factor on the level of symptoms may be the result of the effect of helplessness on unresolved inner motivational conflicts [50] and submission to the external sources of control, which is a frequent occurrence before undertaking psychotherapy [29]. It is probable that previous psychotherapy has additionally increased the patients' awareness of their own limitations [21, 49].

Exactly the opposite phenomenon has been observed in case of the patients who have no previous experience of psychotherapy and who have the lowest helplessness factor. These people had no opportunity to confront and realize their beliefs with regards to their own resources or difficulties they experience.

In the case of patients previously treated in short-term therapy, it is the individual groups of symptoms that have been relatively weakened. This situation can be explained by the fact that short-term therapy usually concentrates on reducing the intensity of symptoms much more than long-term therapy [48]. The least significant changes have been observed in case of the patients who had never been in therapy, which confirms the thesis that although spontaneous remission brings relief of symptoms, it is seldom to the same degree as treatment by psychotherapy may bring [9, 10]. The biggest drop in the level of symptoms during the treatment in the Clinic of Neurotic Disorders has been observed in interpersonal hypersensitivity in case of the patients previously treated in short-term therapy, which is explained in terms of the favourable impact of a high amount of social interactions. This kind of intervention had a lesser impact on the patients after long-term therapy, which is perhaps related to the periodic worsening of symptoms during long-term treatment. Patients without previous psychotherapy do not experience this kind of edification when awaiting treatment, and so their level of interpersonal hypersensitivity is reduced to a lesser degree.

A practical conclusion drawn from this research is that it may be advantageous for a patient to undertake short-term therapy in ambulatory conditions first, and only then approach the inpatient treatment. Some forms of ambulatory therapy, i.e. short-term behavioural-cognitive therapy, are considered to be a particularly effective introduction to an intensive eclectic therapy conducted in an inpatient clinic [51].

A group of patients who had previously undergone short-term therapy was characterized, in terms of the personality aspects evaluated with ACL, with the highest increase in affiliation and highest drop in the case of succorance. The need for affiliation, related to the search for and maintenance of personal relations may, in the case of a patient whose main motivation to look for treatment is a feeling of helplessness, be particularly relevant. The need to affiliate is particularly met through the social interactions offered in the clinic, the goal of which is to assist the patient in feeling good in social situations and help him or her to adapt to the changing requirements of group processes. It seems that the previous participation of a patient in short-term therapy may have contributed to the corrective experience of therapy. It is the level of activity in group therapy that is dictated by the need to affiliate [44]. It seems that the need for shared experiences with other people, the support received from them, the aim for success and, through all these factors, the increase in one's own adaptation and the ability to make one's own self-image real, are the most action-stimulating.

The biggest increase in the sphere of dominance has been observed in the patients previously treated in long-term therapy. The change in the need to dominate means that the patients cope better with disapproval and find it easier to take the role of a leader in a group or community.

It is also worth noting that the trends observed within the dynamics of personality aspects testify to desirable changes in the patient's personality: increase of autonomy and reduction of dependence. This remark also refers to the reduction of all groups of symptoms, an increase in value of component coherences and the reduction of the feeling of helplessness to the benefit of an increased level of activity [20].

The conclusions drawn in respect to the patients treated previously in long-term psychotherapy seem most interesting. It seems that the highest level of symptoms from the interpersonal hypersensitivity group may be related to the relevance of the phenomena of transference and tension resulting from working out an insight, still within the previous therapy. The highest level of compulsive behaviour in this group of patients may be explained in terms of the fact that these symptoms are particularly resistant to psychotherapy (especially when not supported pharmacologically, and so people with this type of symptom may require long-term treatment and are usually referred for it [8]). Other research confirms that the intensity of compulsive behaviour, even in long-term psychotherapy, may slowly and gradually subside [49, 52].

The lowest value revealed for the feeling of being comprehended in the group of people with previous long-term treatment may be explained by the suspicion that perhaps people with more severe disorders are particularly involved in long-term therapy, especially in respect of their

perception of the world and things that happen around them as comprehensible and predictable [53]. This is partly reflected in research into long-term therapy, which concluded that low comprehensibility levels are a precedent of phobias [31].

On the other hand, the values of each component of coherence increase to a relatively high degree as a result of long-term therapy. Coherence perceived as a personality feature is therefore more receptive of long-term psychotherapy, which remains in compliance with Antonovsky's theory of salutogenesis [28], which states that coherence may only change under the influence of crucially essential and relatively long-term events. It is also worth noting that the increase in the coherence value may be interpreted as beneficial to personality integration, because each component of coherence correlates negatively with the intensity of symptoms [28, 54], especially depressive stupor, depression with anxiety and interpersonal hypersensitivity [33]. It is even more advantageous if understood in a way that strong coherence means the ability to evaluate reality correctly, to cope independently or to be ready to actively seek help [23]. People with strong feelings of coherence perceive events as challenges, can distance themselves emotionally from problems and avoid feelings of guilt. In stressful situations, they are conscious of their emotions and concentrate on the task at hand, rather than receive stimuli as destructive stressors, which altogether creates a solid motivational base and releases the coping mechanisms to much higher degree [33].

It is certainly worth considering that the results of this research point out the fact that long-term therapy, although it should concentrate on reducing personality deficits, has in some cases a lesser impact on personality aspects expressed in needs than short-term therapy. Perhaps some of our respondents, who were previously in long-term therapy, were awaiting admission to the clinic, and so it is probable that they somehow delayed the decision of involvement and reaching an insight.

This research does not confirm the results achieved by Kopta et al. [8], who concluded that more psychotherapy (more sessions) corresponds to more sizeable and durable improvement. Also Lambert and Ogles [55] attempted to prove that after 20 sessions one may observe on average a 50% quotient of satisfactory improvement, which increases to 75% after 50 sessions. Perhaps the number of sessions required to observe improvement is mostly dependent on the selection criteria used to admit patients to psychotherapy. For example, Lambert and Ogles postulated that people in acute stress reach 50% improvement of symptoms after 10 sessions, those in chronic stress after 14 sessions and those with personality disorders after 52 sessions. The authors of this research are of the opinion that the question of the number of sessions required for improvement remains open, especially since both Kopta at el. and Lambert and Ogles have not taken the duration of previous therapy into the account.

Obviously, one must not define the intensity of treatment by the number of sessions or duration of therapy, a fact emphasized, amongst others, by Aleksandrowicz [4, 48] who observed that the same results have been obtained by outpatients taking advantage of ambulatory treatment (25 hours) and inpatients who had six times more treatment (150 hours) in the day ward. His suspicion is that the results of psychotherapy depend to a larger degree on the intensity of the therapeutic process than the number of sessions. Aleksandrowicz thinks that short-term therapy results merely in a temporary improvement of symptoms. Moreover, 25 sessions can merely tackle the existing personality structure and in 25% of patients they increase the degree of disintegration. Also, other researchers [56] prove that 75% of real, objective improvement (not just an improvement of how one feels) is achieved in up to 6 months, more or less up to the 26th weekly session, and then it increases once therapy is extended to 104 sessions. Perhaps the fact that after the initial fast improvement of symptoms, patients in long-term therapy feel less dynamic progress and even a temporary worsening of symptoms, which results in a lower subjective evaluation.

Our results are different from the results of the research mentioned at the beginning of this paper by Hamburg et al. [15], Klein [16] and McNair at al. [17], who have attempted to prove that prior psychotherapy has no relevant impact on the current treatment. It is worth emphasizing that these authors evaluated the effective-

ness of previous psychotherapy, based on the relations of therapists undertaking the next therapy and omitting the evaluation by the patients. The authors of this research are of the opinion that such procedure for obtaining data may have failed to fully reflect the changes felt by the patients, and essentially disable the far reaching conclusions on the effect of previous psychotherapy on the effect of current treatment.

Taking into account just one variable pertaining to previous psychotherapy, i.e. its duration, and considering the data from the questionnaires filled in by patients independently (a patient may have had difficulties in evaluating the real duration of earlier psychotherapy) has been a definite limitation of this work. Further work is intended in this area, taking into consideration other conditions of previous therapy such as: the therapist's education and the theoretical basis of the psychotherapy. These restrictions do not however negate the proposition that in forecasting the results of psychotherapy it is necessary to take into account, among other factors, the duration of the previous treatment.

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