SLIDE 1

Horst Kächele[1]

The Role of Treatment Research in Psychotherapy Training - twenty good reasons for knowing more about treatment research[2]

SLIDE 2

TOP 1 Psychoanalytic Education

The first issue pertains to the "traditional Eitingon-Model" which regulates, as well as the later French model, the standard training of the IPA. The true revolution of the Berlin foundation was not just in its being a tripartite training institution.
For it was conceived by Freud and Eitingon from the beginning as a research institution and as providing treatment free of charge for the general population, thus fulfilling Freud's (1919a) Budapest requirement[3].

SLIDE 3

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[1]Department Psychosomatic Medicine and Psychotherapy,
Universitätsklinikum Ulm
Center for Psychotherapy Research Stuttgart

[2]Keynote lecture delivered at the 1st Conference of ECPP
Ljubljana October 2004.

[3]Freud, S. (1919a). “Lines of advance in psycho-analytic therapy.” SE vol XVII: 157-168.

It was in this sense that Fenichel´s summary of ten years of the Berlin´s Institut psychoanalytic Out-Patient Facility in the Berlin "Ten-Years-Report" demonstrated the viability of psychoanalytic outcome research (1930[4]). It reported on the relationship of diagnosis, duration and outcome and was very specific in pointing out differential outcome of different disorders.

SLIDE 4

The first edition of Bergin & Garfield´ s Handbook of Psychotherapy and Behavior Change (1971) contains the first fair and critical review on psychoanalytic outcomes by Bergin (1971[5]). Further editions of the handbook - the bible of psychotherapy researchers - are a must for every library in the field (2nd. ed. 1978, 3rd. ed. 1986, 4th. ed. 1994 and the most recent 5th. ed. by M. Lambert in 2004[6]).

SLIDE 5

TOP 2 Balint´s critique from 1948 and its consequences for today

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[4]Fenichel, O. (1930). Statistischer Bericht über die therapeutische Tätigkeit 1920-1930. Zehn Jahre Berliner Psychoanalytisches Institut. Poliklinik und Lehranstalt. S. Radó, O. Fenichel and C. Müller-Braunschweig. Wien, Int Psychoanal Verlag: 13-19.

[5]Bergin, A. (1971). The evaluation of therapeutic outcomes. Handbook of psychotherapy and behavior change. A. Bergin and S. Garfield. New York, Wiley: 217-270.

[6]Lambert, M. J., Ed. (2003). Bergin and Garfield´s handbook of psychotherapy and behavior change. New York Chichester Brisbane, Wiley.

"The original idea: psychotherapy for the broad masses..., became completely lost in the years of the development. It is a justified charge against us analysts that we are so little concerned about it, and only a fair consequence that the therapy of the masses is passing more and more into other hands and will eventually be solved - rightly or wrongly - without us. The same is true about the second original aim of the institute, about research. The results in this direction are so poor that they are hardly worth mentioning. Perhaps the only exception to this sad record is the Chicago Institute" (p. 168[7]).

Thus, any psychoanalytic training should be directed to the application of psychoanalytic therapy in its most patient-oriented form considering the given social and psychological constraints. Therefore todays most pertinent issue can be couched in the following question:
Is there one form of psychoanalytic therapy or are there many forms?[8]

SLIDE 6

TOP 3 The present challenge

[7]Balint, M. (1948a). “On the psychoanalytic training system.” Int J Psychoanal 29: 163-173.
[8]Wallerstein R (1988) One psychoanalysis or many. Int J Psycho-Anal 69: 5-21

The German Board on Professsional Standards in Psychotherapy demanded from the German Psychoanalytic Umbrella Organisation (DGPT) a statement on the evidence for psychoanalysis and psychoanalytic/psychodynamic psychotherapies. After some discussions our committee agreed on the generic name: „Psychoanalytic Therapy“ to cover the field: „This name refers to psychoanalysis with its theories of personality, of disorder, of treatment. It seemed suitable to cover all forms of application of the principles of psychoanalytic treatment theory “(Hau & Leuzinger-Bohleber)[9].
The Ulm textbook on Psychoanalytic Therapy by Thomä & Kächele (1985, 1988) has been written in that spirit[10].

Politically this decision could signal a breakthrough. Like „behavior therapy“ covering many diverse techniques the generic name "psychoanalytic therapy" could act as a unifying medium.

SLIDE 8

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[9]Hau, S. and M. Leuzinger -Bohleber (2004). “Psychoanalytische Therapie - Eine Stellungnahme für die wissenschaftliche Öffentlichkeit und für den Wissenschaftlichen Beirat Psychotherapie.” Forum Psychoanal 20(1): 13-125.

[10]The German version was first published in 1985 (Volume 1: theory) and 1988 (volume two: practice); meanwhile it has been translated in quite a number of other languages: english (1987, 1992); hungarian (1987, 1991), spanish (1989, 1990), italian (1990, 1993), tchech (1992, 1996), portuguese (1992), polish (1996, 1996), russian (1997, 1997), roumanian (1999, 2000) and armenian (2004). A third volume (research) is available in its full length in German and English on the internet (www.la-vie-vecu.de); shorter versions have appeared in Russian (2003) and Italian (2003).

Following the logic of the German Board (WBP[11]) a procedure has various forms of application (i.e. methods) thus the generic name would include

1 analytic individual psychotherapySLIDEynamic psychotherapy

7 analytic child- and adolescent psychotherapy (individual /group)

8 psychodynamic child- and adolescent psychotherapy (individual /group)

SLIDE 9

TOP 4 What is needed for psychoanalytic training?

There are four main points to delve on:

a) Self-experience - didactic analytic experience

b) Guidance how and what to read when

c) Practical experience under supervision

d) Knowing about research findings

<u>ad a) Self-experience - didactic analytic experience</u>

Thomä and Kächele (2000[12]), made the recommendation that the right of psychoanalytic institutes to influence directly or indirectly

[11] http://www.wbpsychotherapie.de/

[12] Thomä, H. and H. Kächele (2000). "On the devaluation of the Eitingon-Freud model of psychoanalytic educuation. Letters to the editor." Int J Psychoanal 81: 806-808.

the training analysis should be restricted. We fully agree with Kernberg that we should avoid "any bureaucratic restriction and bureaucratic extension of the personal analysis" (Kernberg, 2000, p. 114[13]).

To restrict the power of Institutes with regard to the length of the 'didactic' or 'training' analysis is not a bureaucratic measure, but a sound way of doing three things:

(a) to rescue personal rights

(b) to preserve the otherwise permanently threatened therapeutic function of the personal analysis and

(c) to create a professional curriculum where the work and knowledge of candidates is judged independently of diagnostic evaluations and unspecified expectations about what changes are to be brought about by further "purifaction" (that is, by extending the analysis beyond the required quantitatively defined term of analytic "self-experience").

Can one work without training analysis?

In order to avoid further endless discussions about differences between 'didactic' and 'therapeutic analysis', Thomä and Kächele suggested speaking of 'self-experience' (Selbsterfahrung),

[13]Kernberg, O. (2000). “A concerned critique of psychoanalytic education.” Int J Psychoanal 8: 97-120.

assuming that most analysts agree that such a 'self-experience' is necessary for professional reasons. However, in our opinion candidates should be evaluated exclusively on the strength of their performance as clinicians instead of being diagnosed as patients[14]. In principle, candidates who think that they can work without any self-experience should be allowed to prove their psychoanalytic attitude, thinking and skills in intensive supervision and clinical courses.

Although this is an utopian point of view we have to take it as a matter of principle and for historical reasons. It is well known that many influential members of the IPA had a relatively short analysis. So far it is not evident that the length of the analysis either in the Eitingon model or in the French one correlates positively with later clinical or scientific competence.

ad b) Guidance how and what to read when?

Do we need a curriculum with standard reading lists?

My recommendations: Let the candidates choose depending on their own curiosity, encourage small group work. Start with the contemporary textbooks first, work your way back.

[14]My favourite comparison is judging the performance of a musician; no one would aks how many lessons a application for a job has; it be be a matter of his or her performance. Could it be that we have unsolved problems how to judge psychoanalytic performance that makes us move to counting numbers of sessions for self-experience?

For a true primer look for evidence-based textbooks like Luborsky L (1984) Principles of psychoanalytic psychotherapy[15].

ad c) Practical experience under supervision

Better to begin without supervision than not to begin at all.

Use of peer-supervision should be mandatory.

Use of e-mail or telephon supervision.

Don´t worry about issues of frequency or couch.

Encourage difficult patients to make use of second opinion (patient´s supervisory experience!).

Sharing of tape-video recording of sessions.

Mind: the task of learning psychoanalytic therapy is a longterm enterprise - it never stops. See as many patients as possible.

ad d) What should one know about research in psychoanalytic training?

There are two main pillars of wisdom for psychoanalytic work in what form ever:

A developmental research

B treatment research

[15]Luborsky L (1984) Principles of psychoanalytic psychotherapy. A manual for supportive-expressive treatment. Basic Books, New York

There are other influential domains, socio-cultural developments, economics, linguistics etc and most likely in the near future it will be essential to at least get a feeling of what neurobiologicy has to tell us (Roth 2001[16]).

SLIDE 10

TOP 5 Psychoanalytic Basic Assumptions

A significant assumption is the role which conflicts play during the lifespan of a person - starting from birth, manifest in his /her interpersonal contact and his/her personal well-being. If the role conflict plays in the emergence of a psychic or psychosomatic illness is purely considered as innerpsychic and not also interpersonal, the implications of the theory as well as the technique would be limited.

Traditional psychoanalytic understanding of a symptom almost requires a search of its origin in the life history of the person. This genetic point of view is not in contradiction with Kurt Lewin's belief that only forces and conditions which are present in the here and now, can induce an effect in the here and now. He would say that much of what is "presently seen" in the individual in the here and

[16]Roth, G. (2001). Fühlen Denken Handeln. Wie das Gehirn unser Verhalten steuert. Frankfurt, Suhrkamp.

now can only be recognised by genetic discovery of what came before (Rapaport 1960[17]).

SLIDE 11

TOP 6 Early Mother-Child Relationship

By now there has been a great change in the understanding of various developmental processes which take place in early childhood. Empirically based research of the early mother-child relationship began with René Spitz. Already in 1935 he was able to observe hundreds of infants growing up in orphanages and described the hospitalism he saw, which he attributed to emotional deprivation.

Mahler (1975; 1978) followed in the tradition of Spitz, and developed his work further in her groundbreaking monograph entitled “The Psychological Birth of the Human Infant".

The more recent research into the evolution of the mother-child relationship in the first year of life was able to provide the until then constructed or reconstructed psychoanalytic world of the infant or child with new thoughts.

[17]Rapaport, D. (1960). The structure of psychoanalytic theory. A systematizing attempt. New York, Int Univ Press.

Daniel Stern´s (1985[18]) monograph put together the up-to-then divided worlds of psychoanalysis and developmental psychology. The new theories of childhood development have had two main effects. They have promoted an integration of ethology as well as theories of communication and action and they have also had an marked impact on psychoanalysis and other psychodynamic schools

SLIDE 12

TOP 7 Good bye to Freuds drive/discharge model

The drive/discharge model saw development with the eyes of the entropy model. However, today's developmental psychobiologists take into account that the neurobiologically determined complexity, due to billions of neurones with millions of interconnections, leads to uncertainty and a limitation in the ability to predict behaviour.

This degree of complexity guarantees individuality and assures self-determination. Complexity grows in the course of development. Humans are attributed with the ability to socialise themselves into the animate and inanimate world. Activity generated endogenously represents a fundamental principle

[18]Stern, D. (1985). The interpersonal world of the infant. New York, Basic Books.

which has taken the place of the drive/discharge hypothesis (Kächele et al. 2001)[19].

SLIDE 13

TOP 8 The concept of schema has become a building block for both developmental and clinical theories

From today's point of view the inner object is not seen as an isolated object, but rather as a memory framed by a context of activity. From birth the object representations take place in a multiple context of acts of varying quality. By repeated communicative acts unconscious schemata are created, which can become very stable.

Stern (1985) refers to this active process as the representations of interactions that have been generalised (RIG). He assumes that the infant divides the flow of an interaction into episodes (e.g. feeding) and from repeated similarities (invariances) a prototype or schemata is built and generalised. This schema guides the expectations and the behaviour for the interactional sequences to follow (Kächele et al. 2001).

SLIDE 14

TOP 9 Attachment theory

[19]Kächele, H., A. Buchheim, et al. (2001). Development, attachment and relationship: New psychoanalytic concepts. Contemporary Psychiatry. F. A. Henn, N. Sartorius, H. Helmchen and H. Lauter. Berlin, Springer: 358-370.

Having first developed as a theory of normal development, the last years have seen the impacting of attachment theory on clinical issues (Kächele et al. 2001). It is clear to me that it can hardly be over estimated in providing a sound basis for early developmental failures (clinically known as the so-called early disturbances).
Attachment theory provides a testable model for the construct of re-staging in the therapeutic process (Strauss et al. 2002[20])
A desirable increase in attachment security is a curative and protective factor in psychic disorder working by change of procedural memories systems (Bowlby 1988[21])

Furthermore two items are of relevance:
Therapeutic alliance provides an attachment environment
and
The therapist functions as an attachment figure providing corrective emotional experience

Attachment status is related to psychopathology; read Peter Fonagy´s (1996) paper on the relation of attachment status, psychiatric classification and response to psychotherapy[22].

[20]Strauß, B., A. Buchheim, et al., Eds. (2002). Klinische Bindungsforschung. Theorien - Methoden - Ergebnisse. Stuttgart, New York, Schattauer.
[21]Bowlby, J. (1988). “Developmental psychiatry comes of age.” Am J Psychiatry 145: 1-10.

Write to Prof. Peter Fonagy (p.fonagy@ucl.ac.uk) for his report on psychobiological foundations of attachment at the conference of the Society for Psychotherapy Research in Rom 2004.

SLIDE 15

TOP 10 What does one has to know about contemporary treatment research ?

It seems useful to organize our present knowledge by differentiating stages of research:

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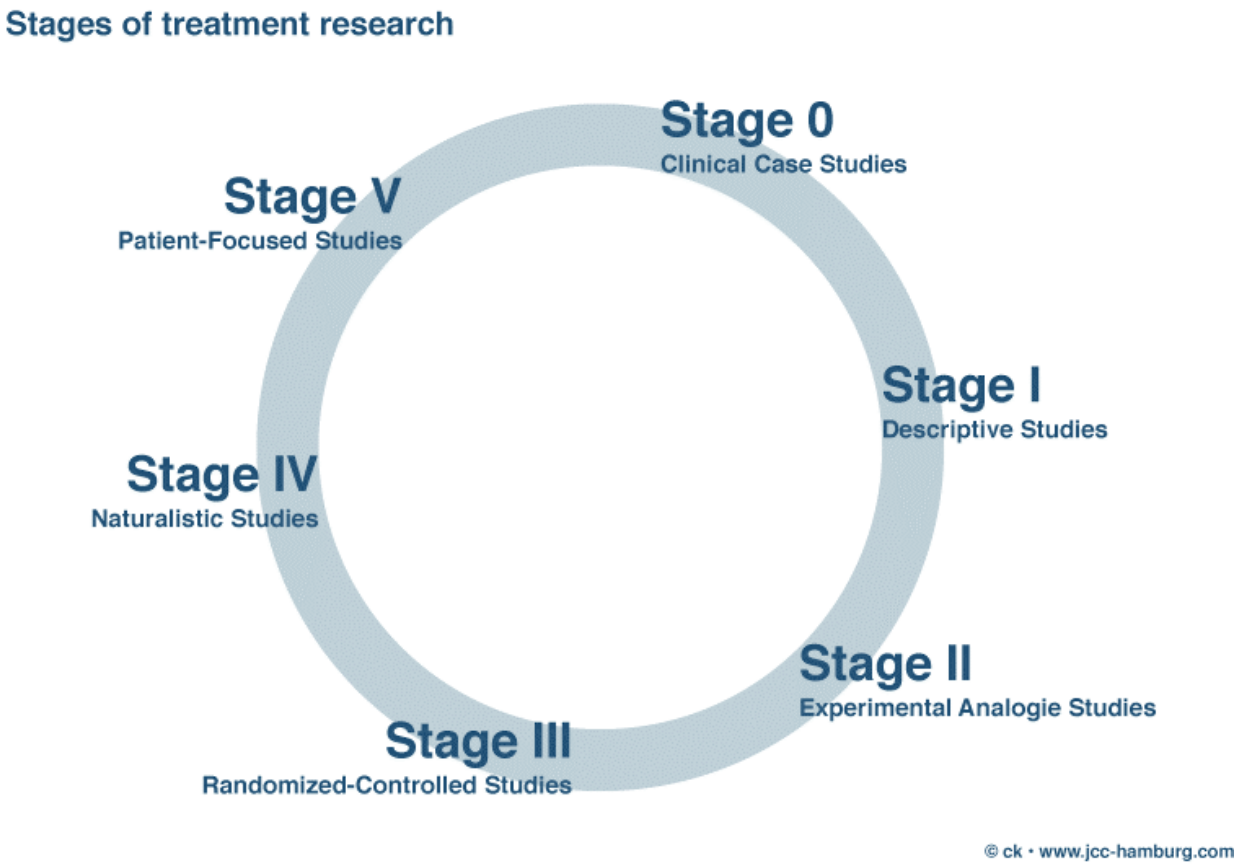
[22]Fonagy P, Leigh T, Steele H, Kennedy R, Mattoon G, Target M, Gerber A (1996) The relation of attachment status, psychiatric classification and response to psychotherapy. J con clin psychol 64: 22-31



SLIDE 16

TOP 11 Stage 0 Clinical Case-Studies

"Today the historically fertile narrative procedure Freud´s is no longer able to carry the responsability for the existence of psychoanalysis, even they still are a major tool for didactic and identity formation of the members of the analytic community, because case stories may be a rich material means of communication“ writes Stuhr (2004[23]), a former student of

[23] in Hau & Leuzinger-Bohleber (2004)

Germany´s most prominent psychoanalytic researcher A O Meyer.

SLIDE 17

In 1994 Meyer himself espoused a strong view about the genre of semi-fictional case stories: "To hell with the novella as representation of psychoanalysis - long live the account of the interaction" so the title of his philippika. „Novellas as psychoanalytic case stories today are anti-psychoanalytic and unscientific “(Meyer 1994[24]).

SLIDE 18

However learning from other fields of formal investigation of soft subjects - for example fairy tale research (Propp 1928[25]) - a way not to discard the clinical reports would be the accumulation of materials as demonstrated by the Ulm Clinical-Case-Archive which contains more than 900 final reports by candidates of the German Psychoanalytic Association. These are most usefuls materials to study formal issues of theory and practice developments by means of comparative methodologies

[24]Meyer A E (1994) Nieder mit der Novelle als Psychoanalysedarstellung - Hoch lebe die Interaktionsgeschichte. Z Psychosom Med Psychoanal 40: 77-98

[25]Propp, V. (1928) Morfologia delle fiabe. Einandi, Torino.

(Jüttemann 1990[26]). The most recent study detailed gender issues in diagnosis (Lang et al. 2009[27]).

SLIDE 19

TOP 12 Stage I Early Descriptive Studies

It may come as a surprise how early psychoanalysts were curious about what their collegues really do in the office. Take as an impressive example the E. Glover`s questionaire on technical issues issued on July 8th, 1932[28]:

	E. Glover`s ORIGINAL QUESTIONNAIRE (issued July 8, 1932) (Q)
1.	Interpretation
1.	Form Do you prefer:
(1)	short compact interpretation, or
(2)	longer explanatory interpretation, or
(3)	summing up type: (a) trying to convince by tracing development of a theme: (b) proving (or amplifying) by external illustration.
2.	Timing Query: favourite point of interpretation?
(1)	early in session;
(2)	middle or before end (allowing a space for elaboration);
(3)	at and: "summing-up" fashion.
3.	Amount
(1)	General: as a rule do you talk much or little?
(2)	Early stages: how long do you usually let patients run without interference? How soon do you start systematic interpretation?

[26]Jüttemann, G., Ed. (1990). Komparative Kasuistik. Heidelberg, Asanger Verlag.

[27] Lang F U, Pokorny D & Kächele H (2008) Psychoanalytische Fallberichte: Geschlechtskonstellationen und sich daraus ergebende Wechselwirkungen auf Diagnosen im Zeitverlauf von 1969 bis 2006. *Psyche – Z Psychoanal, im Druck*

[28]Glover, E. and M. Brierley, Eds. (1940). An investigation of the technique of psycho-analysis. London, Baillière, Tindall & Cox. republished in Glover, E. (1955). The technique of psychoanalysis. London, Baillière Tindall & Cox.

(3)	Middle stages: is your interpretation on the whole continuous and systematic, or do you return from time to time to the opening system of letting them run?
(4)	End stages: do you find your interpretative interference becomes incessant?

Today there are a number of such instruments on therapists attitude and strategies; the most recent by Sandell (2000[29]) that helped to differentiate the outcome of middle and high frequency psychoanalytic therapies in interaction with technique.

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TOP 12 Stage I Descriptive Studies

This has been a truely rich field, sometimes registered under the heading of process research. The details of the massive amount of work can be found in Dahl et al. (1988[30]), Miller et al. (1993[31]) and the process chapters in Bergin & Garfield´s Handbook (Lambert 2004[32]). To name but a few developments that should be known widely:

working alliance f.e. Luborsky ´s helping alliance 1976[33]

[29]Sandell, R., Blomberg, J., Lazar, A., Carlsson, J., Broberg, J., & Rand, H. (2000). "Varieties of long-term outcome among patients in psychoanalysis and long-term psychotherapy: a review of findings in the Stockholm outcome of psychoanalysis and psychotherapy project (STOPP)." International Journal of Psychoanalysis 81: 921-943.

[30]Dahl, H., H. Kächele, et al., Eds. (1988). Psychoanalytic Process Research Strategies. Berlin Heidelberg New York London Paris Tokyo, Springer.

[31]Miller, N. E., L. Luborsky, et al., Eds. (1993). Psychodynamic Treatment Research. A Handbook. New York, Basic Books.

[32]Lambert, M. J., Ed. (2003). Bergin and Garfield´s handbook of psychotherapy and behavior change. New York Chichester Brisbane, Wiley.

[33]Luborsky, L. (1976). Helping alliance in psychotherapy: the groundwork for a study of their relationship to its outcome. Successful psychotherapy. J. L. Claghorn. New York, Brunner, Mazel: 92-116.

transference f.e. Luborsky´s CCRT 1977[34], Dahl´s FRAME 1988[35], Gill and Hoffman´s PERT 1982[36]

technique, f.e. Q-Set of Jones 2000[37]

mastery, fe. Weiss & Sampson´s plan analysis 1986[38], Grenyer 1996[39]

analytic process-Scales,f.e. Waldron 2004[40]

countertransference, f.e. Bouchard et al. scales 1995[41]

SLIDE 21

TOP 13 Stage I Descriptive Studies: Methods to Measure Core Relations Patterns

Ever since the first international conference on psychoanalytic process research in Ulm in 1995 it has become obvious how

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[34]Luborsky, L. (1977). Measuring a pervasive psychic structure in psychotherapy: the core conflictual relationship theme. Communicative structures and psychic structures. N. Freedman and S. Grand. New York, Plenum Press: 367-395.

[35]Dahl, H. (1988). Frames of mind. Psychoanalytic Process Research Strategies. H. Dahl, H. Kächele and H. Thomä. Berlin, Heidelberg, New York, London, Paris, Tokyo, Springer: 51-66.

[36]Gill, M. M. and I. Z. Hoffman (1982). “A method for studying the analysis of aspects of the patient's experience in psychoanalysis and psychotherapy.” J Am Psychoanal Assoc 30: 137-167.

[37]Jones, E. (2000). Therapeutic Action: A Guide to Psychoanalytic Therapy. Northvale, New Jersey: J, ason Aronson.

[38]Weiss, J., H. Sampson, et al., Eds. (1986). The psychoanalytic process: Theory, clinical observation, and empirical Research. New York, Guilford Press.

[39]Grenyer, B. F. S. and L. Luborsky (1996). “Dynamic change in psychotherapy. Mastery of interpersonal conflicts.” J con clin psychol 64: 411 -416.

[40]Waldron, S., R. D. Scharf, et al. (2004). “What happens in a psychoanalysis? A view through the lens of the Analytic Process Scales.” Int J Psychoanal. in press

[41]Bouchard, M. A., L. Normandin, et al. (1995). “Countertransference as instrument and obstacle: a comprehensive and descriptive framework.” The Psychoanalytic Quarterly 64: 717-745.

intensive the core construct of psychoanalysis´s theory of technique, the transference, has been studied:

1 Luborsky ´s Core Conflictual Relationship Theme Method (CCRT)
2 Horowitz´s Configurational Analysis
3 Dahl´s Frames Method
4 Gill & Hoffman´s Patient's Experience of the Relationship with Therapist (PERT)
5 Strupp & Binder: Dynamic Focus
6 Weiss & Sampson Plan Diagnosis

Critique of these semi-quantitative methods is unevitable and desirable (Dreher 1998[42]). Formal research methodologies are easily criticised for not capturing the full richness of the clinical phenomena. Whatever they may lack in this respect, the gain is an increase in validity!

SLIDE 22

TOP 14 Stage I Descriptive Studies Measures of „Structural Change“

[42]Dreher S (1998) Psychoanalytische Konzeptforschung. Verlag Int Psychoanalyse, Stuttgart

An never ending story among psychoanalysts is the issue how to measure „structural change“ in contrast to mere symptom change.

At present we have three good candidates:

"Scales of Psychological Capacities" (Wallerstein 1991[43]) which is in a stringent testing procedure by the Munich study group[44]

"Heidelberg Structural Change Scale" (Rudolf et al. 2000[45]) which also is used to differentiate the outcome between low and high frequency psychoanalytic therapies.

The "Adult Attachment Interview " (Main 1995[46]) has become one of the major instruments in borderline research in Great Britain[47] and in the New York study on the treatment of borderlines[48]

SLIDE 23

TOP 15 Stage II Experimental Analogue Studies

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[43]Wallerstein, R. S. (1991). Assessment of Structural Change in Psychoanalytic Therapy and Research. The Concept of Structure in Psychoanalysis. T. Shapiro. Madison:, International Universities Press.

[44]Huber, D., G. Klug, et al. (2001). Die Münchner Prozess-Outcome Studie - Ein Vergleich zwischen Psychoanalysen und psychodynaamischen Psychotherapien unter besonderer Berücksichtigung therapiespezifischer Ergebnisse. U. Stuhr, M. Leuzinger-Bohleber and M. Beutel. Stuttgart, Kohlhammer: 260-270.

[45]Grande, T., G. Rudolf, et al. (2003). Investigating structural change in the process and outcome of psychoanalytic treatment - The Heidelberg-Berlin Study. in P. Richardson, H. Kächele and C. Renlund (Eds) European Psychoanalytic Therapy Research. . London, Karnac: 35-61.

[46]Main, M. (1995). Recent studies in attachment: overview, with selected implications for clinical work. Attachment theory: Social, developmental, and clinical perspectives. S. Goldberg, R. Muir and J. Kerr. Hilldale, NJ, The Analytic Press, Inc.: 407-474.

[47]Fonagy, P., M. Target, et al. (2003). “The developmental roots of borderline personality disorder in early attachment relationships.” Psychoanal Inquiry 23(3): 412-459.

Truely this methodology is not our strength. There are many good reasons for this because convincing analogue research in our field is hard to implement. There is one exemption: Studies on Free Association have shown some encouraging results.
I would recommend to replicate the Ulm experimental study on free association as part of any training experience. It is really a lot of fun and it helps to better understand mechanisms of change[49].

SLIDE 24

TOP 16 Stage III Randomized-Controlled Studies

Randomized Controlled Treatment Studies are the sine qua non of modern medical treatment research.
They can provide the highest level of evidence and are the hallmark of Empirically Supported Treatments[50]. They provide findings for the efficacy of treatments under experimental conditions. There are a number of shortcomings one should be aware of:
Selection of patients (exclusion of co-morbidity, 10% of the real world samples are in such studies)
Manualisation of procedure

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[48]Clarkin, J., P. Kernberg, et al. (1991). The Cornell Borderline Project. Psychic change and its assessment. 1st IPA Research Conference, London.
[49]Hölzer M, Heckmann H, Robben H, Kächele H (1988) Die freie Assoziation als Funktion der Habituellen Ängstlichkeit und anderer Variablen. Zsch Klinische Psychologie 17: 148-161

Training of therapists

Limitation of treatment length

Standardized instruments

The goal is to reach high internal validity; price is is low external validity.

I like to call this test tube research!

SLIDE 25

To illustrate this concern we checked the average number of sessions in the meta-analysis by Grawe et al (1994[51])

Duration of Experimental Studies[52]

Cognitive-Behavioral Therapies
– 429 Studies, average 11,2 sessisons
– 434 Studies, average 7, 9 weeks
Humanistic Therapies
– 70 Studies, average 16,1 sessions
– 76 Studies, average 11, 6 weeks
Psychodynamic Therapies

[50]Chambless, D. L. and S. D. Hollon (1998). "Defining empirically supported therapies." J Con Clin Psychol 66(1): 7-18.

[51]Grawe, K., R. Donati, et al. (1994). Psychotherapie im Wandel. Von der Konfession zur Profession. Göttingen, Hogrefe- Verlag für Psychologie.

[52]Kächele, Eckert, Schulte Hillecke, in Vorb

– 82 Studies, average 27,6 sessions – 80 Studies, average 30,7 weeks

One has just to check out one´s own clinical experience be it behavioral, humanistic or psychodynamic to realize that these average figures are not representative of business as usual.

SLIDE 26

Still there is no need to despair:

Few clinicians are aware of that at least three RCT are available for psychodynamic/psychoanalytic treatments in the following areas (Leichsenring 2002[53]):

depression (ICD-10 F3)
anxiety disorders (ICD-10 F40-42)
stress reactions (ICD-10 F43)
Dissociative, conversion- and somatoform disorders (ICD-10 F44, F45, F48)
eatings disorders (ICD-10 F50)
psychic and social factors with somatic diseases (ICD-10 F54)
personality- and behavioral disorders (ICD-10 F6)

[53]Leichsenring, F. (2002). “Zur Wirksamkeit psychodynamischer Therapie. Ein Überblick unter Berücksichtigung von Kriterien der Evidence-based Medicine.” Zeitschrift für Psychosomatische Medizin und Psychotherapie 48: 139-162.

dependency and abuse (ICD-10 F1,F55

SLIDE 27

TOP 17 RCT with longer, low and high frequency treatments

Very often we hear that RCTs with longer psychoanalytic treatments are impossible. In this vein one convincing demonstration has been published by Sandell et al. (1997[54]). However a randomized, controlled out-patient study, performed on behalf of a group of practicing psychoanalysts by two research psychoanalysts has been staged by the Munich study group[55]. The commentary by Peter Fonagy in the IPA Review[56] has been: an extremely promissing study. This study measures symptom change with the SCL-90 instrument: a much loved and hated measure. The findings so far are: Symptomatic burden changes linearly during treatment in both low and high frequency treatment. The TRANS-OP Study of the Stuttgart Center for Psychotherapy - an effectiveness study - shows the same results[57]

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[54]Sandell, R., J. Blomberg, et al. (1997). "When reality doesn´t fit the blueprint: doing research on psychoanalysis and long-term psychotherapy in a public health service program." Psychother Research 7: 333-344.

[55]Huber, D. and G. Klug (2003). Contributions to the measurement of mode-specific effects in long-term psychoanalytic therapy. European Psychoanalytic Therapy Research. P. Richardson, H. Kächele and C. Renlund. London, Karnac: 63-80.

[56]Fonagy, P., H. Kächele, et al., Eds. (1999). An open door review of the outcome of psychoanalysis. London, Research Committee of the International Psychoanalytic Association: http://www.ipa.org.uk.

[57]Kraft, S., R. Percevic, et al. (2003). "Änderungsmuster im Verlauf psychischer, sozialer und körperlicher Gesundung." Psychotherapie in Psychiatrie, Psychotherapeutischer Medizin und Klinischer Psychologie 8: 218-224.

Correlation of duration of treatment (in months) with primary outcome measures: SCL-90-R Depressivity; IIP Global Score, SPC Global Score

Variable		Post Treatment		Follow-up 1	
	Gruppe	Korrel. r	Signif. p	Korrel. r	Signif. p
SCL-90-R Depressivity	PA	- 0,190	0,281	- 0,020	0,918
	PD	0,328	0,088	0,158	0,421
	CBT	- 0,066	0,735	0,013	0,945
IIP Global Score	PA	**- 0,506**	**0,002****	**- 0,534**	**0,003****
	PD	- 0,016	0,936	- 0,272	0,161
	CBT	0,293	0,122	0,075	0,699
SPC Global Score	PA	- 0,194	0,271	- 0,287	0,112
	PD	0,107	0,582	0,086	0,657
	CBT	0,242	0,197	0,278	0,145

The Munich study also shows medium sized correlations of outcome with duration and dose in the Inventory of Interpersonal Problems of +0.50.

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TOP 18 Stage IV Naturalistic Studies

This is the true domain of psychoanalytic treatment studies. Quite a number of good studies are available:

Classical studies that most of us know:

like the Menninger-Studie: PI Robert Wallerstein (1986[58])

like the Berlin I Studie: PI Annemarie Dührssen (1962[59])

like the Penn-Studie: PI Lester Luborsky (1988[60])

like the Heidelberg I Studie: PI Michael von Rad (1998[61])

like the Berlin II Studie: PI Gerd Rudolf (1991[62])

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Ongoing Top-Studies that most of us should know:

liked the Stockholm Study: PI Rolf Sandell (2000[63])

like the Göttingen Study: PI Falk Leichsenring (1999[64])

like the Heidelberg Study: PI Gerd Rudolf (1997[65])

like the New York Borderline-Study: PI Otto Kernberg (1999[66])

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[58]Wallerstein, R. S. (1986). Forty-two lifes in treatment. A study of psychoanalysis and psychotherapy. New York, Guilford.

[59]Dührssen, A. (1962). "Katamnestische Ergebnisse bei 1004 Patienten nach analytischer Psychotherapie." Z Psychosom Med Psychoanal 8: 94-113.

[60]Luborsky, L., P. Crits-Christoph, et al. (1988). Who will benefit from Psychotherapy? New York, Basic Books.

[61]Rad, M. v., W. Senf, et al. (1998). "Psychotherapie und Psychoanalyse in der Krankenversorgung: Ergebnisse des Heidelberger Katamneseprojektes." Psychotherapie psychol Med 48(4): 88-100.

[62]Rudolf, G. (1991). Die therapeutische Arbeitsbeziehung. Untersuchungen zum Zustandekommen, Verlauf und Ergebnis analytischer Psychotherapie. Berlin Heidelberg New York, Springer.

[63]Sandell, R., Blomberg, J., Lazar, A., Carlsson, J., Broberg, J., & Rand, H. (2000). "Varieties of long-term outcome among patients in psychoanalysis and long-term psychotherapy: a review of findings in the Stockholm outcome of psychoanalysis and psychotherapy project (STOPP)." International Journal of Psychoanalysis 81: 921-943.

[64]Staats, H., F. Leichsenring, et al. (1999). Changing problems, changing aims: The development of change in psychoanalytic psychotherapy evaluated by PATH, a tool for studying longterm treatments. Psychoanalytic Process Research Strategies II. H. Kächele, E. Mergenthaler and R. Krause. Ulm, http://sip.medizin.uni-ulm.de.

[65]Grande, T., G. Rudolf, et al. (1997). Die Praxisstudie Analytische Langzeittherapie. Ein Projekt zur prospektiven Untersuchung struktureller Veränderungen. Psychoanalytische Katamnesenforschung. M. Leuzinger-Bohleber and U. Stuhr. Giessen, Psychosozial Verlag.

like the finnish comparative Study, PI R. Knekt (2004[67])

like the Stuttgart TRANS-OP study PI Hans Kordy (2001[68])

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In-Patient Psychotherapy-Studies

like the Stuttgart Studie: PI Volker Tschuschke (1994[69])

like the nation-wide group-therapy-Study: PI Bernhard Strauss (2002[70])

like the TR-EAT Study: PI Horst Kächele (2001[71])

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A special case in the field of naturalistic follow up studies are the retrospective catamnestic studies, f.e. The German Psychoanalytic Associations Follow- up study[72]. This first large

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[66]Clarkin, J. F., F. E. Yeomans, et al. (1999). Psychotherapy for Borderline Patients. New York, Wiley.

[67]Knekt, P. and O. Lindfors (2004). A randomized trial of the effect of four forms of psychotherapy on depressive and anxiety disorders. Helsinki, KELA The Social Insurance Institution, Finland. Studies in social security and health Nr, 77

[68]Puschner, B. and H. Kordy (2001). "Der Zugang zur ambulanten Psychotherapie." Verhaltensther & Psychosoziale Praxis 33(3): 487-502.

[69]Tschuschke, V. and R. R. Dies (1994). "Intensive Analysis of Therapeutic Factors and Outcome in Long-Term Inpatient Groups." International Journal of Group Psychotherapy 44(2): 185-208.

[70]Schmidt, S., B. Strauss, et al. (2002). "Subjective physical complaints and hypochondriacal features from an attachment theoretical perspective." Psychology and Psychotherapy: Theory, Research and Practice 75: 313-332.

[71]Kächele, H., H. Kordy, et al. (2001). "Therapy amount and outcome of inpatient psychodynamic psychotherapy of eating disorders. Results of a multi center study across Germany." Psychotherapy Research 11: 239-257.

[72]Leuzinger-Bohleber M, Target M (Hrsg) (2002) Outcomes of Psychoanalytic Treatment Perspectives for Therapists and Researchers. Whurr Publishers,, London and Philadelphia,

scale follow up study showed few differences between psychoanalyses and truely long term psychoanalytic psychotherapies with experienced psychoanalysts.
Both forms of treatment lead to long time stable results in the majority of patients, if the indication was well conceived
self reflection and the internalization of the analyst were more comprehensive in analytic patients , the evaluation of achieved outcomes more differentiated, and the development of creative ressouirces more innovative

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A major outcome was the identification of Clinical Prototypes based on three dimensions: Capacity for relationship - Capacity to work - Creativity-Self reflection. These three dimensions allowed the classification of the large samples into eight clinical prototypes:

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Type 1: „well done... The really good ones“
Type 2: „succesful, but why,?..the unreflecting successful ones“
Type 3: „with success and little capicity for reflection, but socially well integrated...“
Type 4: „.the tragic ones, that were able to accept their lot „
Type 5: „..professionally successful and creativ, but still alone...“

Type 6: „successful within limits in their creativity and capacity to work but with clear limits...“

Type 7: „...therapy didn´t do any good.. “

Type 8: „ the severly traumatized people“

This is a finding that may well be used in the day -by-day clinical evulation of our clientel.

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TOP 19 Stage V Patient-focused studies

This will be a growing domain of outcome research which needs large data basis and a lot of statistics. So it is very technical yet very close to the clinicians´hopes to get tools for evaluting individual´s course of treatment.

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Using hierarchical-linear modeling the course of individual treatment may be predicted and the factual course compared with the prediction[73].

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TOP 20 Consumer Satisfaction

Consumers´ satisfaction is a new topic in psaychotherapy evaluation research ever since Marty Seligman changed his mind from being a 'Saulus' advocating only RCT findings[74] to a 'Paulus' now decrying that RCTs are the wrong way to do psychotherapy research[75]. The by now famous CONSUMER REPORTS study showed that increasing duration of treatment up to hundred sessions of mainly once a week psychotherapy leads to greater satisfaction which - as shown by critical re-analysis - is not related to symptom change. This could be replicated in the German study on Jungian psychoanalysis. So satisfaction with treatment seems to be but one of the many dimensions of outcome.

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Good News Bad News

The impact of research findings on treatment is steadily growing. Thus psychoanalytic education has to keep a watchful eye on it. Research will one of the powerful anti-ideological weapons in our field. For example theStickholm study has quite exciting findings to teach us a lesson:

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[73]Lambert , M. J. (2001). “Psychotherapy outcome and quality improvement: Introduction to the special section on patient-focused research.” J Con Clin Psychol 69: 147-149.

[74]Seligman M (1994) What you can change and what you can´t. A.A. Knopf, New York

[75]Seligman, M. E. P. (1995). “The effectiveness of psychotherapy.” Am Psychologist 50: 965-974.

At a first glance it looked that psychoanalsis is doing better in the long run. However taking into account therapists´style they found a different picture

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A technical attitude of providing supportive-interpersonal qualities was the true winner.

So research may help to guide clinical training. The impact of research findings on treatment is steadily growing. Thus psychoanalytic education has to keep a watchful eye on it. Research will one of the powerful anti-ideological weapons in our field.

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Therefore never give up.