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How to study the 'quality of psychoanalytic treatments' and their long-term effects on patients' well-being:

A representative, multi-perspective follow-up study[1]

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How can we study the 'quality of psychoanalytic treatments'? The authors attempt to answer this question by discussing a naturalistic, multi-perspective and representative follow-up study of psychoanalyses and long-term psychoanalytic psychotherapies. We studied a representative sample (n = 401) of all the patients who had terminated their psychoanalytic treatments with members of the German Psychoanalytical Association (DPV) between 1990 and 1993. Between 70 and 80 per cent of the patients achieved (average 6.5 years after the end of treatment) good and stable psychic changes according to the evaluations of the patients themselves, their analysts, independent psychoanalytic and non-psychoanalytic experts, and questionnaires commonly applied in psychotherapy research. The evaluation of mental health costs showed a cost reduction through fewer days of sick leave during the seven years following the end of long-term psychoanalytic treatments. The results achieved using non-psychoanalytical instruments are complemented by the richness of the idiosyncratic findings, gained by the psychoanalytic research instruments.

Keywords: psychoanalytic outcome research, representative follow-up study, combining quantitative and qualitative instruments

Introductory remarks

The concern of many psychoanalytic clinicians that quantitative empirical studies might not provide adequate means for observing, 'measuring' and interpreting the specific quality of psychoanalytic treatments and their outcome is the basis for their scepticism towards (quantitative) empirical psychotherapy research. This concern is still partially justified because the specific subjects of our science, unconscious processes and fantasies, are not directly

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[1] This article is a modification of our presentations at the Empirical Pre-Congress of the International Psychoanalytical Association in Santiago de Chile in August 1999, the IPA Research Conference in London, 4 March 2000 and the EPF Conference in Prague, 6 April 2002. The study reported in this paper was planned by the 'Projektgruppe Katamnesestudie' with about twenty members of the German Psychoanalytical Association. The chairs are M Leuzinger-Bohleber, U Stuhr, M Beutel; the Consultants: B Rüger (Statistical Consultant) and H Kächele (Consultant of the Research Committee of the IPA).

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measurable per se and require a special qualified scientific approach to be observed, investigated and understood in their idiosyncratic meanings. Therefore many analysts still maintain that only psychoanalytic clinical research in the psychoanalytic situation itself enables analysts as well as their patients to assess the quality of the psychoanalytic experience and its 'effects' on neurotic symptoms, helping the patient to transform them into 'ordinary misery' (see also Rothstein, 1985; Green, 1996; Sandler and Dreher, 1996; Leuzinger-Bohleber and Stuhr, 1997; Beenen, 2002; Bürgin, 2002; Dreher, 2002). In many European countries and in the United States, however, during recent decades, public and scientific pressure on psychoanalysis has grown to 'prove' its overall effectiveness as a psychotherapeutic method that has to be financed by insurance companies (see Lear, 1995, 1997; Tuckett, 1998; Kernberg, 1999, 2002; Fonagy and Target, 2001; Widlöcher, 2001; Fonagy, 2002; Freedman, 2002; Keller et al., 2002; Sandell, 2002; Wallerstein, 2002). Should we resist this request and risk losing more and more relevance in relation to current public, medical and scientific discourse? Or should we try to make a great effort to formulate and assert our arguments within these discourses? Or should we even take up the challenge and perform our own empirical and psychoanalytical studies, for example clarifying what we and our patients think about the 'quality' and the long-term effects of psychoanalytic treatment?[5]

In this paper we shall try to summarise some of the experiences with such an attempt to perform a *psychoanalytic* empirical study aiming, on the one hand, at elaborating our specific psychoanalytic understanding of the quality of psychoanalytic treatment, both in terms of its outcome and in terms of our understanding of psychoanalytic research, its unique methodology and its specific scientific criteria. On the other hand, we tried actively to conduct a dialogue with non-psychoanalytical psychotherapy researchers and with their methods and understanding of scientific truth. We hope to be able to illustrate that, for us and for many of our colleagues who were engaged in this research project, empirical research in psychoanalysis always has to walk a tightrope between two extreme poles: on the one hand, we are in danger of withdrawing too much into the psychoanalytic ivory tower, concentrating more or less exclusively on controversies and discourses within the psychoanalytic community. This withdrawal could have detrimental consequences for the future of psychoanalysis. Psychoanalysis could lose its relevance for medicine and academic psychology, for interdisciplinary scientific dialogue and for society. In our view, in the long run such a withdrawal could put at risk psychoanalytic innovation and creativity. On the extreme other hand there is a danger that quantitative empirical researchers in the field of psychoanalysis could succumb too much to a research methodology which is not suitable for studying the characteristic subjects of

[5]Incidentally, we should realise that we find open ears for these arguments even in contemporary psychotherapy research because qualitative approaches have been discussed more seriously within this scientific community for several years (see Faller and Frommer, 1994; Stuhr and Wachholz, 1999). It is beyond the scope of this article to give an overview of this historical development of psychotherapy research (see Kächele, 1995; Stuhr, 1997). The trend towards 'qualitative psychotherapy research' is based on insight into the limits of quantitative outcome research and the contemporary focus on studying the therapeutic process itself. Studying verbal or non-verbal aspects of therapeutic interactions is not possible without applying hermeneutic interpretations of the complex and often idiosyncratic meanings of these symbolically defined social interactions. Another important fact is that these interactions are processes, always taking place within an ongoing period of time, a fact which can only be taken into account with great difficulty by quantitative, static measurements. This is one reason why qualitative researchers are interested in *systematic methods condensing information about social and therapeutic interactions.* In this context, which is sometimes characterised as a '*narrative revolution*', an old tradition in psychoanalysis is rediscovered: communicating complex information by narratives (case histories) (see Leuzinger-Bohleber, 1998, 2002a, 2002b). In the follow-up study summarised in this article we applied, as our central research instrument, the *clinical psychoanalytical research method* which can be defined as one *specific qualitative approach* in this context: it is centred around the interpretation of unconscious meanings (a hermeneutic process) on the one hand and tries to study changes within certain periods of time on the other hand, communicating these observations in the traditional way, through psychoanalytic case studies (narratives).

psychoanalysis: unconscious processes, conflicts and fantasies. This submission may be determined by an uncritical identification with a historically past 'unified' conceptualisation of science and scientific methods (the so-called '*Einheitswissenschaft*') inappropriate for psychoanalysis (and, at least in the eyes of leading contemporary philosophers, inappropriate for most other sciences as well, see Hampe, 2000; Holzhey, 2001; Leuzinger-Bohleber et al., in press). Therefore there is the danger that psychoanalysis—as a unique and specific science—could be swallowed up by a 'unified science' and thus become just one of many medical disciplines, in the long run losing precisely its provocative specificity and relevance, the '*Stachel* Freud' (the 'spine Freud', as Alfred Lorenzer, 1985, called it) which makes psychoanalysis interesting and inconvenient in the best sense of the word, not only for public intellectual discourse but also for our scientific interdisciplinary partners.

In our study we tried to 'walk this tightrope' creatively, constantly discussing and reflecting on the basic scientific questions connected with an empirical approach to psychoanalytic processes and their outcome. We will not be able to document all our discussions within the frame of this paper (see Leuzinger-Bohleber et al., 2000, 2001, 2002 and in press). We focus, first, on an overview of the context and the aims of the study, the design and the control of representativity and selected results. We then summarise some results from our (quantitative) questionnaire sample, followed by results from the (qualitative) interview sample. We conclude with a brief discussion of the question 'Do clinicans learn from extra-clinical research?'

Context and aims of the study

In Germany and Switzerland the '*Zeitgeist*'[6] described above has led to a questioning of psychoanalysis as a science, and a questioning of the 'outcomes' of psychoanalytic treatments and its cost-effectiveness over recent years. It is strange that in this current debate the historical fact seems to have been denied that some of the most famous studies in the field of psychotherapy research on outcomes of therapies have been performed by analysts (e.g. the Menninger Study, the Columbia Research Project, the Boston Psychoanalytic Institute Prediction Study, studies done at the New York Institute etc.; see e.g. Leuzinger-Bohleber and Stuhr, 1997; Wallerstein, 2002; and, in the German-speaking world, see also Stuhr et al., 2001). Besides, many very sophisticated studies on long-term psychoanalytical therapies are currently in progress. Some of these studies (like the Stockholm Study by Sandell et al., the Multicentric Study by Beenen et al., the Finish Psychotherapy Study by Hanulla et al., the Ongoing Study at the Anna Freud Centre by Fonagy et al., the Praxisstudie by Rudolf et al. and the Munich Psychotherapy Study by Huber et al. in Germany) are prospective studies in which different psychotherapeutic or psychoanalytic treatments of particular groups of patients are compared in an empirical design (some of them even randomising the patients) (all these studies are summarised in Leuzinger-Bohleber and Target, 2002). Prospective studies have many advantages, for example in trying to control the effect of therapy over a specific period of time, having different points of measurement before, during and after treatment and so on, but there

[6] We see many parallel lines between these attacks on psychoanalysis in Europe and the *Zeitgeist* in the United States, which was characterised by the philosopher Jonathan Lear (1995, p. 97) and others as 'Freud bashing'. Looking back on the history of Western civilisation, he clearly demonstrated that the current critique not only aims at attacking Freud as a historical person and as a scientist, but also psychoanalysis as a representative of a specific idea and an understanding of human beings, each having their own very special life history, dignity and individual fate as well as their idiosyncratic unconscious wishes, conflicts and fantasies, which resist the cognitive control of consciousness with their untamed drives and radical longings, although they might be—at the same time—a source of personal sufferings and social maladaptation. Therefore Freud-bashers try—once again—to deny the unconscious as a symbol which reminds us that not everything within mankind is controllable, measurable and manageable, not even by 'objective', 'clean' and 'technical' scientific instruments.

are also some disadvantages, for example the influence of the research setting on the psychoanalytic process, the problem of drop-outs, the sample size (often the number of patients and therapists has to be relatively small because of the tremendous costs of prospective studies), their long duration (it often takes years to achieve the first results, and this means there is a risk that the instruments used may become out of date while the study is in progress). In contrast, follow-up studies, like the one we summarise here, have the advantage of not influencing the ongoing therapy, but the disadvantage of only being able to retrospectively evaluate the before, during and after states of former patients by these patients themselves, their therapists and independent observers. On the other hand, the sample size can be quite large and results can be achieved within a relatively short period of time and—what is especially important for us in our project—this sort of study is naturally constituted, which means that it is close to and relevant for current clinical practice.

Because only our psychoanalytical institutions enable us to do such 'naturalistic research' (with 'real patients', 'qualified and experienced therapists', 'real' indications of certain treatments etc.) the Research Committee of the German Psychoanalytical Association (DPV), after long and controversial discussions, finally decided to undertake a naturalistic follow-up study in 1997. The major aim of the project is to study the patients' retrospective views of their experiences with psychoanalytic therapy and its effects more than four years after the end of their psychoanalyses or long-term psychoanalytic therapies. We also wanted to know whether the subjective views of the former patients correspond to those of their former analysts, and those of independent psychoanalytical and non-psychoanalytical observers, and to the results of tests and questionnaires used in psychotherapy research.

Control of representativity and study design

Basic assessment—aims, results and representativity

In the first months of 1997 we sent a questionnaire to all 774 members of the DPV, in order to determine the feasibility of our study—which was dependent on the co-operation of the members—and in order to ascertain the total number of patients accessible for the study and to make it possible to establish a representative sample of former patients. Ninety-one per cent of the members responded to the 'baseline assessment'. A great majority (89 per cent) voted for the study. At the meeting of the German Psychoanalytical Association in Köln, in May 1997, the study was agreed to officially and financially supported.

As a second step, we asked the analysts willing to participate to send baseline assessment questionnaires to all former patients of psychoanalysis and psychoanalytic long-term treatments who had terminated their treatments between January 1990 and December 1993. Our baseline assessment enabled us to study a representative sample of all the patients in long-term psychoanalytic treatments who have ended during this period of time ($n = 401$, see below).

The basic assessment included detailed questions on the kind of therapy conducted during the time period under study, on basic characteristics of patients (e.g. level of disturbance, global outcome). Thus we could establish representativity at each step of recruitment (see Table 1). The fact that the two frequency distributions are almost identical corroborates the representativity of the treatment cases of the 207 participating analysts. Their (subjective global) evaluation of therapy success appears not to be biased towards 'more successful' cases. In fact, there is a slight (statistically not significant) tendency towards 'less successful' cases in the participating group.

The second control of representativity was based on an evaluation of therapy outcome by the

Table 1 — Spontaneous global evaluation of therapy outcome by the analysts separated into number of cases (absolute and in %) and according to co-operation

Evaluation	All 321 analysts responding to question 9	Among them 207 co-operating	Among them 114 not co-operating
Bad	184 8.4%	127 9.2%	57 7.2%
Middling	705 32.4%	446 32.2%	259 32.6%
Good	981 45.0%	620 44.8%	361 45.4%
Very good	309 14.2%	191 13.8%	118 14.8%
Total	2179	1384	795

patients themselves, which was part of the short questionnaire that they received by mail from their analysts. The high level of similarity of corresponding frequency distributions again corroborated the representativity of the samples of participating patients.

Figure 1 illustrates how we controlled each step of the reduction of our sample descriptively (as shown in Table 1) and by a test of representativity, developed by Rüger (2002a, 2002b).

As we will show, it would have been impossible to interview all 401 former patients because of the limited financial and personal resources. Thus it was necessary to create a sub-sample of patients (sample size 194), who could participate in the complete research procedure (interview sample). The remaining patients (sample size 207) were asked to fill out several questionnaires, one of which contained open questions (questionnaire sample). The two sub-samples were drawn according to the random principle: the interview sample consists of two stratified random samples, one of which included only psychoanalyses and one only long-term psychotherapies. The two variables used for stratification were 'analyst's evaluation of therapy outcome' and 'patient's evaluation of therapy outcome'. We chose a random sample of the therapy patients using a analogous procedure (see Rüger, 2002a, 2002b).

As far as we know, our ongoing study is the first in which it is possible to study a *representative* sample of psychoanalyses and psychoanalytic therapies (representative with respect to therapy outcome).

Design of the study

We have attempted to avoid limitations of former studies on long-term psychoanalytic treatment, for example, representative sampling, reliance on training cases, treatment evaluation by the treating analyst (cf. Bachrach et al., 1991; Leuzinger-Bohleber and Stuhr, 1997) by careful selection of inclusion criteria, the recruitment of a representative sample and the choice of measures. Our *inclusion criteria* were defined with the purpose of studying long-term treatment of experienced psychoanalysts:

treatment conducted by a member of the DPV (German Psychoanalytic Association);
treatment duration of at least one year;
treatment termination between January 1990 and December 1993;
exclusion of training and teaching cases.

In our study design we have tried to combine *qualitative* with *quantitative*, *clinical* with '*extra-clinical*' methods, that is, psychoanalytical interviews and their clinical evaluation with questionnaires, psychological tests, health insurance data etc. As described above, a stratified random sample of 194 patients was drawn for intensive interviewing, the interviews being further analysed by qualitative and quantitative procedures. In addition, we interviewed the

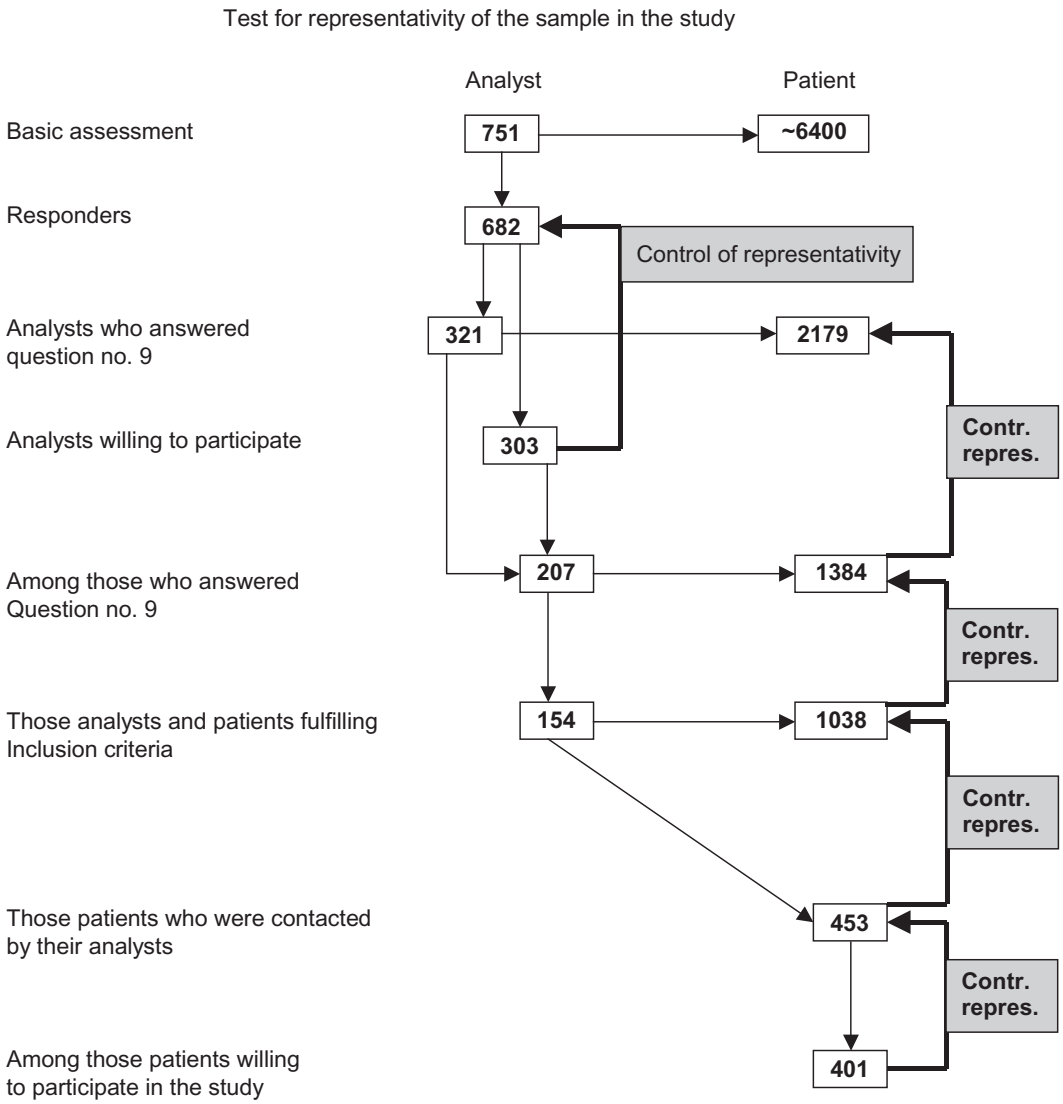


Figure 1 — Test for representativity of the sample in the study

psychoanalysts and asked them for their written assessments and progress reports sent to the insurance companies before and during treatment. The assessments of health data from the insurance companies gave us the chance to trace data back to the time periods before and during the long-term treatments.

Selected results

Results from the questionnaires: treatment satisfaction, current distress and absenteeism

All former patients who had agreed to participate received standardised questionnaires on distress (SCL-90R), resources (SOC, Sense of Coherence; Antonovsky, 1993) and Life Satisfaction (IRES; Gerdes and Jäckel, 1995), and additional questionnaires on *well-being*, *utilisation of medical services* before, during and after treatment and *treatment satisfaction.*

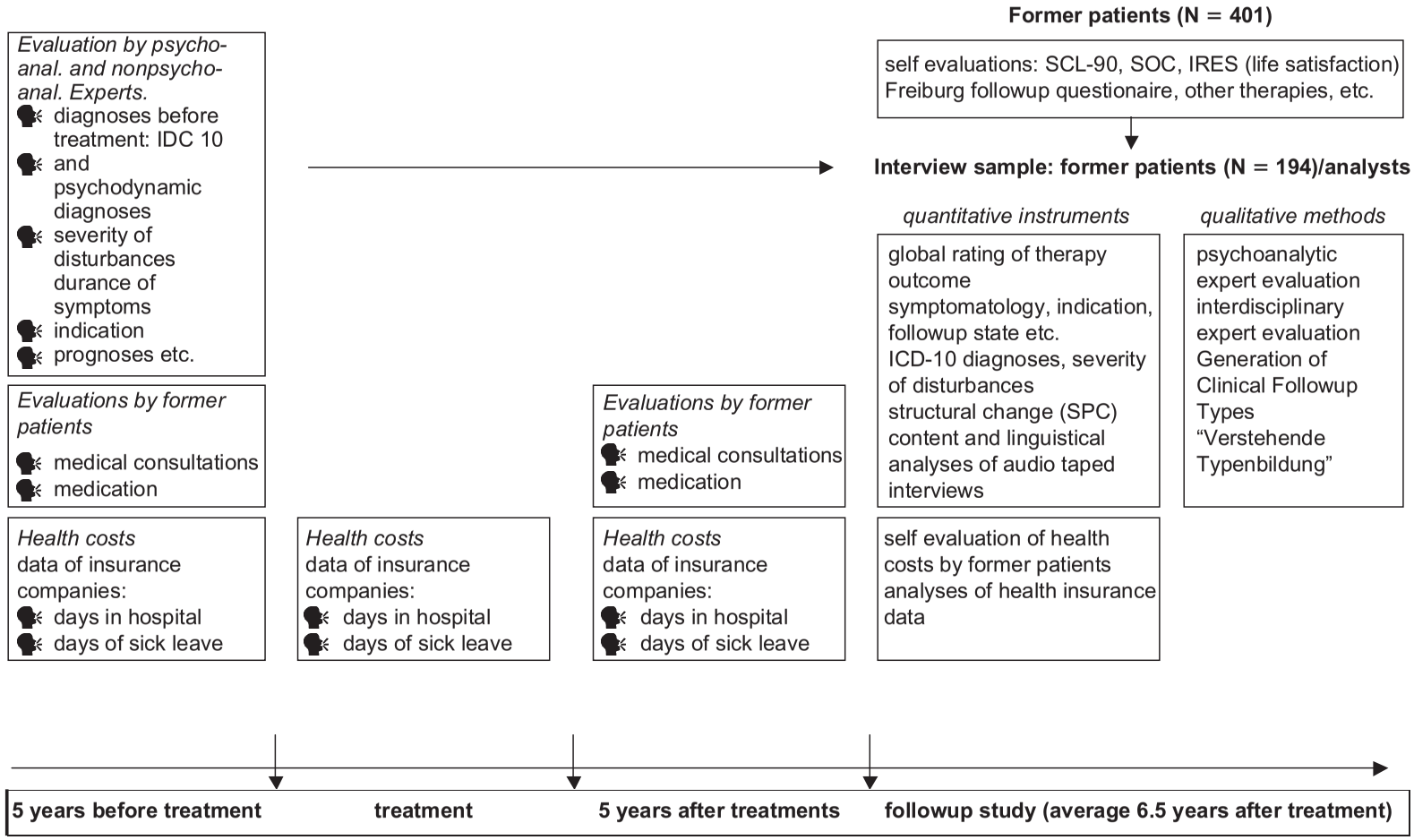


Figure 2 — Design of the study

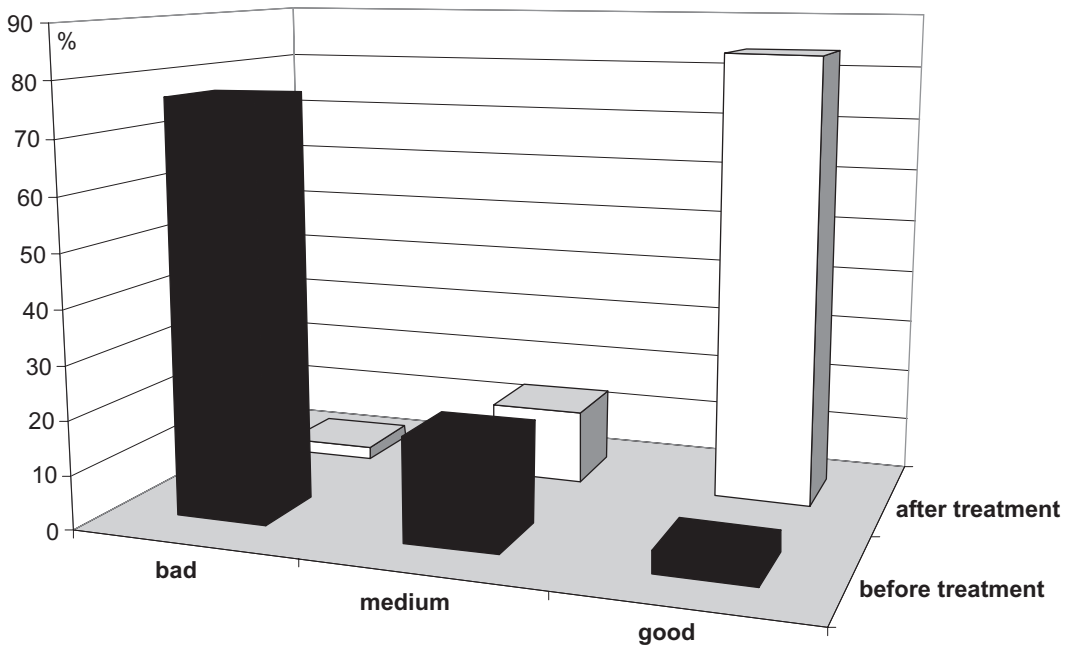
We informed the patients whom we could not interview because of our limited resources ($n = 207$) and asked them to fill out the enclosed questionnaires including a number of *open-ended questions* (based on the interview questions) regarding goals, causes of treatment and relationship with the analyst. We offered all of these patients a personal interview, which few accepted. Considering the complicated recruitment procedures we followed to secure confidentiality the patients' return rates (75 per cent) and the treating analysts' return rates (92 per cent) exceeded our expectations. We also asked the former patients of the interview sample to fill out the questionnaires. The response rate of this sample was slightly lower than the one just mentioned (66 per cent). Many of the interviewed patients told us that being interviewed was much more satisfying for them than filling out questionnaires. As expected, we did not find a significant difference in the questionnaire results of both samples. Therefore we present the results of all the questionnaires together ($n = 282$).

Psychotherapies with one to two sessions per week and psychoanalyses with three and more sessions per week were about equally represented. Treatments had a mean duration of about four years and had been terminated an average of six-and-a-half years before follow-up, irrespective of treatment setting. According to our inclusion criteria the treating analysts were clinically experienced (with an average experience of thirteen years). Study participants had an average age of 45 years at the follow-up assessment. As in other psychotherapy studies about two-thirds of the participants were women. Almost half (45.2 per cent) were married. With regard to levels of education, 88.2 per cent had the German '*Abitur*' (equivalent to British A levels); 8.6 per cent had taken O-Levels and 3.2 per cent had completed '*Hauptschule*' (in the British school system this would be similar to the completion of secondary modern school without taking GCSEs). It came as a surprise that a large part (84.3 per cent) of the former patients were 'social climbers', that is, they had moved from one stratum of society to another. Most patients (65.2 per cent) worked full-time; 21.7 per cent had a part-time job and only 2.2 per cent were out of work.

As Figure 3 shows, the majority of the patients (76.7 per cent) reported retrospectively that their general well-being had been severely compromised before treatment; at follow-up, however, the majority (83.7 per cent) reported a good well-being (Wilcoxon; $p < 0.00$; representative sample!). About two-thirds reported that their well-being had remained stable from termination to follow-up. We found comparable improvements of physical and psychological complaints, relationships, work ability etc. based on the views of the former patients and their psychoanalysts. We could not find consistent differences between psychoanalysis and psychotherapy patients regarding the retrospective assessment of their impairment before treatment and of their well-being at follow-up. We have to stress that this finding does not mean that psychoanalysis and long-term psychoanalytic treatment lead to the same results because, within the design of our study, we could not ask this research question. We can only say that—if the indication was correct—patients had good outcomes in psychoanalyses as well as in psychoanalytic long-term therapies.

Figure 4 shows about 80 per cent of the former patients reported positive changes regarding well-being (83.7 per cent), personal development (85.2 per cent) and relationships to others (79.2 per cent), between 70 and 80 per cent regarding coping with life events, self-esteem, mood, life satisfaction and work ability. The proportion of patients with a stable partnership increased from beginning of treatment to follow-up from 67 to 76 per cent (Chi^2; $p < 0.05$).

Table 2 compares treatment satisfaction of patients and analysts' views regarding treatment results. A total of 76 per cent of the patients were satisfied with the treatment (only 15 per cent reported that they were unsatisfied to varying degrees; 4 per cent were very unsatisfied); with a 65 per cent satisfaction rate, the analysts were clearly more critical. The overall agreement was



5-point scale (1, 2 = bad, 3 = medium, 4, 5 = good)

Figure 3 — Well-being prior to and after treatment: Participants of the follow-up-study ($n = 282$)

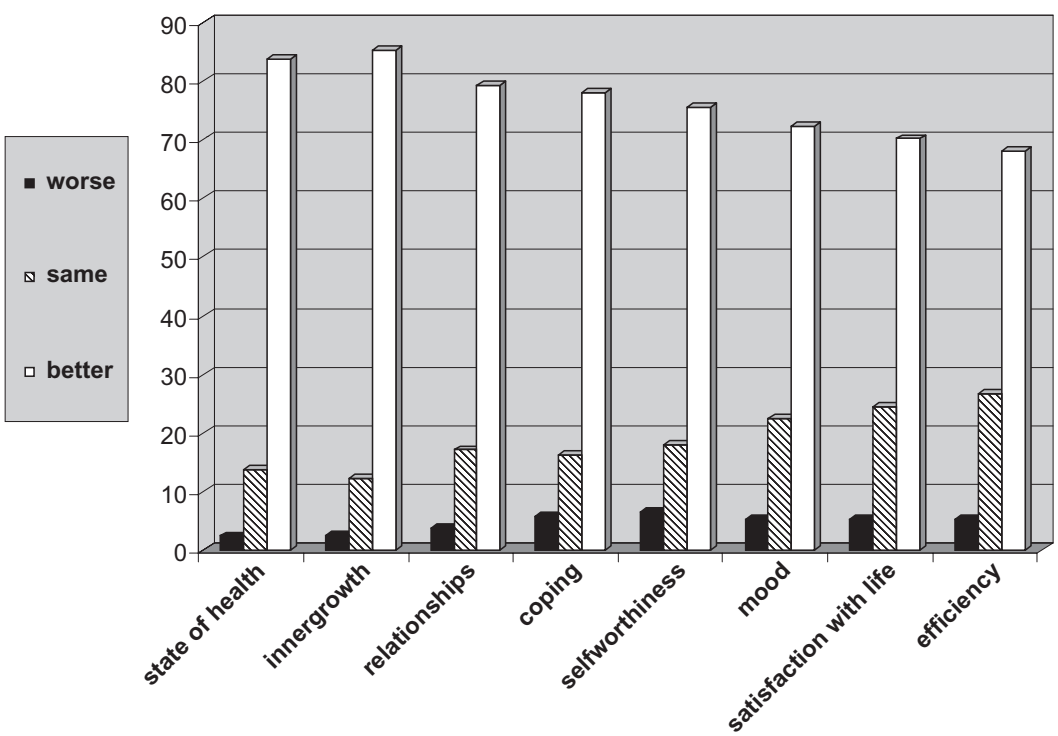


Figure 4 — Former patients' experience of changes during therapy

Table 2 — Treatment satisfaction in the view of patient and analyst ($n = 141$)

	Analyst					
	Very dissatisfied	**Dissatisfied**	**Undecided**	**Satisfied**	**Very satisfied**	
Patient						
Very dissatisfied	0%	1.4%	2.1%	1.4%	0.7%	5.7%
Dissatisfied	0%	2.1%	2.1%	4.3%	0.7%	9.2%
Undecided	1.4%	1.4%	1.4%	5.0%	0%	9.2%
Satisfied	0.7%	3.5%	5.7%	15.6%	5.7%	31.2%
Very satisfied	2.8%	2.8%	7.1%	15.6%	16.3%	44.7%
	5.0%	11.3%	18.4%	41.8%	23.4%	100%

good; evaluation differed more than one scale point in only 27.5 per cent of patients and analysts (on a 5-point-scale from 'very dissatisfied' to 'very dissatisfied').

Current distress was based on the total score of the SCL-90R (GSI). The validity of the positive evaluations of the former patients is underscored by the fact that the total distress at follow-up was mostly in the normal range and therefore differed significantly (*t*-test, $p < 0.001$) from out-patients and in-patients from the Department of Psychosomatic Medicine (University of Giessen) and from a sample of patients from private psychoanalytic practices in Germany at the beginning of treatment.

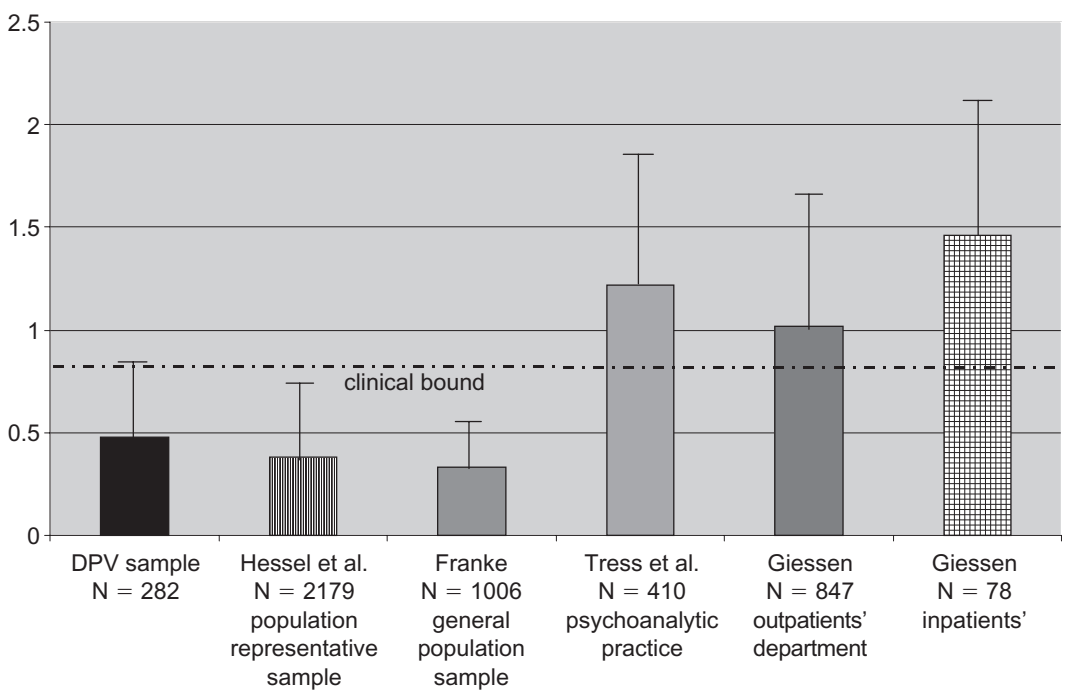


Figure 5 — Current symptom strain (SCL-90-R) – as compared to other samples

The same applied to *life satisfaction*: at follow-up, 70 to 80 per cent were satisfied with various life areas (family, friends, work etc.). Again, patients were in the range of a sample matched from the community sample of the German general population ($n = 1{,}800$) according to age, sex and education.

As indicators for disease costs, we enquired about the number of ambulatory physician consultations and days of sick leave. Absenteeism from work was significantly reduced in the first year of treatment compared to the year before treatment. This reduction was maintained throughout follow-up. The number of ambulatory medical consultations reduced accordingly. Our analyses of the records of the health insurance companies support these observations. To

Table 3 — Work loss days and medical consultations based on patients' reports

	1 year before treatment		1 year of treatment		1 year before follow-up		Friedman non-parametric Anova
	M	*SD*	*M*	*SD*	*M*	*SD*	
Days of sick leave							
Complete health data (n - 29)[1]	9.5	9.7	5.7	6.4	2.1	3.9	$\chi^2 = 17.5^{***}$
Others ($n = 140$)[2]	7.9	14.3	5.0	16.3	5.8	29.8	$\chi^2 = 19.6^{***}$
All patients (169)[3]	8.2	13.6	5.1	15.0	5.2	27.2	$\chi^2 = 29.9^{***}$
Medical consultations							
Complete health data ($n = 32$)	4.4	3.6	3.0	3.3	2.9	3.9	$\chi^2 = 10.7^{***}$
Others ($n = 130$)	6.1	90	3.4	5.4	3.7	4.6	$\chi^2 = 20.3^{***}$
All patients (162)	5.8	8.2	3.3	5.1	3.5	4.5	$\chi^2 = 29.7^{***}$

[1]Employed patients with complete self-report and health insurance; [2]employed patients without complete health insurance data; [3]all patients employed throughout the study period; $^{***}p < 0.001$.

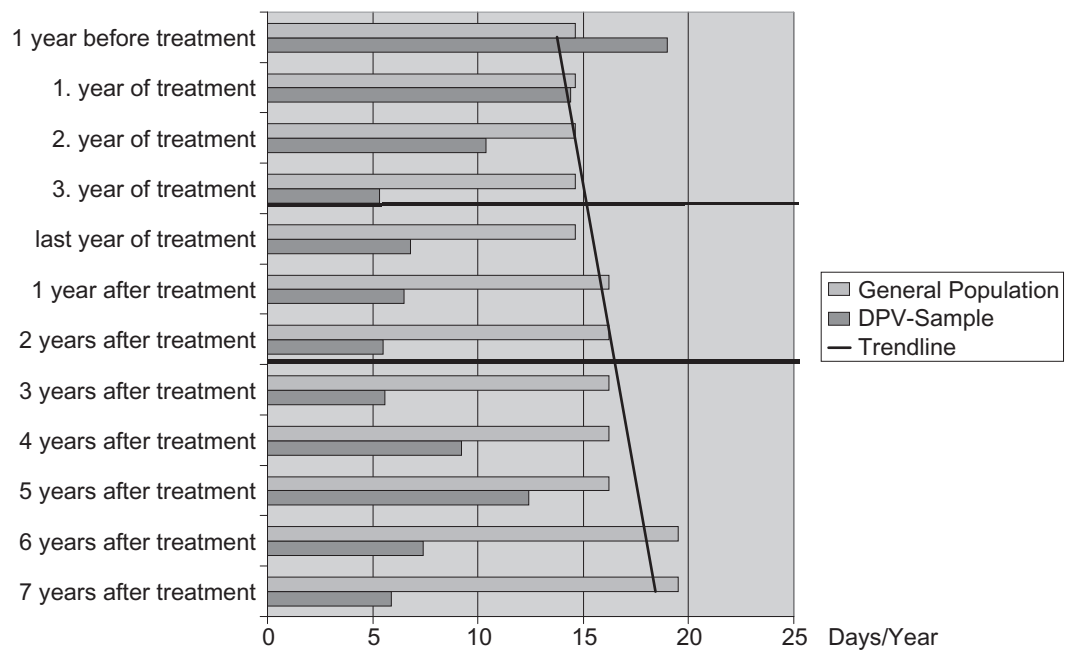


Figure 6 — Days of sick leave per year (DPV sample compared with general population)

Table 4 — Cost-effectiveness of long-term psychotherapy: Means of patients compared to (a) general population and (b) pretreatment level

	Reduction in days		X DEM 354		Accumulated	
	(a)	(b)	(a)	(b)	(a)	(b)
1 year of therapy	−0.2	−5.6	70.8	1982.4	70.8	1982.4
2 year of therapy	−4.2	−8.6	1486.8	3044.4	1557.6	5026.8
3 year of therapy	−9.3	−13.7	3292.2	4849.8	4849.8	9876.6
Last year of therapy	−7.8	−12.2	2761.2	4318.8	7611.0	14 196.4
1 year after therapy	−9.7	−12.5	3433.8	4425.0	11 044.8	18 620.4
2 year after therapy	−10.7	−13.5	3787.8	4779.0	14 832.6	23 399.4
3 year after therapy	−10.6	−13.4	3752.4	4743.6	18 585.0	28 143.0
4 year after therapy	−5.0	−9.8	1770.0	3469.2	20 355.0	31 612.2
5 year after therapy	−3.8	−6.6	1345.2	2336.4	21 700.2	33 948.6
6 year after therapy	−12.1	−11.6	4283.4	4106.4	25 983.6	38 055.0
7 year after therapy	−13.6	−13.1	4814.4	4637.4	30 798.-	42 692.4
					= 79.9%	= 97.0%

our surprise, there is no statistical significant difference between the subjective memories of the former patients and the tendency of the objective reductions of mental health costs (see Beutel et al., in press).

Evaluating the mental health costs, we found that the cost reduction in terms of fewer days of sick leave during the seven years following the end of treatment had been about DM 42,000. This amount is about 97 per cent of the total cost of treatment, which was estimated to be DM 44,000 (for more detailed analyses see Beutel and Rasting, 2002, pp. 110–29).

These ratings and questionnaire data were supplemented by very detailed, personal and touching accounts patients gave of their analytic experience and its personal meanings. The following quote of a former psychoanalysis patient illustrates the need to combine quantitative data with qualitative analysis:

> I encountered an overwhelming feeling of concern and empathy which did not restrict me in any way or force me into a defensive stance, and which at the same time was distant and would not become dominated by me. There was the liberating possibility to reflect, to probe arguments which were received with concentration, occasionally questioned in a surprising way. I have very much learned to change perspectives and not to be frozen in the first impression. I would not say that I have this behaviour always available, however I often manage to change position and thereby gain insight and new options for action.

Thus we should mention that by interviewing former patients intensively (see below) we also gained an impression of the indirect reduction of costs in the mental health system as, for example, in regaining the energy to look for a new job, patients taking more care of their own health—for example, dealing better with stress factors, preventing burn-out syndrome and thus early retirement—patients empathising in a better way with their own children and their needs etc. (see case illustrations below).

The interview sample: procedure and selected results

Procedure for conducting and evaluating the psychoanalytic follow-up interviews

As our central instrument for collecting data we used two psychoanalytical follow-up interviews. It was possible to interview 129 former patients in different places in Germany.

Sixty-two analysts have been working on this in nine different local research groups in Frankfurt, Hamburg, Giessen, Tübingen, Freiburg, Munich, Köln and Kassel. In order to guarantee confidentiality, interviewers from one city (e.g. Frankfurt) travel to other cities (e.g. to Hamburg) in order not to identify the colleague who had treated the interviewed patient. This was very time-consuming. We never expected that so many colleagues would be willing to support this study in such an active and enthusiastic way. The main reason for this was probably that the follow-up interviews used genuine psychoanalytic (qualitative) research methods (as observing transference/countertransference reactions, free associations etc.) and proved to be clinically very interesting and relevant. Most of our colleagues told us how much they learned from listening to the patients in the follow-up interviews. Many of them also told us that, for the first time in their lives, they felt able to combine their clinical identity with that of a partially extra-clinical researcher.

Our observations confirm, for example, the common finding of preliminary studies (e.g. Pfeffer, 1959, 1961, 1963; Oremland et al., 1975; Norman et al., 1976; Schlessinger and Robbins, 1983), according to which the major transference constellations in psychoanalytic treatment replicated themselves very quickly in the follow-up interviews and—as a sort of 'mini-analysis'—give a view of some of the major (conscious and unconscious) outcomes of the former psychoanalytic treatments. As the interviewers and the researchers (who evaluate the data) are experienced psychoanalysts, we wanted to use follow-up interviews as our major methodological approach, a decision which has proved to be wise. Incidentally, we can also show theoretically that using interviews is an excellent method for studying complex psychic and psychosocial phenomena, taking into account the current discussion on the 'narrative revolution in psychoanalysis, the social sciences but also the neurosciences' (see Koukkou-Lehmann et al., 1998).

We have gained rich and interesting information and insights concerning relevant aspects of psychoanalytic treatments. The 129 'single case studies' offer a good possibility to open our eyes to the highly individual and idiosyncratic experiences of a therapeutic process and its outcomes, including unconscious dimensions, in the evaluation of the psychoanalytic process by the former patients, their analysts, the interviewer and the expert group. Therefore they offer unique insights into psychoanalytically and clinically relevant subjects. To summarise our procedure:

1. In the first follow-up interview we open an intermediate space, in an unstructured part of the interview, for the former patients to communicate to us (consciously and unconsciously) their views of their experiences with their psychoanalytic treatments. We try to obtain manifest as well as latent (unconscious) information about the interaction between the former patient and the follow-up interviewer. In the last part of the interview some follow-up topics are addressed (e.g. asking for the reasons and motives for treatment, their subjective evaluation of the therapy, motivation for participating in our study etc.). The interviews are tape-recorded.
2. After the first interview the follow-up analyst records his/her impressions and information offered by the interview (on important subjects, psychodynamics, hypotheses taking into consideration countertransference reactions etc.) on tape. He/she also rates some questions concerning his/her first global evaluation of the outcome of the psychoanalytic treatment and the Scales of Psychological Capacities (Wallerstein et al., 1996) in order to identify the issues to be asked about in the second interview.
3. He/she then meets with one member of the research group for a supervision and narratively summarises the interview. In the subsequent dialogue the two exchange their im-

pressions, evaluations, psychodynamic hypotheses, open questions etc. in order to help the interviewer to test some of these hypotheses clinically in the second interview and gather more information in order to deepen or correct the preliminary hypotheses.

4. The second interview again begins in an unstructured way in order to be able to observe and reflect the possible effect of the first interview with the former patient. The interviewer then asks a set of questions regarding the patient's views about the former therapy, the therapist–patient relationship, the symptoms, the personal significance of the treatment for the patient, life events before, during and after therapy, the global evaluation etc. (part of the semi-structured interview).
5. Another member of the research group interviews the former analyst of the patient (semi-structured interview) without having any information about the patient.
6. Afterwards the local research group meets.

(a) The interviewer reports his/her experiences, observations and hypotheses gained in the two interviews narratively. Afterwards the group listens to a five-minute clip of the tape-recorded interview. Then the (six to eight) members of the research group rate the global evaluation questions before starting discussion. A thorough exchange of ideas concerning the diagnosis, the indications, the results of the treatment etc. follows. The interviewers of the former patient and his/her analyst are silent—only the other group members are associating and discussing (thirty minutes)
(b) Now the group member who has interviewed the analyst summarises his/her findings.
(c) All the group members discuss again and finally try to find a common clinical view of the follow-up (about fifteen minutes).
(d) Finally the members of the group independently rate their 'global evaluations' again and the Scales of Psychological Capacities. Afterwards the group tries to find a 'consensus' concerning the Scales (according to the method developed by Leuzinger-Bohleber, 1987/1989]).
(e) After the session one member of the group summarises the discussion and hands his/her summary back to the members of the group to be corrected.

The session of the research group is tape-recorded. Thus the process of clinical judgement can be analysed by different methods (e.g. by content analyses or linguistic analyses).

By this procedure we try to use a kind of a 'natural, narrative control', because we have two independent 'stories' of the same therapy: one told by the patient and one told by the analyst. One of the most striking clinical observations is that, in successful treatments, both partners, patient and analyst, seem to remember and tell 'the same story' (e.g. they independently report the same key events of the treatment and agree on their views of the global results of the treatment). If the treatment has not been successful (especially with severely disturbed patients) we have found much more divergence between the narratives of the patient and the analyst.

Let us illustrate this finding with two very short narratives while, at the same time, pointing to some of the very fundamental questions which were raised by our interviews—for us another 'quality' of our methodological approach.

Mrs X, a 55-year-old woman, who—due to her psychoanalysis—reached a stable but in many respects still very unusual psychic and psychosocial equilibrium. On the one hand, she is now able to work continuously as a well-paid secretary (before psychoanalysis she was sick and unable to work), but, on the other hand, she often does 'crazy things' in her leisure time. During the follow-up interviews the two parts within her personality also became visible: on the one hand she was able to develop a congruent emotional contact with the interviewer. On the other hand she seemed suddenly to break off this contact, showing some kind of bizarre behaviour.

In the research group we first had the hypothesis that Mrs X might have suffered from a psychosis.

The analyst had a different diagnosis: malign hysteria with a borderline structure. His report on this analysis was, at least in some respects, quite different from the one given by Mrs X (for example, Mrs X told us that she often sat on the floor of the consulting room looking at the analyst, a detail that he did not mention). Mrs X started treatment after having been hospitalised several times in psychiatric clinics because she had suffered from a dangerous kind of sado-masochistic enactment: she had abruptly left her husband and daughter to live with a cruel unemployed alcoholic who obviously abused her sexually. She had also abruptly left analysis after 300 sessions because she had accidentally found a report by her analyst for the insurance company and felt insulted by it. To summarise our long discussion in the research group: because of many details in the follow-up interviews (e.g. some biographical information but also the report of her repeated dreams of *someone coming up the stairs and opening the door of her bedroom*—an event that made her wake up in panic) we formulated the hypothesis that Mrs X had probably been sexually abused during her childhood—and showed some of the typical symptoms of such patients like dissociation, dangerous and cruel sexual enactments unconsciously repeating the trauma etc. We thought that our colleague may have misunderstood these symptoms and that this may have been the deeper reason for the patient to break off her treatment—a bitter pill for Mrs X—which made us all very thoughtful and alert to the fact that we may disappoint patients because sometimes we are not able to understand them 'well enough'—a shadowed side of our profession!

Already, at the very beginning of the interview with Mr Y the interviewer notices a strong and intensive feeling of being seduced, to follow him right into the middle of a dream-like world. She is fascinated by this phenomenon and registers some kind of a drug-like seduction of entering a paradise world losing the sense of separateness from the other, developing a symbiotic fantasy of being merged.

Mr Y tells the interviewer that he had to terminate analysis 'too early', after little more than 300 sessions, because he had to move to another city due to his fantastic career (manager in a big firm). He still regrets this early termination. For a long time he missed his analyst, and the way in which they both tried to understand his dreams in depth. Thanks to psychoanalysis he claims to have found 'the key to my unconscious, that is, my dreams. This is still very important for me. When I cannot remember my dreams in the morning, I know that something is wrong and that my job is sucking me up. Then I am in danger of losing my inner equilibrium and my creativity even in my profession. Whenever I realise this, I have to calm down and take a time out. But often I think, in general, psychoanalysis has opened a possibility for me to combine my stressful job with my personal creativity. Every day, coming home from work, I just sit in my armchair and day-dream for about half an hour. I absolutely need that—otherwise I get mixed up'. Shortly after the end of my analysis, Mr Y said, his analyst 'was still present during my daily day-dreaming—today this is no longer the case, at least in not such a concrete form. But even today I sometimes miss the analytic session . . .'

His severe psychosomatic symptoms (asthma and heart problems) as well as his drug abuse disappeared during psychoanalysis. Besides, he was able to dissolve an unhappy marriage and still maintain a close and intensive relationship with his daughter. He now lives in a stable and satisfying relationship with a woman 'whom I really love'. But psychoanalysis, in his view, was not always very easy and agreeable. 'The most terrible things I ever went through in my life were some sessions during which I really feared going crazy . . .'

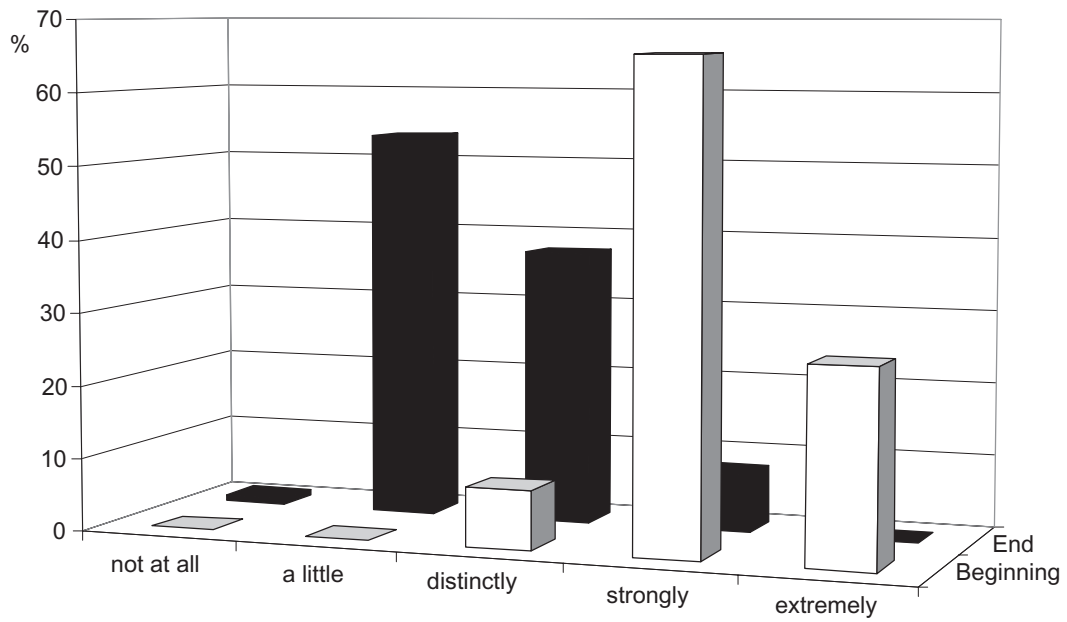
The analyst confirms in his interview that Mr Y went through a psychotic episode in connection with an enactment in the transference, an enactment of one of his infantile

traumatisations when his home was on fire. In his view, it was possible to understand this traumatic event through new memories from the patient and the analysis of transference phenomena which had been connected with it. After this sequence of analysis the psychosomatic symptoms had disappeared. This is just one example of a case in which analysand and analyst spontaneously told 'the same story' when remembering the therapy.

The intensity of the follow-up interviews indicated to all the members of the research group that Mr Y had undergone a psychoanalysis (in contrast to a low-frequency therapy). They were impressed that the 'original blurring of the boundaries between self—and object—representations' (see drug abuse of Mr Y) became visible in the transference during the first minutes of the follow-up interview. The group had the impression that—within the two follow-up interviews—some of the phases of psychoanalysis were repeated, an observation that Mr Y himself talked about finally. He told the interviewer at the end of the second interview: 'I was very glad of the opportunity to talk to you. I have just realised that something in me now has come to an end—I think these interviews have helped me to finally complete my analysis. I no longer have the feeling of having left my analyst too early. Talking to you I realised that I am in good contact with my unconscious and can continue the dialogue with the hidden parts of my soul without my analyst now . . .'

Degree of severity of the disorder and diagnoses in the interview sample

On the basis of all information available, two raters estimated the degree of severity of the disorder at the beginning of treatment and at the point the follow-up study took place (BSS, GAF, GARF, SOFAS, different versions of the Global Assessment Functioning Scale). The symptomatology at the beginning according to ICD-10 was rated too, in case both the former patient and—independent of him/her—his/her analyst had mentioned it in the interviews.



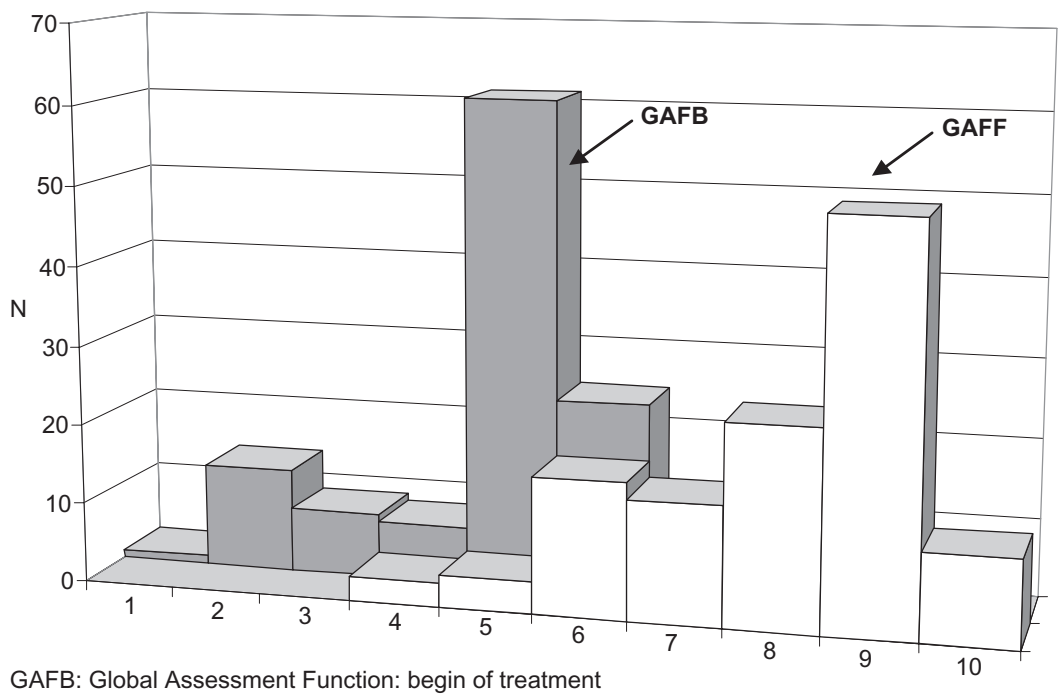
5-point scale (0 = not at all, 1 = a little, 2 = distinctly, 3 = strongly, 4 = extremely)

Figure 7 — BSS (Impairment severity score)

Although the agreement turned out to be good enough (κ Coefficient = 0.59, corrected = 0.73), we determined the main diagnoses and the severity degree of the disorder on the basis of consent values, which had been determined in a second rating. According to these ratings, the 129 former patients had suffered from severe psychological and psychosomatic disorders prior to their treatments (88 per cent had an 'extreme' or 'serious' severity score according to Schepank).

We gained analogous results in the ratings of the Global Assessment Functioning Scale (see Figure 8).

We were also able to show that we had severely disturbed patients in our sample according to the ICD-10 diagnoses: 50.8 per cent suffered from personality disorders, 27.3 per cent from affective disorders, 10.9 per cent from neurotic disorders and 6.3 per cent from schizophrenia (according to ICD-10 classification). Apart from the former patients suffering from a personality disorder, there was a large number of multiple diagnoses: 22.5 per cent had three, 9.3 per cent four and 4.7 per cent five or more diagnoses, which points to multiple psychosomatic and psychopathological disorders. These results prove that analysts in private practice treated a group of severely disturbed patients in the period of time covered by the study. Thus, psychoanalysts correspond to expectations in society that they—by practising the profession with probably the most expensive and time-consuming training—treat a group of the most difficult people who can receive out-patient treatment.



GAFB: Global Assessment Function: begin of treatment
GAFF: Global Assessment Function: follow-up

Figure 8 — Severity degree of disturbances at the beginning of treatment (GAFB) and follow-up (GAFF)

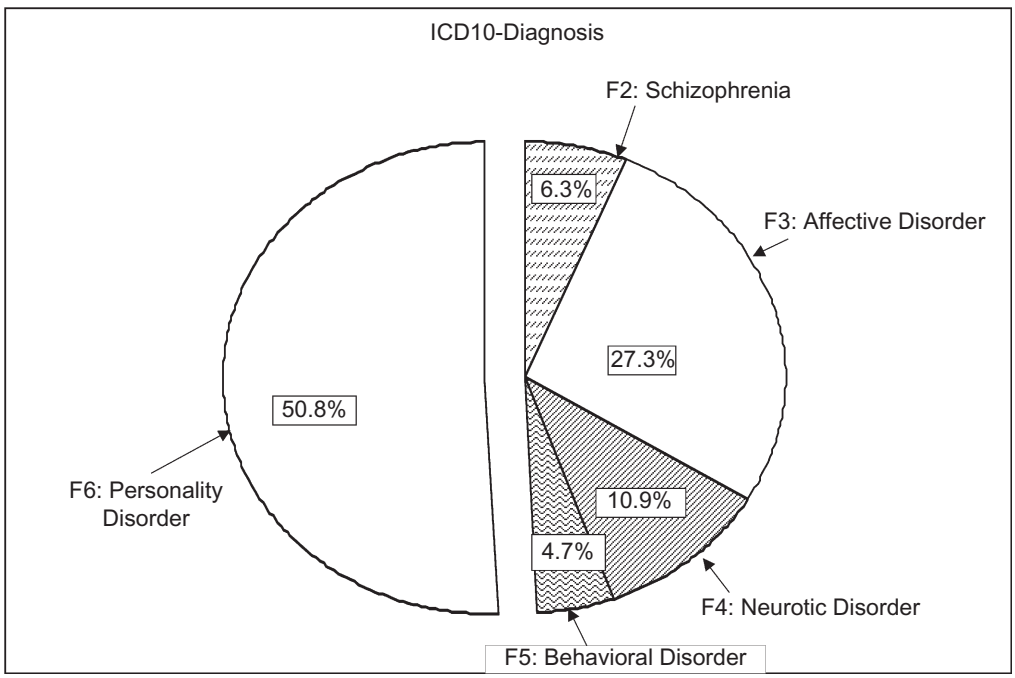


Figure 9 — Primary Diagnosis (ICD-10)

Combining qualitative and quantitative instruments in analysing the collected data

Because this project provided us with the extraordinary opportunity to study a representative sample of all patients who terminated their treatment between 1990 and 1993, we were able to combine the results of our qualitative analyses of our data with the results from the quantitative analyses. We understood this as a chance to combine psychoanalytical with non-psychoanalytical, clinical with extra-clinical, and qualitative with quantitative approaches. We applied a variety of such combinations.

(a) Narrative psychoanalytic single case studies each related to the representative sample. Many qualitative psychotherapy researchers and psychoanalysts point out that some complex clinical findings, especially the discovery of unconscious psychodynamics and fantasies, can only be communicated by narratives, which is one reason why psychoanalysis has developed the tradition of communicating by case studies (see e.g. Leuzinger-Bohleber, 1995; Stuhr, 1997, 2002). Therefore we also use this form of communication, an ambitious and difficult task (hardly anyone is such a gifted writer as Freud). In regard to the above-mentioned scientific quality of our study, it is important that these case presentations can be related to the whole sample and that the selection and condensation of the information in the narratives are discussed carefully and self-critically in the local research groups.[7]

[7]In the Frankfurt research groups we worked for months discussing and writing up such preliminary versions of narratives (also using the tape-recorded interviews), and looking for a solution to the difficult problem of dealing with the confidentiality of our data. It was not always possible to show the former patients our narratives, for example, because we did not want to risk disturbing them by our view of the follow-up. In these cases, we have to write 'constructed case studies' containing the psychodynamic findings was a very difficult task. Unfortunately, we cannot present an example of such a case narrative—they are often impressive idiosyncratic life and therapy stories offering simultaneously a highly differentiated insight into opportunities and dangers of our psychoanalytic treatments, even communicating—as usually only art and literature are capable of doing—unconscious observations of the follow-up interviewer, the author of the narrative.

(b) Narrative case presentation as illustration for findings in the questionnaires. This combination of qualitative and quantitative data is the most usual in psychotherapy research. Usually statistical analyses of the quantitative data are taken as the first step, adding some case presentations in a second step as illustrations of statistical findings (e.g. illustration of prototypes found in a cluster analysis).

(c) Systematic evaluation of qualitative findings by the 'bottom-up' procedure of clinical clustering (*klinische Typenbildung*). Applying this method we tried to take into account the basic 'philosophy of our study' in relating our genuine psychoanalytic (qualitative) findings to the non-psychoanalytic (quantitative) ones. Therefore we favoured a strategy opposite to the strategy in *(b) above*, where qualitative single case studies 'only' serve as illustration of the quantitative data. We tried to turn the whole perspective the other way around, defining our psychoanalytical, qualitative findings as our basis, the 'bottom', then trying to evaluate systematically the psychoanalytical discoveries, step by step, from 'bottom' to the ' top' of the quantitative data of our representative sample. We have described this procedure elsewhere (see Leuzinger-Bohleber, 2002; Leuzinger-Bohleber and Rüger, 2002).

(d) Applying the qualitative assessment of 'Verstehende Typenbildung' (U. Stuhr), studying the image of the analyst using a representative sub-sample of transcribed follow-up interviews. Ulrich Stuhr has developed this specific, elaborated qualitative method during the last years (see e.g. Stuhr, 1995, 2002; Wachholz and Stuhr, 1999). He has applied this method also to verbatim protocols of follow-up interviews in our study and compared its findings with those gained by a quantitative cluster analysis. He has presented this part of the study in detail elsewhere (see Stuhr *et al*., 2001, pp. 154–79).

(e) Narrative case presentation combined with 'objective data' (costs for the insurance companies) and quantitative data from the questionnaires. Work disability and hospitalisation data that we collected from the health insurance companies becomes more meaningful when combined with single case reports (see Beutel and Rasting, 2002).

(f) Comparing psychoanalytic-qualitative hypotheses to structural change in narrative psychoanalytic single case studies with quantitative findings gained by the Scales of Psychological Capacities (Wallerstein et al.). In our presentations at the Empirical Pre-congress of the IPA Congress in Santiago de Chile (July 1999), the Congress of the Society of Psychotherapy Research in Chicago (June 2000) and at the meeting of a Research Section of the American Psychoanalytical Association, CAMP in New York (December 2001), we have illustrated how we try to combine our clinical psychoanalytical findings on structural change of the former patients with the ratings on structural change measured by the Scales of Psychological Capacities (Wallerstein et al., 1996; see also Leuzinger-Bohleber et al., 1999).

(g) Combining narrative single case studies with quantitative theory guided computerised content analyses using a representative sub-sample of transcribed follow-up interviews. We also use the same transcribed sub-sample of the follow-up interviews in order to analyse them systematically by a modified form of a theory-guided, computerised content analysis which was developed some years ago (Leuzinger-Bohleber, 1987/1989). These analyses aim at comparing the extra-clinical, non-psychoanalytical analyses of the follow-ups with our psychoanalytic expert evaluation.

Do clinicians learn from extra-clinical research?

In conclusion, we want to come back to one of the main arguments clinicians use against extra-clinical research in psychoanalysis, which is that the results of this study are irrelevant for the clinical psychoanalytic practitioner (see Edelson, 1992). On the one hand, we agree with this

criticism partly because of the reflections on the history and philosophy of science mentioned in our introduction (see also Leuzinger-Bohleber, 2002a, 2002b). When it comes to the central clinical question—which interpretation can be given to which patient at what time and in what context of a psychoanalysis—the results of our extra-clinical studies are indeed not of much help. These questions can only be pursued by clinical psychoanalytic research. On the other hand, the sixty-two colleagues who were actively engaged in the study as interviewers maintained unanimously that active involvement in the follow-up study made them start thinking and were an emotional enrichment, which was of benefit to their psychoanalytic practical work. At the last DPV Congress, some of the research group members spoke and opened up some of their observations for discussion. We would like to present some of these observations, and we would like to combine this with the plea for more curiosity and enthusiasm for discovery in the broad area of psychoanalytic research. We hope that these observations speak for themselves and illustrate that, by conducting the follow-up study, an attempt has been made to bridge the gap between the clinically and extra-clinically orientated analysts in our psychoanalytic society (see also Luezinger-Bohleber, Dreber and Canestri, in press).

'Good enough' therapy outcome with analysts of different schools

Among those analysts whose treatments had a 'good enough' outcome were representatives of diverse sub-schools of contemporary psychoanalysis. The colleagues were either devoted to psychoanalytic ego-psychology, the 'modern' or Kleinian object-relations theory, self-psychology or intersubjective approaches of today's psychoanalysis etc. Even if it became apparent that these penchants could be discerned in the use of psychoanalytic concepts and their relevant terms (as for instance spontaneous mention of 'projective identification' and the depressive versus the paranoid-schizoid position by Kleinian analysts, of self-object or mirroring transference by self-psychologists etc.), we did not find any indication that the analysts' theoretical penchants restricted their horizon of perception and insight rigidly (in the group with 'good enough' therapy outcome). The analysts applied their own theoretical concepts to the clinical material in a careful and tentative way, and adapted them to the new experiences. Thus we observed in this group of colleagues an 'open and self-critical flow' of circular processes of perception and insight which we outlined in another article with regard to Ulrich Moser's model (see Leuzinger-Bohleber et al., 2002): the analysts moved in a cautious and creative way in a continual process of reflection and exchange between theory and clinical practice.

Patient-orientated versus analyst-orientated treatment technique

As we learned from case studies in our publications, we found in 'good enough' treatments many characteristics of treatment technique described in psychoanalytic literature. The analysts and therapists in these psychoanalyses and therapies were successful in showing empathy and adapting flexibly, openly and professionally to their analysands' special traits and idiosyncrasies: their technique was orientated towards the patient's needs, not primarily towards their own convictions or beliefs!

Regarding the treatments with negative results, both treatment technique and the underlying dynamic and adaptive processes of perception and insights seemed restricted and narrow. Some of the analysts described their painful memory that they were not able to enter into an 'inner, resonant' dialogue with the patient over a long period of treatment. Some of the former patients complained about an analogous perception. Some of them mentioned their assumption that the analyst had forced his/her own concepts and ways of understanding on them.

In the interviews this 'non-understanding' was reflected by the fact that the former patient

told a story different from the one his/her analyst reported. The two narrations remained side by side as if unconnected. In the memories of their work together there were obviously traces of a communication and understanding which went wrong.

In their interviews, the majority of the analysts mentioned such painful experiences with some patients. Usually it was possible to find a way out of such difficult phases of non-understanding—for instance by taking advantage of supervision or intervision. However, some colleagues mentioned that they could finally see no other way out but to refer their former patients to a colleague. Most analysts felt this as a failure and capitulation. Observations of individual cases partly cast new light on such solutions: in most cases the new analyst succeeded in counterbalancing the patient's disappointments and anger in an adequate emotional way and in understanding some of the reasons for the failure in communication that had characterised the former treatment. This helped to reinitiate a productive analytic process which could finally be terminated with a satisfactory outcome. We believe that such decisions could have prevented some of the tragic processes we observed in the 4 to 6 per cent of treatments with very negative outcome which understandably left deep wounds, wrath and desperation, and particularly an intense hatred towards the analyst or psychoanalysis in general. Does a change of therapist as a possible way out of a therapeutic stalemate constitute a taboo in our profession?

Observations as to indication

Many analysts in our study emphasised that they considered the diagnosis and the degree of the disorder less decisive than the observation of potentials the patient might have, for example, a core of good experience with object relations despite severe traumatisations, partial self-reflective capabilities or signs of positive reaction to interpretations.

Post-analytic phase and therapeutic outcome

The patient's ability to continue the analytic process effectively in the post-analytic phase was decisive for the stability of the therapy success. In the follow-up interviews it was in this dimension that we found the most striking differences between the successful psychoanalyses and the successful long-term therapies. The former analysands had internalised the analytic attitude and the way of pursuing traces of the unconscious and subsequently understanding them more intensely than the therapy patients. They had developed a creative 'inner analyst' (cf. Zwiebel, 2003) and were thus able to continue with the analytic process more effectively in the post-analytic phase than the therapy patients. These observations correspond to the results of the Stockholm Study (see Sandell, 2002) which showed that successful treatment of psychoanalytic patients differed more distinctly from patients who had had low-frequency treatment, the longer the follow-up period lasted.

Conditions for treating borderline patients in out-patient settings

In our study borderline patients whose acting out was heavily destructive were only treated with 'good enough outcome' if the analyst him/herself had enough personal (e.g. in supervision) or institutional support during treatment. In the ongoing study of the New York Group on therapies with borderline patients (Clarkin et al., 1999) he institutional and scientific framework should probably be taken into account in interpreting the future results.

Psychotic patients

Our study included 6.2 per cent of psychotic patients who were treated with permanent success in an out-patient environment. However, it should be added that the psychoanalyses of all

out-patients were preliminarily supported by medicines. The analysts treating them co-operated with a psychiatric institution. They used a modified technique of treatment (as a rule taking up the face-to-face position and low frequency). These observations, too, deserve to be examined systematically.

Many social climbers in our sample

Of the former patients in our sample, 84 per cent were social climbers.[8] Often we asked ourselves in the research groups whether these people hold up a mirror to us, in which the distorted images of our modern, 'flexible' societies, characterised by the sometimes extreme rootlessness of the individual and the tearing apart of generations, become visible (see Sennett, 1998).

Germany—still a traumatised society?

Another unexpected finding is how many severely traumatised patients (real traumatisations in the context of the Second World War, long separations from primary objects, psychiatric illnesses of care givers, sexual abuse, illnesses during childhood etc.) we have found in our sample (63 per cent in the interview sample). Many of the treating analysts seemed to have treated these patients with a modified psychoanalytical technique. It was interesting that there seemed to be two groups of severely traumatised patients with good therapeutic outcome: in the first group the trauma was reactivated and worked through in psychoanalysis itself as described in psychoanalytic literature. Another, smaller group of patients seem to protect the analytic relationship from the enactment of the severest traumatisations and—instead—used the analytic relationship as a 'holding function' reflecting with the analyst the reactivation of the trauma in a object relation in the outside reality. All these analysts told us that they were irritated that analysis has proved to be quite successful, but negative transference was not worked through thoroughly. It also seemed unusual that these former patients mostly still lived with a helpful but concrete form of dialogue with the analysts, which seemed somehow to be protected and isolated from inner destructive impulses and therefore was not fully integrated psychically. We are still analysing these findings further.

Finally, we would like to mention a positive finding which corresponds well to the one reported by Peter Fonagy and his co-workers from studies using the Adult Attachment Interview (Fonagy, 1998, 2003). Even in psychoanalyses with only medium results in the eyes of the patient and the analysts, in which it was nevertheless possible to at least partially understand the severe traumatisations, the analytic process offered the possibility for the patient to interrupt the unconscious transgenerational transmission of the traumatisations To quote just one of these patients: 'In my psychoanalysis I gained the insight that it is not possible to really restore some of my deepest psychic wounds: my mother has been psychotic after the loss of my father in Russia (during the Second World War) and abused me psychologically, for example by threatening to commit suicide over many years. My brain is not able to eliminate these experiences—I probably will have my problems really trusting my beloved partner deeply and feeling some closeness with him for the rest of my life. But I am so happy that I at least can deal with these problems much better in relation to my two children. I can let them grow up and find their own ways to live—not having to abuse them unconsciously in a similar way as my mother has done with me. I am so grateful that psychoanalysis enabled me to cut the terrible and tragic umbilical cord with my family . . .'

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[8]Social climbers were defined according a definition of social classes: if the former patient belonged to a higher social class, than the parent of the same gender, he/she was defined as a 'social climber' (e.g. female patient: teacher, mother: housewife).

Summary

How can we study the 'quality of psychoanalytic treatment'? This was the question we have tried to explore in this paper, discussing some facets of our naturalistic follow-up study of psychoanalyses and long-term psychoanalytic therapies. We hope that we were able to give an impression of the fascinating complexity of our study, which seems, in our personal view, to belong to its very specific 'quality' although it leads us into a much darker and more demanding research labyrinth than studies that apply exclusively quantitative instruments. We tried to show that *psychoanalytic* topics (like studying the outcome of psychoanalytical treatments) have to be studied using *psychoanalytical* instruments, because only an application of the unique research methods of psychoanalysis will allow us to perceive and to investigate systematically manifestations of the unconscious. This was why we chose to use two psychoanalytic follow-up interviews as the major methods of collecting data in our study, interviews done by experienced analysts who were able to work with their professional psychoanalytical research instruments (e.g. the systematic observation and interpretation of transference and countertransference reactions etc.). We also applied other 'classical' psychoanalytical methods in our study: for example, supervisions between the two follow-up interviews, psychoanalytical expert evaluations in the local research groups and the communication of the complex psychoanalytical findings in (systematically controlled) narrative case studies. We then illustrated how we try to combine and contrast these psychoanalytical qualitative approaches with non-psychoanalytical quantitative ones. We used the opportunity of a representative sample of follow-ups to apply a variety of different combinations of qualitative and quantitative approaches in analysing our collected data. Through all these approaches, we try to take up the challenge of a tight-rope walker between the two extreme poles of psychotherapy research, that is, not withdrawing into the psychoanalytical ivory tower on the one hand but also not submitting defensively to a research methodology of a 'unified science' on the other, a methodology which is not appropriate to psychoanalysis with its unique subject, research methodology and criteria of scientific quality.

Unfortunately we did not have the opportunity to share another advantage of applying qualitative methods (in combination with quantitative ones): we could not report some of the very impressive narratives summarising the idiosyncratic therapeutic experiences of former patients.[9] Many of our colleagues have told us how valuable it has been for them to listen to former patients and what they have to tell us, consciously and unconsciously, about their positive and negative experiences in their psychoanalytical treatments. Listening to former patients helps us to appreciate the sunny side of our clinical work and the potencies of our psychoanalytic treatment approach, but it also confronts us with many neglected, tabooed and difficult sides of our profession. Therefore we thank all the former patients who were willing to participate in our study—as well as our colleagues who gave us their trust, their time, their psychoanalytical competence and their enthusiasm as their very special gifts.

Of course, our naturalistic design and methodology also has disadvantages and limitations, for example, the difficulty of summarising in an adequate way the complexity of our results and observations, and communicating them while taking into account the idiosyncrasies of the therapeutic outcome of specific patients as well as the representativity of our findings. Our design (with only one point of measurement) also often limits the systematic empirical evaluations of some aspects of our research questions. Finally a critical fact remains that,

[9] This is one of the well-known disadvantages of qualitative approaches: they need much time and space to be presented and communicated in an adequate form.

mainly because of ethical considerations (not wanting to disturb the therapeutic process), we have decided to focus on the *retrospective* view of former patients. For us, the patients themselves have been considered as being the real experts, deciding whether or not, and how, their former treatment has had a long-term effect on their well-being. Of course, this view can be criticised in many ways. We tried to correct possible subjective disturbances of the patients' own views by comparing them in a multi-perspective design with the views of their former treating analysts, psychoanalytical and non-psychoanalytical experts, 'objective' data from the insurance companies, independent text analyses etc.—and, what was especially important, by locating the different treatments and their outcomes in a controlled representative sample. We also conduct a critical dialogue with non-psychoanalytical psychotherapy researchers. It would be interesting, for example, to compare our findings with a *naturalistic control group* like a representative sample of former patients of behavioural therapies an average of five to seven years after termination of treatment, assessed by the same research instruments.

The richness and the clinical relevancy of our results are the attractive, sunny side of our study. The dark side of a naturalistic study might be that it generates more questions than it is able to answer definitively. For us this dark side—reflecting it from a psychoanalytical and philosophical point of view—can hardly ever be eliminated studying human beings and such complex phenomena as the long-term effects of psychoanalytical therapies. In our eyes, raising interesting questions always belongs to research. Therefore we hope that our clinically and empirically orientated colleagues might be inspired by some of our questions, findings and observations, and take up the challenge to assess them further in clinical or empirical research. For us—this study has been an adventure. Carrying out the study we have learned a lot—about being researchers as well as practising analysts. Therefore we hope that our study might, at least, contribute to reducing the gap between clinicians and researchers in psychoanalysis.

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Translations of summary

!Wie kann die Qualität psychoanalytischer Behandlungen und ihr Langzeiteffekt auf das Befinden vun Patienten utnersucht werden? Eine repräsentative, multiperspektivische katamnesestudie. Wie können psychoanalytische Behandlungen untersucht werden? Diese methodologische und wissenschaftstheoretische Frage wird diskutiert. Wir illustrieren diese anhand einer naturalistischen, multiperspektivischen und repräsentativen Katamnesestudie von Psychoanalysen und psychoanalytischen Langzeittherapien. Wir untersuchten eine repräsentative Stichprobe ($n = 401$) ehemaliger Patienten, die zwischen 1990 und 1993 ihre Behandlungen bei Mitgliedern der Deutschen Psychoanalytischen Vereinigung (DPV) beendet haben. Zwischen 70% und 80% erzielten, durchschnittlich 6,5 Jahre nach Therapieende, gute und stabile Veränderungen (nach Einschätzung der Patienten, ihrer Analytiker, unabhängiger psychoanalytischer Experten, Fragebögen der Therapieforschung). Zudem wurden die Gesundheitskosten reduziert. Diese Ergebnisse, erzielt mit nicht-psychoanalytischen Forschungsinstrumenten, werden durch die reichen idiosynkratischen Ergebnisse ergänzt, die durch die psychoanalytischen Untersuchungsmethoden gewonnen wurden.

Cómo estudiar la 'calidad de los tratamientos psicoanalíticos' y sus efectos a largo plazo sobre el bienestar de los pacientes. Un estudio de seguimiento representativo y de perspectiva múltiple. ¿Cómo podemos estudiar la 'calidad de los tratamientos psicoanalíticos'? Se intenta contestar esta pregunta en el presente artículo, en el que se discute un estudio de seguimiento naturalista, de perspectiva múltiple y representativo, que portó sobre los psicoanálisis y de las terapias psicoanalíticas de largo plazo. Estudiamos una muestra representativa ($n = 40$) de todos los pacientes que habían terminado sus tratamientos

psicoanalíticos con miembros de la Asociación Psicoanalítica Alemana (DVP), entre 1900 y 1993. Entre 70% y 80% de los pacientes lograron (unos años promedio después del final del tratamiento) cambios psíquicos buenos y estables, de acuerdo a las evaluaciones de los pacientes mismos, sus analistas, los expertos independientes psicoanalíticos y no psicoanalíticos, y los cuestionarios que se suelen utilizar en la investigación en psicoterapia. La evaluación de los costos de la salud mental mostró una reducción del costo, debida a la disminución de los días de ausencia por enfermedad en el curso de los siete años posteriores al final de los tratamientos psicoanalíticos de largo plazo. Los resultados obtenidos usando instrumentos no psicoanalíticos se complementaron con los ricos hallazgos obtenidos por los instrumentos de investigación psicoanalítica.

Comment étudier la 'qualité d'un traitement psychanalytique' et ses effets à long terme sur le bien-être du patient: une étude complémentaire et représentative à diverses perspectives. Comment étudier la 'qualité d'un traitement psychanalytique'? Cette question est abordée dans cet article dans une discussion d'une étude complémentaire naturaliste, représentative, à diverses perspectives de psychanalyses et de psychothérapies psychanalytiques à long terme. On étudia une section représentative ($n = 401$) de tous les patients ayant terminé leurs traitements psychanalytiques avec des membres de L'Association Psychanalytique Allemande (DPV) entre 1990 et 1993. Entre 70 pour cent et 80 pour cent des patients atteignirent (après un moyen d'ans après le traitement) de changements psychiques positifs et stables selon les évaluations des patients eux-mêmes, leurs analystes, des experts psychanalytiques et non psychanalytiques indépendants et des questionnaires fréquemment utilisés dans la recherche psychanalytique. L'évaluation des coûts de la santé mentale démontra une réduction de coûts qui résultait d'une réduction de congé de maladie pendant sept ans à la suite des traitements psychanalytiques à long terme. Les résultats obtenus par des moyens non psychanalytiqes sont complétés par la richesse des découvertes particulières, faites par les techniques de recherche psychanalytiques.

Come studiare la 'qualità dei trattamenti psicoanalitici' e i loro effetti a lungo termine sul benessere dei pazienti: uno studio rappresentativo, da vari punti di vista, del follow-up. In che modo possiamo studiare la 'qualità dei trattamenti psicoanalitici'? Quest'articolo cerca la risposta attraverso la discussione di uno studio naturalistico, rappresentativo e condotto da vari punti di vista, del follow-up di psicoanalisi e psicoterapie psicoanalitiche di lunga durata. È stato studiato un campione significativo (in numero di 401) di tutti i pazienti che hanno concluso un trattamento psicoanalitico con membri dell'Associazione psicoanalica tedesca (DPV) tra il 1990 e il 1999. Tra il 70% e l'80% dei pazienti ha conseguito (in media dopo lo stesso numero di anni dalla fine del trattamento) buoni e stabili cambiamenti psichici, secondo la valutazione dei pazienti stessi, del loro psicoanalista, di esperti indipendenti, psicoanalisti e non psicoanalisti, e i questionari normalmente adottati nella ricerca psicoterapeutica. La valutazione dei costi nell'ambito della salute mentale ha mostrato una riduzione degli stessi, con la diminuzione del numero di giorni di congedo per malattia nei sette anni successivi alla fine di trattamenti psicoanalitici di lunga durata. I risultati ottenuti utilizzando strumenti non psicoanalitici sono integrati dalla ricchezza degli esiti peculiari ottenuti con gli strumenti di ricerca psicoanalitica.

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