DGPT

**Deutsche Gesellschaft für Psychoanalyse,
Psychotherapie, Psychosomatik und
Tiefenpsychologie e.V.
German Society for Psychoanalysis,
Psychotherapy,
Psychosomatics and Depth Psychology**

in conjunction with the:

Deutsche Gesellschaft für Analytische Psychologie (DGAP)
German Society for Analytic Psychology

Deutsche Gesellschaft für Individualpsychologie (DGIP)
German Society for Individual Psychology

Deutsche Gesellschaft für Psychotherapeutische Medizin (DGPM)
German Society for Psychotherapeutic Medicine

Deutsche Psychoanalytische Gesellschaft (DPG)
German Psychoanalytic Society

Deutsche Psychoanalytische Vereinigung (DPV)
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Vereinigung Analytischer Kinder- und Jugendlichenpsychotherapeuten (VAKJP)
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Psychoanalytic Therapy

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Position paper on psychoanalytic therapy

Alf Gerlach

Psychoanalytic Therapy – Professional and Scientific-Political Implications of the "Position Paper on Psychoanalytic Therapy"

This position paper, developed by the DGPT in association with the DGAP, DGIP, DGPM, DPG, DPV and VAKJP,[1] came into being in response to public demand in Germany for a new presentation of the current state of knowledge on the efficacy of psychoanalytic therapy. In this respect its publication in 2004 falls in the context of the recent changes in social and health-care policy by which old decisions are being reconsidered and their legitimacy reexamined while new legal provisions, such as the psychotherapist law in force since 1.1.1998, are transforming the discourse on health-care and science policy. Psychoanalytic therapy in particular, whose unarguable successes in patient treatment made it the first psychotherapeutic method to be integrated into the statutory health care system in Germany, must now examine and explain itself in the altered political and social landscape.

At the same time, the position paper represents a statement of common understanding among psychoanalytic therapists and researchers regarding their methods and the theory of personality, disease and treatment upon which these are based. In this respect it also serves for internal clarification and discussion among specialists. It gives an overview of the present state of research on the efficacy of the various applications of psychoanalytic therapy and is intended as a contribution towards answering the question as to which problems now deserve special attention and which type of research is best suited to meet present challenges.

In Germany the therapeutic applications of the psychoanalytic method have been integrated since 1967 into the statutory health care system (GKV) under the names "analytic psychotherapy" and "depth psychology-based psychotherapy." In German-speaking regions the term "depth psychology-based psychotherapy" is used to refer to an application of the psychoanalytic method entailing "a concentration of the therapeutic process by a limitation of the treatment goal, a primarily conflict-centered approach and a restriction of regressive processes" (Psychotherapy Guidelines

[1] Deutsche Gesellschaft für Psychoanalyse, Psychotherapie, Psychosomatik und Tiefenpsychologie (DGPT); Deutsche Gesellschaft für Analytische Psychologie (DGAP); Deutsche Gesellschaft für Individualpsychologie (DGIP); Deutsche Gesellschaft für Psychosomatische Medizin und Psychotherapie (DGPM); Deutsche Psychoanalytische Gesellschaft (DPG); Deutsche Psychoanalytische Vereinigung (DPV); Vereinigung Analytischer Kinder- und Jugendlichen-Psychotherapeuten (VAKJP)

1.1.1). In the international discussion and nomenclature, depth psychology-based psychotherapy corresponds to psychodynamic therapy. According to the Psychotherapy Guidelines for treatment of the insured issued by the Federal Association of Physicians and Public Health Insurance Organizations,[2] those techniques are authorized for treatment purposes "which are based on a comprehensive system of etiological theory and whose specific treatment methods possess proven therapeutic efficacy." In the case of "depth psychology-based psychotherapy" and "analytic psychotherapy," which the Psychotherapy Guidelines collectively designate as "psychoanalytically based techniques," their therapeutic efficacy could be considered established once they were listed in the compensation catalog of the statutory health insurance. Doctors and licensed psychologists with the appropriate further training were able to offer specifically authorized forms of psychotherapy in treating ongoing unconscious conflicts—and since 1976 also analytic psychotherapy aimed at structural change—to suitable patients at the cost of the statutory health insurance. At the same time high qualitative standards for professional training were set down in the Psychotherapy Guidelines and agreements. In this way psychotherapy became an important component of the health care system in outpatient, inpatient and rehabilitative treatment. A great number of individuals have taken the opportunity to benefit from this form of patient care, experiencing their symptoms disappear or change, or learning to live differently with them. They approach both themselves and others with broadened understanding, experience their inner conflicts more consciously and have a better grasp of the inner dynamics which repeatedly draw them into the same difficult relationship patterns.

Any psychotherapeutic treatment in the context of outpatient care is subject to a prior expert review process. In the review procedure, patients submit an application to their medical insurance for the assumption of the cost of the prospective psychotherapy, and the treating psychotherapist prepares a report on the patient's biographical development, psychological and somatic findings and psychodynamics as well as a treatment plan with specific aims and the prognosis for therapy. This report is given in anonymized and coded form to an expert reviewer. The expert reviewer then informs the therapist and health insurance of his opinion. Careful

[2] Bundesausschuss der Ärzte und Krankenkassen

examination of circumstances surrounding the individual case plays a large role in this process, and the choice of a therapeutic technique is made on a relationship-based foundation. The insurer generally accepts the decision of the expert reviewer.

Increasingly in recent years, new criteria have been drawn into to the decision-making process for specific therapeutic measures. This development has to do with the growing importance of quality control procedures in medicine, which has accompanied a fundamental paradigm shift in the German health care system—the "shift from egalitarian care for all to rationed basic care for all with selective supplementary options for some" (Bruns 2000, p.1). The implementation of quality control entails encodable diagnostic schemata such as the ICD-10, outcome and cost studies for medical procedures, success and case cost controls—including those relating to the individual practice—tracking of further training by way of regular recertification, and establishment of norms and quality parameters for all techniques and procedures practiced. As early as 1997 the obligation to perform quality control was set down in the Social Code (SGB V): "Service providers are obligated to assure and continually enhance the quality of the services they perform. These services must conform to the current state of scientific knowledge and be provided in the quality required by the specialty" (§ 135a).

A special role is played in this process by the Federal Association of Physicians and Health Insurance Organizations, governed by § 91 and § 92 of the Social Code (SGB V). It is responsible for composing the Psychotherapy Guidelines, which contain exact specifications as to which treatment methods are applicable to which diseases—including the psychotherapeutic area—in the statutory health insurance system. The Federal Association of Physicians and Health Insurance Organizations is integrated into a coordinating committee, the present Federal Joint Committee[3], which has the task of reviewing "ten diseases per year for which there are indications of erroneous or excessive care provision and whose elimination can have a lasting impact on the morbidity and mortality of the population, and deciding, based particularly on evidence-based guidelines, on criteria for appropriate and economical provision of diagnostically and therapeutically goal-focused services for these

[3] Der Gemeinsame Bundesausschuss

diseases" (§ 137e Abs. 3 Nr. 1). Thus in this case German legislation has expressly required the incorporation of evidence-basing into the guidelines. As it happens, the associated decision that at least ten diseases per year should be dealt with has yet to be implemented.

On the other hand, as early as 1997 the Federal Association of Physicians and Health Insurance Organizations issued a (technique) guideline for assessment of new and established techniques. Here the criteria of evidence-based medicine are explicitly referred to and evidence classes are established. As a condition for acceptance of new techniques of testing and treatment into the statutory health care, a study of the highest degree of evidence is generally required to prove the usefulness of the technique, including a comparison with established techniques. In contrast, studies with a lower degree of evidence suffice for retention or positive assessment of established techniques. Such are the criteria by which the Psychotherapy Guidelines working committee of the Federal Association of Physicians and Health Insurance Organizations is supposed to make decisions on the integration of new techniques into the statutory health insurance system.

In the field of psychotherapy, the important question is if the criteria mentioned above actually do justice to the specific characteristics of this specialty (cf. Gerlach 2003). In response, psychoanalysts might point out that randomized controlled studies performed under laboratory conditions cannot actually yield evidence relevant to care provision, while in respect to effectiveness and efficiency this can indeed be gained from naturalistic studies. All randomized controlled studies in psychotherapy contain one serious fault —the exclusion of the therapist-related factor. Yet across techniques, it is precisely the quality of the relationship between two individuals—the one treating and the one being treated—that is critical to the success of treatment. Here we encounter the well-known methodological difficulties discussed in psychotherapy research, which also play a role in the professional and scientific policy debate with the Scientific Advisory Board on Psychotherapy.[4]

The establishment of the Advisory Board goes back to a provision of the "Psychotherapist Law" of 1998, which in § 11 requires scientific recognition of a

[4] Wissenschaftlicher Beirat Psychotherapie.

technique as a precondition for the exercise of psychotherapy in accordance with this law as well as for the certification of training centers. The task of the Advisory Board is to prepare expert reviews as the foundation for official decisions on this question. It is composed equally of medical psychotherapists, psychological psychotherapists and child and adolescent psychotherapists and is appointed by agencies which represent these professional groups on the federal level.

After setting its procedural rules and principles and establishing definitions for application areas of psychotherapy and minimum requirements for expert review panel approval of efficacy studies, in the years since its foundation the Scientific Advisory Board has completed reviews on conversation psychotherapy, systemic therapy, neuropsychology and psychodrama therapy. As behavioral therapy and the psychoanalytically based techniques had been recognized by the Federal Association of Physicians and Health Insurance Organizations before the law went into effect, they did not need to submit to critical testing by a regional authority or to an expert review by the Scientific Advisory Board. Nevertheless, in March 2001 the Scientific Advisory Board expressed its opinion that "for purposes of equal treatment of all psychotherapeutic techniques it would be advantageous if the guideline procedures would also take the opportunity to evaluate the scientific significance of their own method as well." To this end the Scientific Advisory Board offered to "make available its criteria and procedural principles and—upon request—to deliver an expert opinion itself."

This placed the German scientific community in the position of being required to evaluate its own methods essentially according to the criteria of the Scientific Advisory Board. In the minimum requirements for the approval of efficacy studies in the area of psychotherapy, the Scientific Advisory Board had established that alongside of other criteria, "there must be a control condition which, by comparison with the intervention, makes it possible to estimate what the spontaneous course or the course under a different therapy would have been in the given time period." By this pronouncement, controlled randomized studies had been made the gold standard of psychotherapeutic efficacy research. When random therapy assignment of patients and manualized courses of psychotherapy become the condition, however, this necessarily leads to the selection of studies that have nothing in

common with the conditions of everyday psychotherapeutic practice. Massive criticism of this requirement for an untreated control or placebo group was voiced (among others) by Leichsenring: "As long as only randomized controlled studies are admitted as evidence of efficacy, (psychodynamic) therapies of longer duration will be automatically excluded from empirical validation. That is politics, not scientific research. The realization is dawning today that controlled studies are not the *non plus ultra* of psychotherapy research. What is needed is rather a combination of naturalistic and controlled studies" (Leichsenring 2002, p. 141/142). Similar criticism was heard from elsewhere as well (e.g. Zepf and Hartmann 2002), urging as a first step to accept the invitation of the Scientific Advisory Board to conduct a self-evaluation, until such time as the criteria it had established for the scientific significance of evidence and studies had been subject to fundamental criticism. The DGPT attempted this in two podium discussions at its annual conferences: in 1999 H.Kächele, K.Bell. T.Eith, O.Kernberg, J.Körner, G.Rudolf, R.Emde and A.-M.Schlösser discussed "Psychoanalysis in Flux. Consequences for Research and Practice." In 2002 A.Auckenthaler, W.Schiepek, S.Zepf, M.Buchholz, G.Rudolf and A.Springer spoke on "Effectiveness and Efficiency – Discussion of the Criteria of the Scientific Advisory Board."

The situation changed in November 2001, when the German Society for Depth Psychology-Based Psychotherapy (DFT)[5] submitted to the Scientific Advisory Board an application and "Documentation on Depth Psychology-Based Psychotherapy," which did not take up the criteria discussion. However the Scientific Advisory Board asked the specialist associations to take a position on this documentation. The German Association for Psychotherapeutic Medicine(DGPM)[6] reacted with the submission of a voluminous paper which simultaneously suggested renaming depth psychology-based psychotherapy as "psychodynamic-interactional psychotherapy." In its response, the DGPT[7] objected that the DFT had failed to make clear at any point in its "documentation" that depth psychology-based psychotherapy—if it can be delimited from analytic psychotherapy as a separate psychotherapeutic technique—represents a specific application of the analytic method. However the complete absence of an independent theory of neurosis in the DFT documentation suggested that the authors regarded it as identical to the theory of neurosis that also

[5] Deutsche Fachgesellschaft für Tiefenpsychologisch fundierte Psychotherapie
[6] Deutsche Gesellschaft für Psychotherapeutische Medizin
[7] Deutsche Gesellschaft für Psychoanalyse, Psychotherapie, Psychosomatik und Tiefenpsychologie

underlies analytic psychotherapy (in the terminology of the Psychotherapy Guidelines) and relates to the entire theory of psychoanalytic pathology. Similarly, the concepts on treatment technique used by the authors of the DFT documentation are derived almost entirely from psychoanalytic treatment theory. Accordingly the therapeutic techniques and concepts described in the DFT documentation are applied in both analytic and depth psychology-based psychotherapy, but vary according to the underlying illness, indication-related need and the subjective capacity and readiness of the patient for transference and regression. The Psychotherapy Guidelines in fact take account of this understanding, restricting the indication area of depth psychology-based psychotherapy to circumscribed unconscious conflicts in the absence of an appreciable personality disorder.

The references to “specific” techniques and concepts of depth psychology-based psychotherapy in the DFT documentation were not convincing. All applications of the analytic method involve “developing intersubjective goals,” activating resources and “promoting new emotional experiences in the therapeutic relationship.” In fact, we are informed in the textbook of Thomä and Kächele (1985) that the “focusing” of resistance and transference analysis is actually a characteristic of the psychoanalytic process, which is seen in the successive working through of various transference paradigms. In other words the spectrum of transference is never addressed in its entirety in analytic psychotherapy either, but always selectively in consideration of the factors that relate to the individual patient, the particular disease picture and the therapeutic process.

The DGPT’s criticism was that the authors of the documentation presented depth psychology-based psychotherapy as a independent technique, completely unconnected to the development of psychoanalysis. From the methodological point of view, however, depth psychology-based psychotherapy is not a form of therapy independent from psychoanalysis, but was developed by psychoanalysts as an application of the psychoanalytic method and was taught and researched within the psychoanalytic frame of reference. Accordingly in 1967, when it was introduced into the public health care system, F. R. Faber made reference to the names of Balint, Loch and Malan (Faber 1967, p. 2101).

With the submission of the DFT application and documentation, the danger arose that in its response the Scientific Advisory Board might accept the notion of depth psychology-based psychotherapy as a new, independent technique, ignoring its development within the framework of psychoanalysis, and instead of pursuing further scientific discussion would intervene in the public discussion by setting official standards. To complicate matters, in August 2002 the German Society for Behavioral Therapy[8] and the Society for Behavior Modification[9] submitted a paper entitled "Expertise in judging the empirical evidence of the psychotherapy technique of behavior therapy" to the Scientific Advisory Board. At this point it became politically unavoidable for the DGPT to come out with a public statement that would position it in the scientific debate and in the professional union landscape.

In this situation the DGPT decided to call a research conference in conjunction with the psychoanalytic specialist associations in order to develop a comprehensive picture of the current status of efficacy studies on psychoanalytic therapy and come to agreement on a common stance towards the Scientific Advisory Board. Participating at the conference, which took place in May 2003 at the Sigmund-Freud-Institut in Frankfurt am Main, were: M. Beutel, W. Bohleber, J. Brockmann, G. Bruns, H. Deserno, A. Gerlach, S. Hau, P.L. Janssen, H. Kächele, W. Keller, I. Kerz-Rühling, A. Stadler, F. Leichsenring, M. Leuzinger-Bohleber, W. Mertens, J. Rasche, C. Rothenburg, G. Rudolf, H. Sasse, A.-M. Schlösser, A. Springer, A. Stadler, U. Stuhr, F. Wellendorf, E. Windaus and F. Beenen from Amsterdam. In this way the representatives of the psychoanalytic specialist associations as well as the DGPM, the VAKJP and coworkers of the various German research groups focusing on psychotherapy research in the area of psychoanalytic therapy could all be brought together in a common discussion process. This required a good deal of mediation work between the principled but altogether divergent positions of the various specialist associations and the psychoanalytic researchers. Instead of emphasizing differences as a way of finding and shoring up one's own identity, the occasion now called for communication, mutual exchange and the translation of idiosyncratic concepts. The result is the present position paper on psychoanalytic therapy. It is addressed to the interested scientific community by way of information and to the

[8] Deutsche Gesellschaft für Verhaltenstherapie (DGVT)
[9] Arbeitsgemeinschaft für Verhaltensmodifikation (AVM)

Scientific Advisory Board as a part of this community. By this act the DGPT wishes to underscore that the Scientific Advisory Board too must remain engaged in a discussion process. Initial formulations for the position paper came out of the research conference, while more comprehensive chapters were composed by individual authors and circulated for further discussion and alteration.

Thus on the one hand, there are grounds for hope that the scientific and research theory debate can continue. Psychoanalysis must make clear what specific contribution it has to offer within the pluralism of sciences and also vis-a-vis the unified science model. It must assert its own scientific understanding in such questions as the criteria for evidence of efficacy in psychotherapy research; in this way it can promote a creative discussion on evidence of efficacy. On the other hand, the DGPT position paper on psychoanalytic therapy has laid a vital foundation stone towards acceptance of the relation of all application forms of psychoanalytic therapy to their common foundation in psychoanalytic personality, disease and treatment theory. This makes it possible to accept both a randomized controlled study with 20-session courses of therapy and a naturalistically designed long-term study with 300^{+}-session courses of therapy and long follow-up periods as evidence of the overall efficacy of psychoanalytic therapy. Thus in terms of scientific logic, the great number and variety of efficacy studies cited in this position paper stand as evidence for all the various applications of psychoanalytic therapy and must not assigned singly or exclusively to depth psychology-based or analytic psychotherapy alone.

By making this position paper available in an English-language version, the DGPT hopes that the discussion on the efficacy of psychoanalytic therapy, now ongoing in many countries with a variety of health care systems, can profit from the German debate. At the same time, the English version will make it possible for an international readership to gain insight into the realities of the application of psychoanalytic therapy in the German health care system and into the multiplicity of research studies accompanying these applications. The literature selection takes this into account by concentrating particularly on studies conducted in German-speaking countries.

Position Paper on psychoanalytic therapy

Preface

M. Leuzinger-Bohleber and G. Bruns

Psychoanalytic therapy is based on psychoanalysis, which in the clinical context can be described as a theory of personality, disease and treatment (see chapters 2 – 6 of this position paper). All psychoanalytic theories agree on the central significance of the unconscious in the functioning of the healthy personality and in psychological illnesses. According to the psychoanalytic conception, the chief structures of the personality take form through processes of interiorization in the first years of life through the interplay of individual disposition and interpersonal relationships. The structure-forming processes and the structures themselves remain largely unconscious.

Psychological illnesses arise as a result of disorders in structure formation, which can be pathological in and of themselves or can lead to impairment of the ability to manage contradictory tendencies within the personality and thus indirectly have an pathogenic action. Accordingly, the theory of psychoanalytic pathology posits a structural and/or conflictual genesis of psychological illnesses. Once established, psychological illnesses are associated with a specific tendency to interpret one's own person, other people and interpersonal events from the perspective of the disease.

Psychoanalytic treatment theory holds to an etiological model; i.e., its primary orientation is not towards treating a symptom but towards eliminating the underlying cause—the structural disorder and/or the unconscious conflict. As a rule this requires working through the patient's reality construction patterns, which takes place chiefly in the therapeutic relationship.

The foundations of a clinical psychoanalytic theory outlined above lead to complex assumptions in terms of theory of science, because in the psychoanalytic view the causes of the illnesses are not accessible to direct perception and because symptom development, change and fixation take place in circular processes passing through the modalities of preconception, perception, interpretation and altered perception or reinterpretation.

For this reason the following position paper on psychoanalytic therapy will be prefaced with a few remarks from the perspective of the theory and sociology of science, briefly setting forth our views on the scientific position of psychoanalytic theory. In citing evidence for the efficacy of a method, account will be taken of the diagnostic systemization (ICD-10) established by the Scientific Advisory Board (ICD-10) as well as the criteria and references specified by it.[10]

Theory of science

It is little noted that the criteria applied to psychotherapeutic efficacy research (cf. below) are based on the idea of the unity of all sciences, which was first proclaimed by German Idealism and later in another form by logical empiricism. At the same time the physical experiment, which tests the quantitative dependencies between exactly defined factors in artificially produced systems, became the paradigm for scientific experience generally (cf. discussions on the randomized controlled trial or RCT). In the theory of science, this unity-of-science model has long been considered passé, as both the natural and humanistic sciences have differentiated and ramified to such an extent in the past hundred years that our present condition is one of a "plurality of sciences" in which the various disciplines have found it necessary to adapt their methods, experiences, theories, standards of knowledge and quality criteria to the specific nature of their object of research (cf. Hampe and Lotter, 2000; Hau, 2003, Leuzinger-Bohleber, 2002; Leuzinger-Bohleber, Dreher, Canestri, 2003, among others).

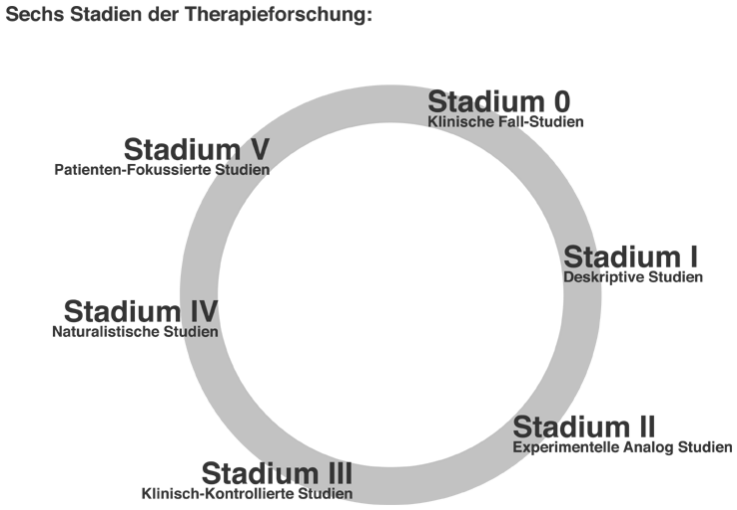
Against this background, the unconsidered application of a research design from pharmacology to the area of psychotherapeutic efficacy research appears inconsistent with the current status of research (cf. preface below and chapters 6 and 8). It should also be noted that even in the medical domain naturalistic studies (cf. 8.1) or detailed clinical single case studies are now receiving a new valuation since they—frequently unlike controlled group statistical studies—prove helpful in understanding idiosyncratic patients and their reactions to therapeutic interventions. An example will illustrate this: Studies that use imaging techniques to track

[10] This also applies to application research which can be summed up under the designation "Phase-IV Research." Here the effects of a treatment (psychoanalysis or depth psychology-based psychotherapy) are studied in the field under naturalistic conditions, i.e. in the setting of customary routine care.

therapeutic changes in individual patients with brain lesions (fMRI or PET) fit historically into a chain of clinical single case studies such as that of Phineas P. Gage (1848). Because of its precise description, this study was used productively in a "scientific" sense decades later not only by Paul Broca and Carl Wernicke, but also by such researchers as Antonio R. Damasio (1994), who linked it to current research. Exact analysis of the interaction between lesion and psychological behavior in this single case made it possible to apply its results—even without group-statistical replication—to other patients with analogous disorders, because of its precise observations and causal theoretical explanations. In (psychoanalytic) psychotherapy research as well, group-statistical studies can be meaningfully complemented by theoretically elaborated and empirically supported process and single-case studies which address the specific research object of psychoanalysis (unconscious processes and the therapeutic interventions used to influence them) regarding both the methodological procedure and quality criteria.

For this reason Kächele (2004) no longer speaks of an absolute hierarchy of quality in psychotherapy studies (where the RCT is the "gold standard" and thus the highest goal), but of different stages of psychotherapy research existing alongside of each other or with a circular connection. Depending on the question motivating the research, in each case a suitable design will need to be developed that appears most likely to reach the desired goal.

Figure 1 (according to Kächele, 2004)[11]



Six stages of therapy research: **Stage 0** Clinical Case Studies; **Stage I** Descriptive Studies; **Stage II** Experimental Analog Studies; **Stage III** Clinically Controlled Studies; **Stage IV** Naturalistic Studies; **Stage V** Patient-Focused Studies

A Sociology-of-Science Perspective

The systematic evaluation of medical treatment methods is a relatively new branch in medicine. From its origin in pharmacotherapy research it has developed into a methodologically well-defined evaluative study of medical techniques in general. In the form of evidence-based medicine (EBM) its goal is provide the clinician with the "best available external evidence" by conducting "research...into the accuracy and precision of diagnostic tests..., the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative and preventive regimens" (Sackett et al. 1996, 71-2). As an important organizational basis for the expansion and further development

[11] In brief, the different stages referred to are:
clinical case studies: detailed single case reports on a course of treatment; *descriptive studies:* e.g. systematically and empirically controlled studies of important psychotherapy process variables (on "makro"-levels as well as on "micro"-levels); *experimental analog studies*: laboratory studies (for example), in which a certain partial aspect of a theory is investigated using extraclinical means; *clinically controlled studies*: chiefly empirically controlled RCT studies; *naturalistic studies*: studies of psychotherapies avoiding interference with the natural course of the treatment process and such techniques as randomization of patients; *patient-focused studies*: an approach requiring more exact definition, in which the patient's perspective is taken as the starting point for the psychotherapeutic treatments to be evaluated and their results.

of this methodological evaluation, the Cochrane Collaboration has been formed with Cochrane Centers in a number of countries, based on principles formulated by Archie Cochrane, a British epidemiologist (Cochrane 1972). Faced with the fact that it was no longer possible for the individual doctor to keep abreast with a flood of information, he undertook a systematic compilation and evaluation of RCT studies (randomized controlled trials) on pre- and perinatal treatment methods. He then suggested extending the principles which he developed in the process to all areas of medicine.

EBM is an important step forward in the organization of innovative medical knowledge. It makes it easier for the doctor to gain access to research knowledge relatively early as well as to order and select it according to specified criteria. The combination of the best available external evidence with individual clinical expertise, as required by EBM (see Sackett), also makes it possible to take into account the particular predicament of the patient. In practice, individual clinical expertise falls to the background structurally because it is generally not recorded or published. In this way the lay and even the medical research community has formed a picture of EBM as a system of evaluation and formulating therapeutic recommendations based entirely on statistical methods—a distortion which has gained facticity as it has spread (e.g. Niroomand 2004).

Systematic evaluation using RCT's as a reference point is the dominant approach to conducting research projects in medicine. While progress in knowledge was once still based on examples of individual patients and on painstaking single-case observation, the reference point today is rather the statistical collective. From the sociological perspective this change represents a challenge. A central focus of research in sociology has always been on unintended side effects, as these often have broader consequences then the intended effects of any measure. For this reason it is of great—indeed perhaps crucial—importance to reckon side effects into one's considerations insofar as these are foreseeable. As an example we shall examine two crucial new orientation points of modern therapy evaluation: stringent diagnostic categorization and proof of efficacy. Both require creating and maintaining strict schematization if populations and results are to be comparable. Traditional creative, adaptive and specialty-related solutions must be given up in the process. Consideration of possible unintended side effects in our view establishes a second

plane of reflection, one that corresponds to the psychoanalytic method: that of being not only an agent but also a self-observing subject.

The diagnostic classification system ICD-10[12]

The ICD-10 was first published in Germany in 1994 as a diagnostic manual and in the following years was gradually introduced into clinics, scientific contexts and outpatient treatment. As a general diagnostic reference system it has been in use since January 1, 2000. An important goal attached to its introduction was to systematize diagnostic procedures across diagnostic schools, as well as to achieve data comparability between various areas of care. With the ICD-10 in use in all areas of medicine, care data can also now be scientifically evaluated with much less effort than in the past—a great gain for epidemiological and care research.

Chapter V of the ICD-10 ("mental and behavioral disorders") is ordered symptomatically and syndromatically; i.e. it is largely descriptive in approach, like the diagnostic system DSM IV developed in the United States. This gives rise to various problems, the most serious of them being that it apparently provides no assessment or weighting but merely an enumeration of findings. It is not possible to put these into a meaningful context, for example for a nosological theory. As a logical consequence the ICD-10 dispenses with pathological theory and etiological concepts.

These two characteristics of the ICD-10 result in compatibility problems with the concepts of psychoanalytic therapy, which apply in an analogous manner to the DSM-IV. The most important of these are:

- Psychoanalytic therapy is a treatment technique that has been in applied use for around 100 years and began evaluation of its treatments at an early date. The diagnostic classifications it developed over decades for this purpose deviate from the ICD-10, and a number of disorder pictures defined in the ICD-10 were in the past subsumed under different diagnostic concepts. Hence in assessing earlier therapy studies it is necessary to allow a certain amount of room for play in diagnostic categories.

- To date only a small number psychoanalytic/psychodynamic therapy studies have been conducted on the foundation of the ICD-10. Such studies are complex and

[12] Our argumentation takes the example of the ICD-10. However, the criticism also applies to the DSM-IV, the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association (APA).

quite demanding in terms of methodology, finances as well as time. Psychoanalytic treatments are medium- to long-term in duration and a multi-year follow-up period is required for results that assess their stability.

- The diagnostic process for psychoanalytic therapy is not primarily symptom-related; rather, elements of the scenic configuration and of the countertransference induced in the research analyst play a critical role in diagnosis as indicators of unconscious processes. Therefore one and the same symptom can be assigned to different diseases. In contrast, the ICD-10 is based on a symptom-related ordering.

- The descriptive nature of the ICD-10 means that assessments of therapeutic success based on it can reflect nothing beyond the disappearance of symptoms. In psychoanalytic pathology, however, the overcoming of symptoms is only one of several criteria of success. In accordance with the etiological model, symptom neuroses also require a working through of the unconscious conflict, and illnesses entailing a structural disorder also require partial structural change as their therapeutic goal. Neither of these is captured by the ICD-10.

- In psychoanalytic pathology, a number of different symptoms or syndromes can be apprehended as the expression of a single psychic illness, which is then diagnosed as a disease. Moreover there can be a change in symptoms. The ICD-10 does not provide for a disease concept with multiple and changing symptoms in psychological disorders. The closest the ICD-10 systematization comes to recognizing this phenomenon is in the concept of comorbidity. However it reformulates what psychoanalytic pathology sees as a connective relationship into an additive one. This too results in divergent therapeutic goal definitions and outcome assessments between the ICD-10 systematization and psychoanalytic diagnostics.

The issues surrounding descriptive diagnostics may be illustrated using the example of depression. The ICD-10 suggests that the single depressive episode (F32) should be distinguished from recurrent depressive disorder (F33) and from dysthymia (F34.1) as a chronic mild form of depression. Within groups F32 and F33, the ICD-10 distinguishes mild, moderate and severe forms of depression and sets them alongside of the minor and major depression of the DSM-IV. However, observations of clinical course and empirical and etiological studies fail to provide evidence that these forms of depression in fact represent nosological entities; they rather appear to represent different degrees of severity on a continuum. Furthermore it appears that

depressive episodes do not in each case point to a pathology but in certain circumstances can fall within the normal range of reactions of the human psyche, as for example in intensive grieving processes. For this reason it is unclear why the magnitude of depressive processing of events can vary to such an extent among different people as well as within the same person at different stages of life. Thus, the existence of a personality disorder seems to favor the onset of depression and aggravate its course. This supports a causal connection and not a simple coincidence, which is the assumption implicit in the concept of comorbidity used by the ICD-10 and DSM-IV. All of these questions require careful investigation, yet they do not appear to be comprehensible within the framework of purely descriptive schemata, but only in the light of etiological concepts (see detailed discussion in Leuzinger-Bohleber 2005, p. 40ff; Corveleyn, Luyten, Blatt 2005).

Because of the difference in conceptualization between the ICD-10 and psychoanalytic diagnostics, the two cannot be completely congruent in their understanding of a given phenomenon. On the background of the problems delineated here, there have for a long time been efforts to supplement the ICD-10's evaluation of psychoanalytic therapy with a system that takes account of the dynamic and fluid nature of psychopathological findings in the course of a treatment and in the course of a lifetime. Operationalized Psychodynamic Diagnostics (OPD) was developed as such a supplement.

Efficacy

In its requirements for proof of efficacy, the Scientific Advisory Board[13] names as forms of proof: controlled group studies, controlled single case studies and metaanalyses. Proofs of success must be multimodal, not based on the assessment of the therapist alone. It also requires indications on the duration of therapeutic success based on follow-up studies and tracing back of effects to a particular therapeutic technique. The requirements make no explicit mention of evidence-based medicine (EBM), but they are clearly indebted to it in their approach. In any case EBM is currently the dominant reference system in the assessment of efficacy studies for treatment techniques and regimes and has been included in the German

[13] Wissenschaftlicher Beirat Psychotherapie (WBP)

social security code[14] since the year 2000. In view of this, it is appropriate to preface this discussion with a few remarks on the efficacy criteria of EBM.

With the world-wide demand for coverage of medical services rising for a variety of reasons, the aim of EBM is to provide a foundation for their more focused application and in this way to lower rising costs, following the principle of "rationalizing instead of rationing." To evaluate the strength of proof of efficacy or "evidence," a graduated system was developed emphasizing the methodological features of the given study. The highest level of evidence is attached to the randomized controlled trial (RCT), which is taken as the standard.

It in turn is modeled on the double-blind test of pharmacological research. In principle, therapeutic effects in medicine can be based on the actual effect of a chemical or physical intervention (known as the "verum"), or on contextual effects such as the doctor-patent relationship. Accordingly in medicine there exist for the explanation of curative effects the relationship model and the scientific model, which in medical practice are thought of as a complementary series. By use of an appropriate test arrangement, the double blind test aims to determine the efficacy of the intervention per se (the "verum") while excluding contextual effects. This is possible in situations where an isolatable and describable "verum" exists.

This is doubtful is the case of psychotherapies. A fundamental characteristic of all interventions in the psychosocial area is that they take place in a relationship field in which the participants relate to one another but are also affected by individual and group-specific preconceptions and presuppositions (spontaneous transference readiness in psychoanalysis, everyday-life orientation in sociology). Hence interventions in this realm cannot be unidirectional or linear in their effect, but are inevitably embedded in a mutual feedback context—in other words they are interpersonal and circular.

The results of psychotherapy research show the significance of the relationship model in psychotherapies: Above and beyond all methods, the quality of the therapeutic relationship is decisive for the success of therapy; the "fit" between patient and therapist even at the onset of therapy is an important predictor of the outcome. This refers to the process in which patient and therapist "select" one another and in this way establish a relationship (cf. for example Strauß and

[14] Sozialgesetzbuch V (SGB V)

Burgmeier-Lohse, 1995).

Thus in psychotherapies the “context effects” appear to be part of the intervention per se. Hence it is doubtful if study designs taken from the scientific model and proofs of efficacy based on them are fundamentally suited to the psychotherapeutic domain.

A general criticism of EBM from the sociological perspective also appears deserving of consideration (see Vogd 2002). EBM, in its view, seems to result in paradoxical effects such as deconstruction of the scientific medical basis, de-differentiation of medical functional relations and limitation of professional medical autonomy. Within a complex to hypercomplex field of practice and research, EBM would appear to provide a source of knowledge promising to reduce complexity and thus facilitate decision-making. In fact, however, this is accomplished by a problematic exclusion of precisely the multimorbid patients who complicate practice, and by referring to specifications established at a distance from the situation instead of resolving a complex situation in relation to that situation. Furthermore, the need for a causal foundation to any medical measure, which until now had the ideal force of a postulate, is abandoned in favor of proof of epidemiological efficacy. This gives rise to a statistical paradox: validity in great numbers, uncertainty in the individual case. Bock (2001) questions the validity of metaanalyses, claiming that because the studies contained are based on different designs, their results do not reflect a distribution around a mean value but methodological differences. He also calls attention to a publication bias: for various reasons (editorial staff, financial backers, etc.), undesired study results are published much less frequently than desired ones - yet another aspect of manipulative selection. Close observation also reveals that political and economic interests unrelated to treatment enter into quality control decisions, one of which is the decision to choose EBM (Hafferty and Light 1995, Haycox and Walley 1999, Vogd 2002, 303ff.). Finally, the extremely high cost of randomized studies means that they can no longer be conducted without powerful financial backing. This leads to the selection of research projects favored by the pharmaceutical industry; other therapies have markedly lower chances of meeting the RCT standard, as for external financial reasons they are now scarcely in a position to create a suitable study design (Kienle et al. 2003, A 2143). The shift to statistical designs undermines an important avenue of medical investigation: causal knowledge derived from the individual case (ibid., A 2144f). One central ethical problem in the inherently exclusive focus of the RCT on the medical success of

measures is it that fails to reflect quality of life aspects (Niroomand 2004) which offer crucial qualifications regarding the application of modern medical technologies. Finally, metaanalyses in the domain of psychotherapy require consideration of the cultural context inasmuch as the therapeutic relationship, a critical factor in efficacy, is subject to strong cultural influences determining styles of communication and interaction.

Since the efficacy of psychotherapy correlates so highly with the therapeutic relationship (Wampold 2001), “simple” RCT studies with randomly generated assignment of patients to a method of treatment as in pharmacotherapy are of minimal validity; for under actual care conditions the patient’s search for the “right” therapist and the treatment agreement based on it are in themselves an important predictor of treatment success. This condition is only met in naturalistic studies, which give the patient the opportunity to select or reject a therapist. Recently complex designs have been developed making this possible while fulfilling the control condition. Under such conditions comparative studies are meaningful, providing psychotherapy research with a valuable instrument (Leuzinger-Bohleber, Hau, Deserno 2005).

It becomes evident that both the foundations and the practice of systems of ordering and evaluation possess a dynamic of their own and are enmeshed in a network of connections which co-determine their results. Hence a critical and thoughtful use of these systems appears necessary.

1. Name of the Technique

“Psychoanalytic Therapy”

This designation explicitly refers to psychoanalysis with its theory of personality, pathology and treatment, thus making it is suitable to serve as an umbrella concept for all the forms in which psychoanalytic therapy is applied. The alternative suggestion, to introduce the term “psychodynamic techniques” as the umbrella concept for German-language usage, abandons this central relation to psychoanalysis. Hence “psychodynamic therapy” is looked upon here as one application of psychoanalytic therapy and corresponds in its substance to “depth psychology-based psychotherapy,” the term commonly used in the German language and also set down in the Psychotherapy Guidelines.

2. Short description of the technique

The technique seeks to work through biographically-based pathogenic unconscious conflicts and pathological disorders of personality development in a therapeutic relationship, giving particular consideration to transference, countertransference and resistance.

3. Techniques and Forms of Application

“Psychoanalytic therapy” is a technique embracing the following applications:

1. Analytic individual psychotherapy
2. Analytic group psychotherapy
3. Psychodynamic/depth psychology-based individual psychotherapy
4. Psychodynamic/depth psychology-based group psychotherapy
5. Analytic couples and family therapy
6. Inpatient psychodynamic psychotherapy

7. Analytic child and adolescent psychotherapy (individual/group)

8. Depth psychology-based child and adolescent psychotherapy

4. Detailed description of the forms of application of psychoanalytic therapy (W. Mertens)

4.1 Analytic individual psychotherapy

As an ideal type, analytic individual psychotherapy represents a technique derived from psychoanalysis. In practice, however, psychoanalytic technique and analytic psychotherapy differ—chiefly in their session frequency (three to four vs. three to two sessions per week) and the more condensed relationship process this makes possible (Thomä and Kächele 1985; Mertens 1990; Will 2003). The working through of an initially unconscious transference/ countertransference process and the various forms of resistance as well as the analyst's adoption of technical neutrality in the sense of non-activation of unconscious role expectations are salient characteristics of psychoanalysis and analytic individual therapy alike (Kernberg 1999). When patients with personality disorders (e.g. masochistic, narcissistic, histrionic) are treated with analytic psychotherapy, interpretation of transference in the here and now is necessary from the very start due to the considerable perceptual distortions which arise. Otherwise interpretation gives way to clarification, confrontation and supportive elements, which limits the degree of technical neutrality towards the psychoanalysis. In practice, however, the differences between the two techniques regarding supporting elements tend to be minimal (cf. Gabbard & Westen 2003). And just as in high-frequency psychoanalysis, in analytic psychotherapy too the central psychoanalytically effective factor is not reconstruction of the past but the concrete process of dealing in the here and now with the conflicts resulting from the transference and countertransference relationship.

As part of the approval process, analytic psychotherapy was defined by the Psychotherapy Guidelines in regard to indications, foci of treatment and scope of services, among other aspects. In this way the historical controversies of the first generation of psychoanalysts (Freud, Adler, Jung) were raised to the general, practical level of action. In a course of up to 300 sessions (the maximum allowed by the health care insurance) over three to four years, it is generally possible to achieve clinically significant changes with analytic psychotherapy (Brockmann et al. 2002, Huber, Klug and v. Rad 2001; Leuzinger-Bohleber et al. 2001, 2002; Stuhr et al. 2001; Rudolf et al. 2001; Sandell et al. 2001; Leichsenring 2002).

The Heidelberg Structural Change Scale developed by Rudolf et al. makes it possible to measure changes in selected conflict foci (Rudolf et al. 2001; Rudolf 2002).

4.2 Analytic group psychotherapy

Analytic group therapy is based on the insight that the conscious and unconscious conflicts and developmental disorders of the participants in a group are configured not only intrapsychically but also interpersonally in the form of externalized pathological object relations, and that these can be worked through in a multi-person relationship with the analytic tools of transference, countertransference and resistance. Thus, the analytic group therapist works to uncover or interpretively accompany the impact of individual psychological and psychosomatic conflicts and/or of developmental impairments on the interpersonal process in a multidimensional transference scenario, in which family-dynamic conflicts and sibling conflicts are frequently actualized. One focus of analytic group psychotherapy is on reestablishing the family/primary group in the unconscious of the participants with a multiplicity of transferences and relationship enactments. Another focus of analytic group psychotherapy is on the group as a whole. The premise is that the individual contributions of the group members unconsciously form a common theme; the evenly suspended attention of the psychoanalyst in the individual setting corresponds to nondirective leadership in the group. Since regressive developments can arise more quickly and more intensively in a group setting than in individual therapy, dealing with them requires especial psychoanalytic competence in order to catch and influence maladaptive developments as early as possible. This requires an awareness of interpersonal defense mechanisms, psychosocial compromise formation (Mentzos 1988) and unconscious group fantasies (Bion 1971, Haubl and Lamott 1994). Extensive evaluations have been conducted on treatments in groups (Tschuschke 2000).

4.3 Psychodynamic / depth psychology-based individual therapy

Although known in Germany—and there alone—as “depth psychology-based psychotherapy” (Hoffmann 2000), this form of therapy is derived strictly from psychoanalysis (Heigl-Evers and Evers 1984; Heigl-Evers, Heigl, Rüger and Ott 1997)

and represents an application of psychoanalytic therapy. Instead of proceeding from the development and working through of a transference neurosis, the psychodynamically guided focus falls more strongly here on currently effective interpersonal conflicts and their symptom formation, with attention towards transference, countertransference and resistance. Interventions involving practice, imagination and other supports for self-worth rank ahead of transference interpretations, which usually concentrate on extra-analytic relationships. In this way the regressive reanimation of unconscious conflict material can be guided along with the concentration on partial goals (Faber et al. 1999). It is indicated for patients with a definable ongoing neurotic conflict and moderate to poor integration of structural competencies and/or for more highly structured patients who for various reasons are not prepared to undertake higher frequency analytic psychotherapy. Empirically, psychodynamic /depth psychology-based individual therapy is currently the most frequently practiced and best studied form of therapy (Rudolf 2002; Rudolf and Rüger 2001, 2002; Rüger and Reimer 2000; Leichsenring 2002).

In outpatient practice too it forms an independent application of psychoanalytic therapy for the indications mentioned. It is not an independent psychotherapeutic technique since it is based on practical application of the concepts of transference, countertransference and resistance, the foundation of psychoanalytic therapy and psychoanalytic pathology.

4.4 Psychodynamic / depth psychology-based group therapy

Psychodynamic/depth psychology-based group therapy differs from analytic group therapy largely in its depth of regression and its mode of interpretation, focusing on derived conflicts that manifest as relationship and role conflicts in the everyday life of the group members and that find their reflection in the group. Originally it was chiefly the interactional principle that was emphasized by Heigl-Evers and Heigl (1983) in “interactional depth psychology-based group psychotherapy”. This principle places value on group members receiving direct feedback regarding (for example) their poorly developed capacity to recognize the effects of their words or actions on other group members. Thus the central concern of this form of therapy is “catching up” developmentally by practicing inadequately developed competencies as reflected by the reactions and evaluations of the other group members and the therapist.

4.5 Analytic couples and family therapy

With the growing emphasis on relationships in the various directions of psychoanalytic object relations theory, family dynamics as well came to be considered an indispensable factor in a biopsychosocial model of disease. Stressors in couples and family relationships can contribute to an intensification of psychic and psychosomatic symptoms, which in turn aggravate partner and family conflicts. Hence another form of application is that of analytic couples and family therapy. Alongside of the intrapsychic focus, the dynamics of the couple or family is of chief significance here. Pathogenic interaction and communication structures can contribute to maintaining a circular pattern of symptom and neurotic experience. The concept of the family index patient brought the adaptive function of symptoms into the foreground. These applications of psychoanalytic therapy have profited chiefly from the communication theory findings of the Palo Alto group on dysfunctional family structures (Bateson et al. 1969), role theory models (Richter 1963; Stierlin 1978), relationship analysis (Bauriedl 1980), the concept of collusion (Dicks 1967; Willi 1975; König and Kreische 1991), the multi-generation perspective (Boszormenyi-Nagy and Spark 1973; Massing et al. 1994), across-school approaches (Buchholz 1982) and system theory approaches. In the latter, family therapy is often equated with systemic therapy or counseling. Family is understood as an organized structure which is changed in therapy. Criticism of the systemic approaches concerns chiefly their failure to take the therapist into account (cf. Hanswille 2000, Cierpka 1996) while simultaneously considering intrapsychic processes in the form of inner object relation experiences which have arisen in the patients' biography. Efficacy studies have now been conducted for selected disease pictures (e.g. Reich 2003).

4.6 Inpatient psychodynamic therapy (Janssen)

Since Simmel's initiative in the 1930's, when he opened a psychoanalytic clinic for the psychologically and psychosomatically ill in Berlin/Tegel, inpatient psychodynamic therapy has had a long tradition of conceptual development and treatment in Germany, particularly since the second World War. At present there are 158 psychosomatic rehabilitation clinics with 13,930 beds and 75 hospital wards for psychosomatic medicine and psychotherapy with 3,196 beds.

Following the improvement of outpatient psychotherapeutic care, the indication criteria for inpatient psychotherapy have concentrated particularly on severe disorders that cannot be treated on an outpatient basis. These are patients who require a stable environment and can learn in the therapeutic community but are scarcely reachable in an outpatient setting. In addition, acute decompensations are admitted for crisis intervention as well as patients who need to be removed from a pathogenic milieu. In particular the multimethod and multiprofessional offerings available in inpatient psychodynamic psychotherapy can help psychosomatic patients with multimorbidity and guide them towards readiness for outpatient therapy.

Over years of concept development, inpatient psychodynamic therapy has developed a multidimensional, multimethod treatment concept. Chief among its elements are psychodynamic depth psychology-based group therapies in combination with individual therapies, therapeutic community, crisis intervention and methods derived from psychoanalysis such as catathymic image experience, creative therapies such as painting and art therapy, music therapy, movement and dance therapy (Janssen 1987, Janssen 2004). The inpatient treatment is always multiprofessional. The nonverbal techniques are particularly suited to patients whose capacities for reflection and verbalization are limited.

According to available data, at present the average duration of treatment in such wards comes to 55 days.

4.7 Analytic and psychodynamic / depth psychology-based child and adolescent therapy (individual/group)

Analytic child and adolescent therapy represents a form of therapy based on the theory of psychoanalysis but modified in practice for treatment of infants, children and adolescents with psychological problems. The process also provides for inclusion of primary reference persons such as mother and father.

Depending on the child's age (infancy, early childhood, mid-childhood, late childhood, adolescence), modifications of the setting and the therapeutic interventions are introduced. As in analytic therapy of adults, however, the aim of analytic child and adolescent therapy is work through to the significance of unconscious processes behind the behavior and symptoms and to understand these in the context of unconscious parent, sibling and family dynamics. Similarly, the therapeutic process

is worked through and guided by an analysis of transference, countertransference and resistance making use of regressive processes (Fonagy und Target 1995; Fuchs 2000). Particular importance is attached to the development of the capacity for play and the capacity for symbolization (Rasche 1992, Bovensiepen 2002). Frequently primary emphasis is placed on measures aimed at “catching up” developmentally for impaired developmental competencies (e.g. affect differentiation, reality checking, mentalization). In the last two decades this form of therapy has received important impulses from infant and early childhood researchers. For the area of diagnosis of conflicts and structural ego functions and competencies, an Operationalized Psychodynamic Diagnostics for children and adolescents (OPD-KJ 2003) has been in place since 1999.

5. Determination of Diagnosis and Indication (G. Rudolf)

The partially structured interview

In analytic and psychodynamic therapies, as a rule the diagnostic process which precedes any kind of therapy and provides the basis for the treatment indication takes place in the form of a partially structured interview. The interview is structured in the sense that it gathers anamnestic findings on the type and severity of complaints, symptom courses, patients' explanatory models, ongoing stressors and significant biographical experiences. It is loosely structured in the sense that it leaves sufficient room for self-presentations and enactments on the part of the patients. By listening to and observing the developing relationship situation and by sensitivity to his or her own countertransference impulses, the therapist arrives at a psychodynamic hypothesis about lasting personality traits and the actualized conflict themes. By reflecting or interpreting these perceptions and hypotheses back to the patient in an appropriate way, the therapist begins to sound out the patient's self-reflective capacities and defense patterns, which are important for a revealing psychotherapy. Here a fluid transition exists from diagnostic to test-therapeutic processes, which ultimately results in an indication. As a result of the diagnostic interview, in institutions a largely structured finding is documented (Rudolf 2000), while in psychoanalytic practice a psychodynamic hypothesis is freely formulated about the connection of symptom genesis and personality development in the biographical and current social context (Rüger, Dahm and Kalinke, commentary to the Psychotherapy Guidelines 2003).

The formalization of this procedure has a long tradition, and successive generations can be recognized in the development of the diagnostic interview. The first generation can be placed in the 1950s. It was in 1951 that Schultz-Hencke presented his model of the depth psychology anamnesis, which was based on the experiences of the Berlin Psychoanalytic Institute as well as those of the National Institute for Psychological Research[15]. This model, with its carefully documented findings, was used particularly in outpatient settings and in clinics (Dührssen 1954, Schwidder 1958). Following the lead of emigré psychoanalysts, American psychiatry developed interview models such as those of Sullivan (1954) or Gill, Newman and Redlich (1955). The British working group of Balint (Balint and Balint 1962 and Malan 1965) also directed its interest to the diagnostic and indicative function of the

[15] Reichsinstitut für psychologische Forschung und Psychotherapie

first examination; A. Freud and her group set up a “metapsychological assessment” (the Adult Profile 1965).

As these developments were taken further and systematized by a second generation, the contrasts in the lines mentioned above became clearer. Argelander (”Das Erstinterview in der Psychotherapie”[16] 1970) and later Eckstaedt (1991) directed their chief attention to unconscious enactments in the diagnostic initial interview. On the other hand Dührssen (”Die biographische Anamnese unter tiefenpsychologischen Aspekt”[17] 1981) and Rudolf (”Untersuchung und Befund bei Neurosen und psychosomatischen Erkrankungen”[18] 1981) directed their diagnostic attention to a detailed documentation of anamnestic findings. In the same year (1981) Kernberg published his new approach of the structural interview, which took into account the patient’s level of psychological functioning and made it possible to modulate diagnostic emphases in the sense of neurosis / borderline organization / psychosis.

The third generation of the interview is characterized by a progressive differentiation in the gathering of findings. Luborsky and Crits-Christoph (1990) and Dahlbender et al. (1993) described the relationship episode interview, which is designed to reveal core unconscious relationship conflicts. Buchheim, Dahlbender and Kächele (1994) summarize the state of development in the middle of the nineties. In the development of the diagnostic system of Operationalized Psychodynamic Diagnostics (OPD working group 1996), a configuration of the diagnostic interview was introduced which is capable of diagnostically working out the OPD aspects of symptoms, relationship, conflict and structure and documenting their operationalization (Janssen et al. 1996, Schauenburg et al. 1998). Tools were developed in support of this procedure, as for example a structure checklist (Rudolf et al. 1998) and a conflict checklist (Grande and Oberbracht 2000).

While the OPD interview evaluates psychodynamically relevant findings across disorders, there are a number of interview variants, rating instruments and tests which complement it by narrowing in on disorder-specific themes of the personality disorder, eating disorder, trauma-related disorder, etc. In this way expert evaluation is increasingly complemented by the patient perspective.

An extension of the diagnostic perspective applies to the dynamics of couples and

[16] ”The first interview in psychotherapy”
[17] “The biographical anamnesis from a depth psychology viewpoint”
[18] “Examination and findings in neuroses and psychosomatic diseases”

families, who are examined in specific forms of the diagnostic interview (Cierpka 1996). In analytic child and adolescent psychotherapy as well, family members are brought into the diagnostic process in order to capture the family dynamics and cast light on the immature patient's perspective by indirect anamnesis. In diagnosing children and adolescents, numerous media are additionally drawn upon which are broadly described as "projective" but in fact make possible a self-presentation and relationship-presentation on an imaginative-symbolic level (sandplay; Sceno family in animals; sentence completion; TAT; Duess fables, etc.)

Diagnostic Classification

The diagnostic process results in a diagnostic classification. In this realm the currently accepted classification instruments, DSM and ICD, are psychiatrically weighted with little psychosomatic and no psychodynamic consideration at all, so that many analytic psychotherapists do not see their diagnostic understanding represented in these forms of logic (cf. preface). On the other side it is argued that any kind of diagnostic standardization is better than none at all and that it makes more sense to use comorbid concepts of the ICD than customary descriptions of neurotic disorders for which no operationalization is available. The main shortcoming of the accepted classification systems is that no or very few therapeutic recommendations can be derived from them; the diagnostic concepts are not indication-relevant. Therefore it represents a significant step forward that the OPD system integrates those finding levels which are essential to a psychodynamic understanding and from which important recommendations on indication can be derived (e.g. conflict-revealing therapies given pronounced conflict and structure-supporting therapies given pronounced structural vulnerability, etc.).

The possibilities for more precise diagnostics have led to more exact epidemiological findings. The Mannheim Cohort Study (Schepank 1987, 1990) largely confirmed the figures reported by other researchers and drew attention to the astonishingly high rate of psychological and psychosomatic disease in the Federal Republic of Germany.

Since the days of American ego-psychology there has been an increased effort to improve status diagnosis and process diagnosis. Best known were the attempts to operationalize ego strength (Sharp and Bellak 1978), precisely describe treatment

goals (Sandler and Dreher 1996) and evaluate the level of children's developmental lines (A. Freud 1965, Bolland and Sandler 1965).

Presently there exist a multiplicity of psychodynamic diagnostic techniques for determining indication and change (Mertens 2000; Schüßler 2000), of which several shall be mentioned here:

Interview techniques: Psychoanalytic first interview (Argelander 1970); biographical anamnesis from a depth psychology perspective (Dührssen 1981); structural interview (Kernberg 1981); diagnostic interview in context of OPD (Janssen et al.1996).

Self-evaluation techniques: e.g. Giessen Complaint Questionnaire (Brähler and Scheer 1995); Inventory of Interpersonal Problems - IIP-D (Horowitz, Strauss, Kordy 2000); Borderline Personality Inventory - BPI (Leichsenring 1997); Helping Alliance Questionnaire HAQ (Bassler, Luborsky 1995); Narcissism Inventory (Denecke, Hilgenstock 2000); Psychological and social-communicative findings - PSKB-Se (Rudolf 1991); Scales of Psychological Capacities – SPC (Wallerstein; Huber and Klug, in press).

Projective Techniques: Rorschach, TAT, Sceno Test, ORT;

Techniques for measuring change: Heidelberg Structural Change Scale (Rudolf et al. 2000); Core Conflictual Relationship Theme (Luborsky and Crits-Cristoph 1990, Luborsky and Kächele 1988); Structural Analysis of Social Behavior – SASB (Benjamin 1974, Tress 1993).

Techniques for measuring the therapeutic relationship and therapist interventions: Helping Alliance Questionnaire - HAQ (Luborsky 1991); Plan Analysis - PA (Weiss and Sampson 1986); Therapeutic Working Relationship – TAB (Rudolf 1991).

Techniques for Attachment Research: Adult Attachment Interview - AAI (Main).

Determining Indications

While the areas of diagnostics and classification are well studied scientifically, the determining of indications leans heavily on expert opinion (cf. Heigl 1972, Baumann

1981, Leuzinger 1981, Leuzinger-Bohleber, Rüger, Stuhr and Beutel 2002, 258-267). Personal training, treatment experience and institutional contexts (outpatient practice, inpatient therapy) play a role in the formulation of treatment recommendations, which are further influenced by aspects of the health care system and its regulations (e.g. outpatient guideline-conforming psychotherapy, hospital treatment, rehabilitation measures) and by professionally authorized payment options of individual therapists. The Berlin psychotherapy study ("Indikationsentscheidung und Therapierealisierung in unterschiedlichen psychotherapeutischen Praxisfeldern"[19]) revealed that patients choosing outpatient analytic, depth psychology or inpatient psychotherapies differ in regard to a variety of psychological and social parameters (Rudolf et al 1987).

Far-reaching definitions are set down in the agreement on guideline-conforming psychotherapy and the associated commentary (Faber/Haarstrick). Among psychoanalytic therapeutic techniques, two chief forms of application are distinguished here: analytic psychotherapy and depth psychology-based psychotherapy. These differ in their therapeutic goals, their therapeutic procedure and the number of sessions they envision, as well as in terms of their primary indication. In the logic of the psychoanalytic approach, the decision on indication is not based on symptom-related considerations but on the nature and severity of the personality pathology. According to Rudolf and Rüger (2001) the indication criteria for analytic psychotherapy are met when a patient's current pathology is characterized chiefly by biographically repetitive patterns of conflict and when treatment success is possible only by processing the corresponding intrapsychically-anchored object relation patterns. Diagnostically this can include a broad spectrum of personality disorders (narcissistic, histrionic, obsessive-compulsive, anxious-avoiding, dependent, schizoid etc.), chronic anxiety disorders and dysthymias. In contrast, depth psychology-based psychotherapy is indicated when symptom development is triggered by an external life event which has destabilized an existing equilibrium in the patient. The therapeutic processing now applies not to the underlying conflict but to the actualized conflict themes deriving from it. Here the therapeutic working relationship concentrates on the present and can be more rapidly transferred by patients into efforts for positive change. The structural lability treated in depth psychology may also have arisen as a result of severe physical diseases or current traumatic events that have destabilized an existing psychic equilibrium. The

[19] "Indication decision and therapy implementation in different psychotherapeutic fields."

two techniques offer an alternative not between full-scale and small-scale psychotherapy, but between approaches with a different degree of conflict focus and a different degree of intensification of regressive and transference processes.

In summary, currently practiced techniques of interview diagnostics, complemented by patient self-evaluations in analytic psychotherapy, are suited for:

1 working out a diagnostically classifiable clinical picture in terms of quality, severity and course characteristics;

2 detecting psychodynamic emphases in terms of unconscious conflicts, structural functional levels and dysfunctional relationship configurations;

3 creating a prognostic assessment and a differential indication regarding possible therapeutic approaches and their different goals.

6. State of theory development (W. Mertens)

Psychoanalytic theory cannot be described without speaking of its epistemology and methods, which constitute a specific field of research in their own right. In decades of scientific discourse, psychoanalysis has been defined methodologically as a unique type of science(one that cannot be assigned uniquely either to traditional scientific epistemology or to the hermeneutic approach of the humanities, but which assimilates elements of both traditions and fashions a new synthesis of them. Currently the discussion is increasingly considering how psychoanalysis, like other scientific disciplines in a time of "scientific pluralism," can establish its own research methods and quality control (cf. preface). It would be simplistic to think of these merely as a combination of quantitative and qualitative methods inasmuch as psychoanalysis, in fundamental contradistinction to a number of other scientific disciplines, is predicated on an epistemological approach which tends to suspend the usual subject-object relationship. Over against the positivist ideal "Concerning ourselves we keep silent," psychoanalysis places reflection on one's subjectivity.

Psychoanalysis is not interested in consciously available knowledge which an can be supplied upon request, but in scenes in which autobiographically repressed and/or nonconscious, non-symbolic interactional connections are manifested. For this reason it must uncover these in an intuitive and abductive process in which the therapist/researcher must take his or her sensory-emotional reactions(i.e., his or her own subjectivity(seriously.

While the use of controlled subjectivity is schooled over years of practical and theoretical training, it remains subject to error and therefore permanently in need of critical reflection. Hence the impression of countertransference, accepted relatively uncritically by Freud and the first generation of analysts, is now complemented by a triangulation of the methodological procedure: the intuitive, holistic and abductive approach to knowledge is validated wherever possible by offline research (Moser 1989), instantiation of models using computer simulation etc. (Moser et al. 1969, Moser 1980), comparative casuistics (e.g. Stuhr et al. 2001, Deneke et al. 2003), testing of hypotheses in experiments (e.g. Leuschner 1998, Hau et al. 1999), qualitative research models (e.g. Buchholz 1993a,b, 1998; Streeck 1999; Boothe 1994) and interdisciplinary research (e.g. Shevrin et al. 1996, Bucci 1997, Leuzinger-Bohleber and Pfeifer 2002). Such validation, however, does not subsume

psychoanalysis under the neopositivist ideal of empirical theory formation, which is supposed to operate by means of continual falsification and allow the individual phenomena to be deduced in the manner of logical conclusions. Instead psychoanalysis(and psychoanalytic methodology(takes account of the nonlinear nature of unconscious and conscious mental phenomena. In particular, the distinction between connotative and denotative theories provides a sound methodological basis on which to characterize the specifics of psychoanalytic theory (c.f. Schülein 1999, 2003). While denotative theories assume an extensive identity of their object area, connotative theories proceed from the principle that the factors to be investigated possess an inherently unpredictable dynamic. For this reason connotative theories cannot be captured in universal laws; rather they must remain unsharp and are always contextual (Warsitz 1997).

Metapsychology and interdisciplinary discourse

Freudian metapsychology with its demand that each psychic phenomenon be looked at topically, economically, dynamically and structurally(i.e. by a plurality of methods and perspectives(is being supplanted today by an interdisciplinary acknowledgment of conscious and unconscious processes in perception, memory, emotion, motivation, speech and action. In this process of interdisciplinary comparison, it is not just a matter of determining the external coherence (Strenger 1991) of psychoanalytic models. Rather, the insights of clinical psychoanalysis equally represent a challenge and an enrichment to the theories and findings of the cognitional and neurosciences (Leuzinger-Bohleber 2002, Leuschner 2002)(to the extent that they are interested in a dialog with psychoanalysis (Bucci 2000; Roth 2001, 2003, cf. also the international journal Neuro-Psychoanalysis)(as well as to the theories and findings of other human and social sciences.

As an example of how ideas on basic metapsychological assumptions can be complemented in the light of present-day theories and findings from the neuro- and cognitional sciences, let us examine Freud's classical structural model. The unconscious processes taking place in the structures he designated as the id, ego and superego represent distinct systems both from brain anatomy and functional points of view (Deneke 2001, Roth 2001). These include not just repressed drives which secondarily have become unconscious, but also impulses which were subject to original repression and thus could never be symbolized, as well as unconscious

operations in the ego(among them the defense mechanisms(and finally unconscious portions of the superego. In current terminology, these latter would include knowledge of conditioning and rules on dealing with emotions in social exchange. Alongside of cultural norms of action and behavior, it also includes the results of countless negotiation processes in which the wishes of parents and child take effect in highly idiosyncratic ways and in which a struggle over the justification of emotional and desire-driven actions is played out. Non-declarative knowledge, which arises already in the first year of life, cannot be equated with psychodynamically repressed material; nevertheless the unconscious of the Freudians(even of Freud himself(encompasses more than psychodynamically repressed material alone. Defense mechanisms are emotional regulation processes triggered by anxiety. Archaic superego introjects can be understood as contents of the classical conditioning memory, which once acquired can remain active for a lifetime without the individual's being able to explicitly remember where they come from(in complete contrast to the contents of conscience, which originate from a later time and can enter into autobiographical reflection, even if they are in principle susceptible to defense processes such as repression. Thus in terms of memory psychology, the ego and superego structures that are concerned with adaptation, control of action and consideration of social norms are characterized by both declarative and non-declarative processes. Based on its clinical experience modern psychoanalysis has developed differentiated pictures of how nonconscious, psychodynamically unconscious and conscious processes are interwoven, e.g. in superego control (e.g. Emde and Buchsbaum 1990, Emde et al. 1991, Emde 1999; Wurmser 1987).

The ego functions described as perception, memory, feeling, planning and control of action can also be grasped in a more differentiated way on the background of constructivist perceptual theories (Pally 1997), cognitive and neurobiological memory theories based on the modularity of human memory (e.g. Squire 1994; Clyman 1992; Sandler and Sandler 1997; Köhler 1998; Davies 2001; Talvitie and Ihanus 2003) and contemporary theories in emotional psychology (e.g. B. Krause 1997; LeDoux 1998; Roth 2001) regarding the emotional and motivational control of action.

Psychoanalytic Disciplines

Psychoanalytic Theories of Drive, Motivation and Emotion

Reversing years of prior neglect in the area of drives and emotions in psychology,

from its inception psychoanalysis has emphasized the drive dynamic of psychological phenomena and their conflictual ramification. In the course of the 20th century the path of theoretical development has proceeded from Freud's early assumption of a self-preservation and sexual drive, through narcissistic libido and object libido and a later dual drive theory of libido and aggression, to White's drive for competence and mastery, Bowlby's attachment drive, Lichtenberg's multiple motivation theory and finally to a revised "drive theory" (Westen 1997).

If Freud's psychoanalytic theory of emotion still displayed numerous inconsistencies, the studies of Krause (1991, 1997) and Moser (1996) in particular prepared the way towards a consistent approach.

Psychoanalytic Theories of Development

Psychoanalytic theories of development deal with the psychological reality of a human being from the diachronic point of view. Thus the focus is not primarily on the observable behavior of a child at a particular developmental age, but rather on how a child or an adolescent processes an experience at a particular chronological age and a particular stage of development on the emotional-cognitive level or(as psychoanalysts express it(on the imaginative level: i.e., how experiences are mentalized as psychic realities and how these representations of experiences in turn influence present perceptions and actions.

Psychoanalytic developmental theories approach development with a conflictual orientation: Conflicts arise in large measure from a disharmony between the child's and the parents' wishes and interests, in lesser measure from the inherent dynamic of somatopsychic processes. Onto this are added the limitations and deficits in parental competencies which, interacting with the child's disposition, lead to deficient development of capacities and to further conflict development in the child. When these factors exceed the child's ability to adapt, they become traumatizing conditions. Not only isolated single traumas, but also cumulative microtraumas, i.e. parental behaviors which fail to meet a child's developmental needs, are a chief object of investigation. Traumatization can also occur when a child is incapable of adequately processing intense feelings because the parents to a lesser or greater degree fail in their containment or in their ability to see the child as having a will and desires of its own and to empathize with its intentions and needs (Fonagy 1998, Fonagy and Target 1996, 1998, 2001). Since parent-child relationships are always embedded in

a sociocultural and socioeconomic setting, the developmental and socialization processes cannot be separated from one another in the models of psychoanalytic developmental theory (Lorenzer 1970a, b).

Recent years have seen a growing interdisciplinary interest in cognitive and behaviorally oriented theories of development, as for example in infant and attachment research. A salient criticism of certain psychoanalytic infant researchers is that psychoanalytic theories of early childhood are theoretically top-heavy and empirically underdetermined. In their view the original metapsychological assumptions lead either to over- or to underestimation of the infant's representational capacities (e.g. Emde 1981; Köhler 1985,1986; Lichtenberg 1981, 1983/1991; Sander 1980; Stern 1985/1992). In coming to terms with these objections, however, several limitations of cognitive developmental psychology were also recognized, some of them immanent to the conception of a competent infant. They lie in an overvaluation of a child's cognitive and rational functions while at the same time neglecting the emotional and relationship aspects of development (e.g. Gergely 1998, 2000; Dornes 1997, 2000).

General and special theory of pathology

In the first half of the 20th century the general theory of pathology was, in its etiological, psychogenetic and psychodynamic modeling, largely oriented to the drive-defense-conflict paradigm of the early Freud and American ego-psychology. Further developments of classical psychoanalysis(C. G. Jung's analytic psychology, A. Adler's individual psychology, the various object relations theories, self-psychology, post-ego-psychology, the post-Kleinian school, the intersubjective and interpersonal directions and in recent years the attachment theory(have brought with them diverse modifications and new emphases, regarding for example the conscious and unconscious neurogenic influence of parents. One innovation is the conceptualization of diverse modes of coping in the form of fantasies, defense mechanisms and character structural attitudes (Mentzos 1982; Rudolf 1996). These also include attachment representations (Fonagy 2003) and the impairments resulting from them due to persistent conflict and trauma dynamics or partially dysfunctional coping mechanisms (Ermann 2004; Rudolf 1996; Hoffmann and Holchapfel 2000; Rüger and Reimer 2000, Senf and Broda 2005).

In the ongoing discourse of developmental psychology, various areas are being

explored as to their clinical importance as foundations of individual trauma and conflict management: attachment research, object relations theories and interpersonal theories, psychological structure formation processes and the acquirement of basal psychological functions (mentalization, symbolization, affect attunement, affect and relationship regulation etc.) (e.g. Beebe and Lachmann 2004; Holderegger 2002; Fonagy et al. 2004).

Conflict and Trauma

The reconstruction perspective, long dominant in psychoanalysis and based on the identification of unconscious conflicts, underwent considerable expansion and differentiation when the results of attachment and trauma research were taken into account(in particular earlier groundwork in trauma theory that had been neglected. Above all, the almost universal occurrence of developmental traumas led to a considerable reconceptualization of reconstruction assumptions.

In contrast to dichotomizing perspectives that acknowledge solely trauma or solely conflict as the basis of a present pathology, new emphasis is placed on the interlinkage of trauma and conflict, even if the starting point is often to be found in developmental trauma. Due to the resulting effects on the functionality of developmental attainments such as the capacity for perspective-taking, there arises a complex fabric of trauma and conflict sequelae along with the structural impairments of ego competencies resulting from them (e.g. affect control, mentalization of affects, perspective-taking, attachment capacity etc. (cf. OPD working group 1996, Fonagy and Target 1996)). A lively discussion developed in the 90's on the implication of traumatization and trauma sequelae in terms of memory psychology (Bohleber 2000, Fischer and Riedesser 1998, Hinckeldey and Fischer 2002, van der Kolk 1998).

Defense mechanisms

More precise theoretical conceptualization has led to improved diagnostic approaches to defense processes (e.g. Ehlers et al. 1995; Hentschel et al. 1993; Leichsenring, 1997, 1999 a, b; Smith et al. 1989; Vaillant 1992, Perry 1993). A variety of methods are used to diagnose defense mechanisms in a range of different clinical disorders (MCT - Meta-Contrast Technique, DMT – Defense Mechanism Test, FKBS[20] – questionnaire on conflict management strategies, SBAK[21] – self-evaluation

[20] Fragebogen zu Konfliktbewältigungsstrategien

of defense mechanisms, DMT – Defense Mechanism Test, BPI – Borderline Personality Inventory, RT – Rorschach Test, HIT - Holtzman Inkblot Technique) (e.g. Küchenhoff 1993, Leichsenring, 1999 a, b, c; Leichsenring, 2004). Early childhood and attachment research, using other terminology in part, has also had a fertilizing action through its efforts towards a theoretically refined conceptualization and observation of the development of defense mechanisms in the mother-child bonding process.

Neurotic styles

The concept of neurotic styles (Shapiro, 1991) integrates cognitive functions, affective functions and the type of object relations. In recent years it has been successfully extended to the functional style of borderline patients (Leichsenring, 1996, 2003). The concept of borderline functional styles connects ego psychology and object relations theory with Piaget's theory of cognitive development. A large number of empirical results are now available regarding this concept, confirming the assumptions on which it is based (e.g. Leichsenring, Roth and Meyer, 1992; Leichsenring, 1996, 2003; Leichsenring and Sachsse, 2002).

Self-worth regulation

The process of coming to terms with Kohut's psychology of the self (1973, 1979) has underscored how important self-worth regulation is and how significant a role it plays in psychological illnesses generally and not only in narcissistic personality disorders.
The narcissism inventory developed by Deneke and Hilgenstock (1988) proved of particular significance in evaluating self-worth regulation, as this area had been conceptually clouded by a lack of terminological clarity. Since then a number of empirical studies have been conducted with the use of this instrument (Ehlers and Plassmann 1994; Fliege et al. 2003; Kruse et al. 2000, Thiel and Schüßler 1995, Thiel et al. 1999, Wietersheim et al. 2003).

Coping strategies

The fashion of speaking of schizoid, depressive, compulsive, etc. personality types, which was current in the 70's and 80's, was transformed for psychodiagnostic purposes into strategies for managing basic conflicts and traumas experienced at an

[21] Selbstbeurteilung von Abwehrkonzepten

early age (Mentzos 1982; Rudolf 2000). Each person reacts to basic conflicts that have arisen in childhood with narcissistic, schizoid, compulsive-obsessive or other management strategies, which come into play situationally, interactionally and age-specifically, yet these strategies cannot be said to constitute a rigid and all-encompassing “personality type” even if they may be altogether habitual. Symptoms set in when the management strategies take too great a toll on the individual because of imbalanced or prolonged use and/or when the associated defense mechanisms decompensate in situations of intense temptation or failure.

Structural ego-competencies, level of personality organization

Since the advent of ego psychology at the latest, psychoanalysts no longer classify symptoms and neurotic impairments of experience and behavior descriptively alone(as in the DSM-IV or the ICD-10(but also in connection with the level of personality organization, which can be defined in terms of structural competencies such as the ability to view oneself and others in a differentiated way, to name, differentiate and tolerate affects, to control and tolerate sexual and aggressive impulses and so on (Blanck and Blanck 1985, OPD working group 1996, cf. also preface). The development of the borderline personality inventory (BPI, Leichsenring, 1997) has created a self-evaluation instrument(now used internationally(which makes it possible to measure the structural criteria of personality organization in the sense of Kernberg (1981) (level of defense mechanisms, identity integration, reality checking). The BPI has shown itself to be reliable and valid in several studies (Leichsenring, 1997, 1999 c; Leichsenring et al., 2003).

Rating of structural level from the viewpoint of the examiner/therapist is described in the diagnostic system OPD, operationalized for the axis “structure”; as a practical support a structural check list is provided. The practicability of the OPD structural rating is considered particularly good, receiving what are comparatively the highest reliability scores in this area (Rudolf et al 1998, 2002)

Special pathology

The special pathology of psychoanalysis has at its command today an ever-expanding body of knowledge on reactive disorders, neurotic disease pictures, psychosomatoses, addictions and posttraumatic neuroses (Ahrens 1997; Ermann

2004, Hoffmann and Holzapfel 2000, Senf and Broda 2005). On the one hand our picture of the etiology and psychogenesis of specific disease pictures continues to gain precision; on the other hand, diagnostic subgroups for certain diseases have been distinguished in particular through psychodynamic differentiations and the consideration of structural levels. Thus, Will et al. (1998) distinguish psychotic depression with disintegrated personality structure, borderline depression in the context of severe personality disorders with minimally integrated structural level, depressive neuroses and depressive personalities on an average structural level with moderately integrated personality structure, depressive neuroses and depressive personalities on an oedipal-neurotic structural level with well integrated structure, and depressive reactions to stressful life situations in the context of generally well integrated structure. An empirically well-founded distinction between anaclitic and introjective depression offers the possibility for a differential therapeutic evaluation (Blatt 2004; Blatt et al. 1995, 1998). Quint (1984, 2000) distinguishes an obsessive-compulsive neurosis of the quasi-classical type with moderately integrated structure from obsessive-compulsive disorders believed to serve as a preventative to psychosis and help control an extremely low sense of self-worth .

Psychoanalytic treatment technique

In over one hundred years, psychoanalysis has built up a productive and differentiated body of treatment knowledge in dealing with the working alliance, free association, psychoanalytic attitude, transference, countertransference, resistance and termination (Thomä and Kächele 1985, 1988; Mertens 1990). In the first half of the 20th century, of course, the treatment technique for neuroses was dominant, i.e. for mental illnesses on a relatively high structural level. Following a growing shift in theoretical interest and indications to “early disorders,” i.e. to disease manifestations such as psychoses, borderline disorders, personality disorders, psychosomatoses, addictions and perversions, the foundations of which are generally laid in the first three years of life, it became evident that other forms of the analytic relationship must be considered and conceptualized in psychoanalytic therapy. Thus alongside of the “as-if” world or the “micro-world” of transference, there is also a relationship regulation based on nonconscious implicit relationship knowledge. In early disorders this relationship regulation has been disturbed and impaired by a great variety of causes (Moser 2001).

In this way it also became increasingly obvious that transference interpretations and the emotional insight resulting from them are predominantly significant in the domain of the transference micro-world (intra- and extraanalytic transferences and resultant distortions in the context of autobiographical knowledge and its consequences for perceiving and structuring relationships), but not for the domain of the fundamental relationship regulations, which is formed by non-verbal, sensory and affective aspects of interaction and communication (Sander et al. 1998, Stern et al. 1998, Schmidt 2003, Ermann 2005). Impaired or deficient relationship regulation arises chiefly out of an inability to appropriately decode affects in oneself and other people (Krause 1983, 1997) and to regulate affects, as well as due to the partial fixation on the equivalence mode of psychic reality, which hinders a reality-based thinking process (Fonagy and Target 1996, 2000, Target and Fonagy 1996).

From the standpoint of treatment technique, the entanglement of relationship regulation with the transference micro-world is taken into account by the introduction of modified strategies, as for example by use of the specific technique of transference-focused psychotherapy (TFT) for borderline disorders according to Kernberg et al. (1993), Yeomans et al. (2002) or with various forms of short-term therapy such as the specific psychodynamic short-term therapy of personality disorders developed by Tress et al. (2003), as well as with specific traumatherapeutic treatment approaches for posttraumatic stress disorders. Imaginative and creative processes long known to analytic child therapy are now increasingly employed in psychotic illness (Benedetti 1983) as well as in supportive psychotherapy for severe somatic diseases and above all in inpatient psychotherapy.

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7. Proving the Efficacy of Psychoanalytic Therapy

7.0 Clinical case studies (U. Stuhr)

a) Historical Starting Point

It was, in Freud's words, the "nature of the subject" and not his preference as a scientifically trained neuropathologist that motivated him (1895b, SE II p. 160) to adopt the narrative method as his chosen form of presentation. Since then countless colleagues have followed this method drawn from the beginnings of psychoanalysis, a representative 50-year sample of whom is listed by Kächele (1981) (see table 1). This development, although it registered a growing number of published case studies, could not be continued uniformly in this manner and requires a differentiated examination.

Table 1 (cf. Kächele, 1981)

Author	**Case**	**Date of treatment**	**Duration**	**Date of Publication**	**Type of Record**	**Length (page count)**
Adler	"Fräulein R."			1928	after-session notes	146
Taft	7-year-old boy		31 sessions	1933	in-session notes	161
Wolberg	42-year-old man "Johan R."	1940	4 months	1945	after-session notes	169
Berg	young man	ca. 1940		1946	in-session notes	ca. 240
Sechehaye	18-year-old woman "Renée"	1930	10 years	1947	after-session notes	107
Deutsch	28-year-old man	ca. 1948	14 sessions	1949	verbatim transcript	140
McDougall/Lebovici	9-year old boy "Sammy"	1955	166	1960	in-session notes	270
Klein M	10-year-old boy "Richard"	1944	93 sessions	1961/ 1975	after-session notes	490
Thomä	26-year-old woman "Sabine"	1958	304 sessions	1961	after-session notes	70
Parker	16-year old boy	1955	200 sessions	1962	after-session notes	355
Bolland / Sandler	2-year-old boy "Andy"	ca. 1960	221 sessions	1965	after-session notes	88
De Boor	22-year-old man "Frank A"	ca. 1960	580 sessions	1965	after-session notes	30
Pearson	12-year-old boy "adolescent"		6 years	1968	after-session notes	140

Milner	23-year-old woman "Susan"	1943-1958	15 years	1969	after-session notes	410
Dolto	14-year-old boy "Dominique"	1968/1973	12 sessions	1971	after-session notes	160
Balint	43-year-old man "Mr. Baker"	1961/1962	29 sessions	1972	after-session notes	130
Dewald	26-year-old woman	ca. 1966	304 sessions	1972	in-session notes	620
Winnicott	30-year-old man	ca. 1954		1972	after-session notes	
Argelander	35-year-old man		ca 600 sessions	1972	after-session notes	75
Stoller	30-year-old woman			1973	in-session notes	400
Winnicott	2--year-old girl "Jiggle"	1964	14 sessions	1978	after-session notes	200
Firestein	25-year-old woman			1978	after-session notes	30
Goldberg	25--year-old man "Mr. I."			1978	after-session notes	108
Goldberg	31-year-old woman	ca. 1966	ca. 600 sessions	1978	after-session notes	98
Goldberg	22-year-old man "Mr. E."	ca. 1972	2 years	1978	after-session notes	134
Ude	6-year-old girl	ca. 1975	2 years	1978	after-session notes	160

The tensions inherent in the contradiction between the narrative approach and scientific explanations held sway to the very end of his creative life (Freud, 1940) and even today occupies psychoanalysts among themselves (e.g. A. Green, 1996 or in the “Open Door Review”: the ‘Anglo-Saxon’ vs. the ‘French’ position, Fonagy, 2002). It would be reasonable to expect these problems to manifest themselves in the composition of case studies as well. Freud himself pointed again and again to the particular nature of his psychological object, “... a special factor inherent in the subject itself; for in psychology, unlike physics, we are not always concerned with things which can only arouse a cool scientific interest” (Freud, 1938/40, SE XXIII, p. 197). Or again: “A physicist does not require to have a patient in order to study the laws that govern X-rays. But the only subject-matter of psycho-analysis is the mental processes of human beings and it is only in human beings that it can be studied” (Freud, 1927, SE XX, p.254). In claiming analysis as their own (cf. Kerz-Rühling, 1993), hermeneutically oriented scientists and philosophers often take sustenance from the indication that the therapeutic dyad is a matter of textual interpretation, just as demanded in hermeneutics, only that the text in analysis is a human being. To the extent that a one-person-psychology is elaborated into an intersubjective two-person-psychology, one can agree with Gill (1997, p. 87) that “the human text answers.”

While this can be understood from a constructivist perspective on analysis, it cannot be in a one-person psychology.

If, like Freud, one refers to the therapeutic dyad—the field that applied psychoanalysis exists for and lives from as a therapeutic technique—then an understanding of this interaction and its psychic processes is the crucial therapeutic and research object of depth psychology; and the aim is to be able to make reliable statements precisely about this therapeutic interaction. If, as in the present context, one wishes to demonstrate the scientific efficacy of the therapeutic technique in a transparent manner, there is no way to avoid setting this interaction in relation to therapeutic success; and so it is in this chapter on clinical studies. Similarly, in Freud's famous "inseparable bond between cure and research[22]" it is not just a matter of a dialectic connection between therapy and research but also of a connection to "beneficent results," i.e. to the therapeutic success of the analytic process.

b) Differentiating: new scientific challenges to case studies

The beginning of modern psychotherapy research, which is associated with the work of Eysenck (1952) (Kächele, 1986, p. 309), likewise appears to derive from statements made by Freud in his "General Introduction to Psychoanalysis" (1916/17) (cf. Rachman and Wilson, 1980, p. 21). Here he states his opposition to a statistical measurement of success, objecting "that statistics are worthless if the items assembled in them are too heterogeneous; and the cases of neurotic illness which we had taken into treatment were in fact incomparable in a great variety of respects" (ibid., SE XVI, p. 461). Freud repeats this argument in his "New Introductory Lectures on Psycho-Analsysis" (Freud, 1933, SE XXII): "[T]oday I shall inquire how much it [psychoanalysis] achieves." "At one time a complaint was made against analysis that it was not to be taken seriously as a treatment since it did not dare to issue any statistics of its successes. ... But statistics of that kind are in general uninstructive; the material worked upon is so heterogeneous that only very large numbers would show anything. It is wise to examine one's individual experiences" (ibid., p. 151-2). Eysenck brought the discussion onto the level of the "very great numbers" mentioned by Freud, and to an even greater extent it was updated by

[22] "Junktim zwischen Heilen und Forschen" - Freud, 1927, p. 299); English from SE vol. XX, p. 256, in the Postcript to "The Question of Lay Analysis."

Grawe (1994, p. 309) and now dominates psychotherapy research. This has surely not been without effect on the analytic movement and is also reflected in the other chapters of this compendium of the DGPT: the individual experience of clinically active therapists, valuable as it is, must be scientifically complemented and the clinical case studies themselves must be systematized in order to improve the basis for the use of case studies as scientific evidence.

Freud's narrative approach, so fruitful historically, is of itself no longer in a position to provide a justification for the existence of analysis today, even if it plays a critical role for members of the "analytic community" as a didactic aid and a formative element of their identity (cf. Leuzinger-Bohleber, 2000). Case reports, after all, can be a stimulating and instructive means of communication (Overbeck, 1994). Beyond this, it would be important to address the issue of the use of the short story *genre* as a scientific case presentation, if not by getting rid of it entirely ("Nieder mit der Fallnovelle als Psychoanalysedarstellung,"[23] Meyer, 1993), then at least by transforming it into a well-founded analysis of therapeutic interaction or into a single case study (cf. Deneke and Stuhr, 1993).

Thus we have now seen attempts to improve the scientific standing of case studies, yet in essence these all revolve around the question whether the therapeutic interaction is to be objectivized (e.g. categorized) or summarized in narrative form.

In spite of the primarily narrative structure of clinical case studies, it clearly makes sense to strive towards integrated and scientifically more objective statements by combining them with quantitative measures, particularly categorical data analysis, the one supporting the other in a complementary fashion. On the background of economic and health-care policy issues (e.g. which therapeutic techniques are to be recognized as guideline-conforming and compensated by the German health care system), the "tension-filled contradiction" inherent in clinical studies has only intensified and brought us to the point where each research approach—that of the clinical case study included—is always judged by whether or not results obtained by a certain method support a certain school of therapy. Hence too this strategy is now more intensively subjected to classical test theory criteria for scientific validity and not just to the preferences of analysts. After all, it is also a matter of convincing opponents of one's own therapeutic direction as well as financial supporters (e.g. in

[23] "Down with the case story as a presentation of psychoanalysis."

the Scientific Advisory Board for Psychotherapy).

An overview of international endeavors (e.g., analysis of transference intensity, Graff & Luborsky, 1977; the Menninger Project, Wallerstein, 1986; analytic processes in juvenile diabetes, Moran and Fonagy, 1987; long-term psychoanalysis of the Mrs. C. case, Jones and Windholz, 1990; change in transference constellations, Dahl, 1988; Dahl and Teller 1994) has recently been compiled by Rennie (2004) for the English-speaking world from the perspective of qualitative research within psychotherapy research.

In this way the question of the relevance of the clinical case study becomes embedded in a far broader epistemological debate over "quantitative vs. qualitative research," in which the clinical case study is necessarily drawn into qualitative research. In their conclusion on the development of qualitative research in the psychotherapy of German-speaking countries, Frommer et al. (2004, p. 68) emphasize the "use of hermeneutics and the ideal type approach in methodology" and the application of particular methods such as qualitative content analysis, objective hermeneutics and psychoanalytic understanding. Testimony to the importance of qualitative research and thus too of the clinical case study is found not only in the journal *Psychotherapy Research* of the Society for Psychotherapy Research, but also at its congresses and meetings, at which German-speaking scientists engage in a cooperative debate with scientists of the English-speaking world (e.g. Elliot, Stiles, Shapiro and Rennie; cf. also Russells, 1994) on the question of qualitative research. Rennie (2004, p. 35) brings the challenge of the clinical case study to a point in his central message that in the past 35 years the social sciences have developed alternatives to statistical analysis and shown that meaningful material is more adequately expressed in words than in numbers.

With these considerations in mind, it makes sense to undertake a differentiation in order to distinguish and contrast the various streams in clinical case studies. A guide to this process might be: from the heuristic single case study, to the hermeneutic-taxonomic phase, to the formalized clinical case study.

a) <u>Heuristic single case studies</u>

Regarding research within and for clinical practice—i.e. naturalistic research conducted under naturalistic conditions and on its conditions—alongside of the systematizing approaches to case studies outlined above (those of the Ulm and

Hamburg groups) we must also mention the approaches cited as case studies by Leuzinger-Bohleber (1995, 2000) and by Frommer et al. (2004, p. 69). These envision primarily a “deepening of our understanding of subjective experience and interaction in psychotherapy” and generally serve the cause of an open and pluralistic discourse within the psychoanalytic community—an aim which they intend to achieve by communicating particularly exemplary case histories that might be designated as “dialectic” (Fischer 1989) or even “dramatic” (Boothe 1994). In the realm of inpatient psychotherapy as well (Senf and Heuft 1994, Ruff and Leikart 1999), we find case studies on the course of therapy and on the follow-up, bringing the discussion beyond linear models to new ideas or models of psychotherapeutic processes—a chief future task of qualitative research. For its historically significant and pioneering work, the research group in Tiefenbrunn (Buchholz and Streek 1999) must not go unmentioned here. Through this and by its publication of the journal *Psychotherapie und Sozialwissenschaft*, it has cultivated this field of interaction by context, conservation and metaphor analysis in the psychoanalytic setting (e.g. Buchholz 1996 and Streek 1999b), highlighting individual foci of the interaction in psychotherapy and drawing these into clinical case studies or simply into vignettes—which, however, are particularly susceptible to a selective presentation of partial aspects (cf. Streek 1995).

Here follow-up research also takes on particular significance, since the complexity of the long posttherapeutic period cannot be captured in simple designs and it is possible to approach it by way of case-related presentations (cf. Kühnlein 1999, Wachholz and Stuhr 1999). Beyond the realm of numbers it also becomes possible to gain a clinically lucid impression of failure research, which is of great importance because it is so often withheld (cf. Stuhr et al., 2005).

If it is true that psychological meaning is best objectified through language, spoken or written, then understanding and text must remain our central research objects (cf. Rennie 2004), particularly if we wish to continue to base our work on unconscious processes and their comprehension.

Thus, if from a structuralist/theory-of-science perspective one can assume a correspondence between object and research method, then we remain bound by the same circumstance which already forced Freud not to follow his scientific inclination—physics and its methods—but to apprehend the object in order to be able

to make valid statements; for it is the object, the subjective factor, that determines the methodology (cf. Stuhr 2004). What is more, we all learn from cases (cf. Overbeck 1994, Moser 1991). Out of the plethora of clinical case studies, which often have their origin in the inclinations or even the problems of the analyst, we shall select several specific exemplary themes: dreams in early disorders (Schwabel, 1989), processing an incest trauma (Kögler, 1991) and psychoanalytic treatment of a woman with cancer (Calogeras and Berti, 1991). The particular opportunity offered by the case study lies in the creative and communicative aspect of this technique, i.e. its heuristic value. This becomes clear especially in areas that are of current scientific interest and require a subjective complement (e.g. neurobiology, Leuzinger-Bohleber and Pfeifer 1998) or where there is a need to make up for missed development (e.g. psychotherapy in the aging, cf. Radebold and Schweizer, 1998). Admittedly these approaches serve “only” to generate hypotheses, but this is the creative part of science and we cannot dispense with it any more than we can dispense with the testing of hypotheses. This is true of every therapeutic direction, which means that it is a necessity and an obligation for us to lead the debate on this plane as well. Of course this survey cannot undertake an exhaustive treatment of all aspects of case studies, but as long as there is a depth psychology we will continue to face the considerable challenge of taking the unconscious into account in the process of therapeutic interaction without sacrificing it, and its highly subjective processes, to the need for scientific recognition. The continued development of science—psychotherapy included—has often been connected with scientists who were prepared to “look beyond their own noses” and consider aspects which might only become relevant in the future. The case studies offer us a particular opportunity in our clinical discussions to continue considering hypothesis-generating and hypothesis-confirming strategies that may be frowned upon or opposed by science, as for example use of the hermeneutic circle alongside of evidence-based criteria.

The meaning of subjective experience for an individual is revealed in language, which is why linguistics (cf. Dröschner 1999) is of great relevance in the presentation and analysis of case studies (cf. also Level IV of the Ulm Group (linguistic computer-assisted text analysis, e.g. Beermann, 1983; Kächele, 1983). The clinical case study will continue to exist in the field of tension between a strategy aiming at objectivity and a more “dramatic” configuration of the case study. It is certain, however, that the clinical case study will continue to live on in practice and contribute its heuristic

potential for new paradigms to science, as long as this is done thoughtfully and remains in an open discussion (e.g. Guthrie 2000).

b) **Hermeneutic-taxonomic single case analysis**

In its quest for an appropriate research strategy in psychoanalysis, the Hamburg working group seeks to design case studies which, while remaining close to clinical practice and based on processes of understanding, aim at insights transcending the individual case. In other words, they strive towards clinically realistic generalization within the framework of a taxonomy (Stuhr 1996).

From rhetoric we know of figures of speech (the paradox, the oxymoron etc.), which occur in our patient reports but for the most part cannot be logically formalized or operationalized. Thus it is not necessarily the complexity of the object so much as the compelling requirement for unambiguousness in operationalism, with its formal-logical structures in the empiric strategies of psychotherapy research, which sets up boundaries and may have forced Freud the scientist to turn “unwillingly” to the narrative as a form of presentation. One supposes that he could have chosen a physical or a more exact, algorithmic presentation form, as he suggests in his “Project for a Scientific Psychology”[24] (1895c).

This is also why philosopher of science Toulmin (1991) laments the fact that a humanistic acknowledgment of uncertainty and ambiguity is suppressed by the strictures of logic in scientific presentations. The “subject” refuses to tolerate anything in its perception that is not in its consciousness (or could be integrated into it) in order to maintain a self-consistent world devoid of contradiction—in other words, a world susceptible to mathematization. According to Adorno (1973), however, this method has liberated itself from its object, replacing the once-vivid experience of the object with a set of conceptual abstractions. Adorno therefore pleads in favor of a retreat from concepts that abstractly objectify everything. Thus to the Hamburg working group it seems critical to preserve concreteness and vividness within a research strategy which at the same time strives to yield results of more general validity (Stuhr, 1995). The Hamburg approach, based on a taxonomic-scientific understanding (Stuhr, 1996), aims to find a connecting link between the nomothetic and the idiographic approaches, which Kächele (1981) and Gerhardt (1986) locate in the concept of the type. In the Hamburg working group the concept of Max Weber’s

[24] "Entwurf einer Psychologie”

(1904) ideal-type approach was developed into an empirical research method, “die Verstehende Typenbildung”[25] Gerhardt, 1986), in the framework of a taxonomic conceptual model (Meyer 1971, Stuhr, 1996, Stuhr et al., 2001). As part of a follow-up project (Meyer et al., 1988) making use of this qualitative method of “die Verstehende Typenbildung,” Wachholz and Stuhr (1999) were able to demonstrate the importance of the therapist as an introject and to validate this in quantitative terms. This research strategy was then further elaborated and also validated (Stuhr et al., 2001, Deneke et al., 2003) in the Hamburg working group and is now being applied to cases of long-term psychotherapy (Stuhr et al., 2002). In this approach, however, the single cases form a corpus which becomes accessible to understanding and taxonomic ordering through a series of formal methodological steps.

c) **Formalized clinical case studies**

In the work of the Ulm group, the case of “Amalia X” is considered a model example of the advantages of a single case analysis study, although it must be added that there was a clear ICD diagnosis and independent standardized initial and final measurements. The manner in which the therapy processes were chronicled—first tape-recorded and then transcribed in verbatim transcripts (cf. Mergenthaler and Kächele 1994)—paved the way for a great number of further partial studies and so to a clinical case study project that was unique in the entire world. This was conceptualized on four planes: I clinical case study, II systematic clinical description, III conceptional clinical assessments (listed below), IV linguistic, computer-assisted textual analysis (cf. Kächele and Thomä, 2005).

- Change in emotional insight (Hohage u. Kübler, 1988)
- Changes in self-esteem and suffering (Neudert et al. 1987; Neudert and Hohage 1988)
- Changes in dealing with dreams (Leuzinger-Bohleber, 1987, Leuzinger-Bohleber and Kächele, 1990)
- Change in transference relationship in the CCRT (Albani et al. 2003)
- Change in reaction to interruption (Jimenez and Kächele 2002)
- The unconscious plan according to the Control Mastery Theory (CMT) and application of the Q-Sort by E. Jones (Albani et al. 2000)

[25] This has previously been rendered in English as “forming types by comprehension.”

- Change in verbal activity during the therapeutic process (Kächele, 1983)
- The adult attachment interview as a retrospective (Buchheim and Kächele, 2003)

This fruitful example of combining qualitative and quantitative approaches in the case of “Amalia X” has a history going back to Thomä’s insistence that the investigation of interaction is an appropriate research topic in psychoanalysis (Thomä, 1974, p. 383). He describes it as “no small satisfaction” for him to be able to assert that “single case studies [are] the form of scientific study that is particularly appropriate in our case” (ibid. p. 382). This was also the conclusion of Strupp (1986, p. 86), drawing the balance on his lifetime of scientific work with an exhortation to “return to single case studies.” This combination of exactness and methodological refinement could be a key source of new insight and raise single case studies, in their central heuristic function, to a high position in therapy research (Elliott, 1999). In a planned compendium of many partial studies, Kächele and Thomä (2005) come to the conclusion that discoveries based on these case studies cannot be made by practicing psychoanalysts, since as participating observers they would be prejudiced by involvement in the process. They recommend that researchers and therapists each be trained in the other’s skills, thus promoting cooperation towards a form of research that can show the way out of the momentary crisis in psychoanalysis.

Also possible are clinical case studies that are subjected to systemization and objectification—in part based on the studies of the Ulm Working Group of Thomä and Kächele, in part following a qualitative categorical assessment, e.g. the CCRT method of Luborsky and Crits-Cristoph (1998) focusing on the transference relationship. Here, the frequency of the category of the CCRT takes on central importance, while narration no longer occupies a prominent position in this kind of single case study (e.g. Albani et al. 2002). Such systemization of clinical case studies for purposes of objectification was undertaken in an especially exemplary fashion by taking a session—number 290 in the long-term analytic psychotherapy of a patient with neurotic depression—and testing and comparing different evaluation paradigms based on this one analytic session (cf. Deserno et al. 1998). Alongside of the chief analytic technique introduced, the CCRT, which serves as a measure of relationship patterns, other evaluative techniques as well were put into effect: the “BIP” technique (Experiencing the Relationship in Psychoanalysis[26]), which is a

[26] Beziehungserleben in Psychoanalysen

German offshoot of the PERT technique (Patient's Experience of the Relationship with the Therapist, Gill and Hoffmann, 1982) and "FRAMES" (Fundamental Repetitive and Maladaptive Emotion Structures). This comparison undertook to establish the scientific validity of these single case study techniques as a way of testing clinical validation methods (cf. Berns and Hemprich 2001). The groundwork for this endeavor was laid mainly by the Ulm textbank, which developed a specific procedure for transcribing the text of therapy sessions in verbatim transcripts following definite rules (Mergenthaler and Kächele 1994), thus making it possible to enhance of scientific validity of the clinical case study through a systematic innovation.

7.1 Studies on the Efficacy of Psychoanalytic Therapy in Adults (F.Leichsenring)

Efficacy Research – preliminary remarks on procedure and methodology of efficacy research

Efficacy studies of psychoanalytic therapy are presented here in reference to the areas of application established by the Scientific Advisory Board (WBP[27]). No exhaustive review or discussion of the literature has been attempted. The current status of research on psychoanalytic therapy is not comprehensively presented. The aim has been to present the minimum required number of studies fulfilling the criteria established by the WBP for acceptable efficacy studies. Also included are meta-analyses, which provide higher-order proofs of the efficacy of psychoanalytic therapy. Adult and child/adolescent psychotherapy are presented separately.

Degrees of evidence are ranked here in relation to the randomized and controlled study (RCT), which is regarded as the "gold standard" by the American Psychological Association Task Force (1995; Chambless and Hollon 1998). From this point of view, proof of efficacy is obtainable exclusively by means of RCTs (APA Task Force 1995; Chambless and Hollon 1998). The RCTs claim to absolute authority is increasingly subject to question (Seligman 1995; Persons and Silberschatz 1998; Beutler 1998). This, however, is not the place for an exhaustive discussion of the issue. The aim here is merely to consider certain central aspects that are significant in demonstrating the efficacy of psychoanalytic therapies (Leichsenring, 2004): RCT´s demonstrate the efficacy of therapies under laboratory conditions in which such aspects as the selection of patients, die manualization of the therapeutic process, the selection and training of the therapists or the length of therapy are strictly controlled. Naturalistic studies, in contrast, demonstrate the efficacy of therapies under the conditions of actual treatment practice. RCTs examine not the forms of psychotherapeutic techniques as actually practiced, but specific forms of these techniques that are tailored to controlled laboratory conditions (selection of patients, therapists, manualization, length of therapy, etc.). Thus altered forms of psychotherapeutic

[27] Wissenschaftlicher Beirat Psychotherapie

techniques are studied. This is true of psychoanalytic therapy as well as behavioral therapy and other forms of therapy when these are tested in RCTs. In this sense the psychotherapeutic techniques applied in RCTs can be described as laboratory forms of psychoanalytic therapy: concepts relevant to treatment theory such as regression, transference, resistance, as well as the type of intervention, are adjusted to the conditions of the controlled study, which include the length of therapy. Because of this difference, evidence of efficacy obtained in RCTs cannot be directly applied to the practice of psychotherapeutic care. For evidence of efficacy of psychotherapeutic techniques as actually practiced, naturalistic studies are required. For this reason, results on the efficacy of psychoanalytic therapy derived from naturalistic studies offer important evidence for its efficacy in practice. Such practice-related research is better represented in the psychoanalytic branch than in other forms of therapy including behavioral therapy, which is stronger on laboratory research (RCTs). For these reasons the present documentation includes results from naturalistic studies, which provide the evidence of efficacy that is so crucial in practice.

7.1.1 Depression (ICD-10 F3)

A number of RCTs testify to the efficacy of psychoanalytic therapy in depression (Hersen et al. 1984; Thompson et al. 1987; Gallagher-Thompson et al. 1990; Gallagher et al. 1994; Shapiro et al. 1994, 1995; Barkham et al. 1996). According to the results of a recent meta-analysis, psychoanalytic therapy and cognitive behavioral therapy (CBT) are equally effective in treating depression (Leichsenring 2001). The study, measuring pre-post differences in the sense of Cohen (1988), showed psychoanalytic therapy to be highly effective in reducing depressive symptoms (0.90 - 2.80) as well as general psychiatric symptoms (0.79-2.65). In two RCTs, psychoanalytic therapy combined with psychopharmacotherapy was found to be more effective than psychopharmacotherapy alone (de Jonghe et al. 1999; Burnand et al. 2002).

Note: The studies on interpersonal therapy of depression (e.g. DiMascio et al. 1979 and Elkin et al. 1989) are not cited here although this would have a certain justification. Thus, therapists conducting IPT in the NIMH study were required to have training in psychodynamic therapy (Elkin et al. 1985, 307, 308). However, empirical investigation of the NIMH study has shown that the interventions conducted in the IPT group corresponded best to prototypical interventions of CBT and that the

interventions typical of CBT correlated most highly with therapeutic success (Ablon & Jones 2002).
In a new meta-analysis short-term psychodynamic therapy was found to be equally as effective as CBT in a variety of psychiatric disorders (Leichsenring, Rabung & Leibing, in press)

7.1.2. Anxiety Disorders (ICD-10 F40-42)

In an RCT by Zitrin et al. (1983) and Klein et al. (1983) on the treatment of agoraphobia, mixed phobia and simple phobia, psychoanalytic therapy combined with imipramine was just as effective as behavior therapy plus imipramine (Klein et al. 1983, 141). This applied to all three forms of phobia, for which the authors conducted separate evaluations: ”In this study, contrary to our initial expectations, we found essentially no differences between BT ... and dynamically oriented ST in treating all three categories of phobia.... It was not that patients did poorly with BT; rather they did unexpectedly well with ST.”
In an RCT on panic disorder, psychoanalytic therapy combined with clomipramine was significantly superior to exclusive treatment with clomipramine at the 9-month follow-up in terms of prophylaxis of relapses (20% vs. 75%) and on a number of psychopathological measures (Wiborg and Dahl 1996). Immediately upon completion of the course of therapy, the two methods still appeared equally effective.
In a new RCT, short-term psychoanalytic therapy was found to be equally effective to CBT in the treatment of social phobia (Bögels et al. 2003, 2004).
In an open trial by Milrod et al. (2000, 2001) as well, psychoanalytic therapy in panic disorder showed significant improvements with large effects which proved stabile at the 40-week follow-up. Here as well success rates were high: 93% at the termination of therapy, 90% at the follow-up. In an open intervention study, Bassler and Hoffmann (1994) reported a significant reduction in (trait) anxiety, which remained stable at the 6-week follow-up. These results were found in patients with panic disorder as well as in patients with agoraphobia following 12-week manualized inpatient treatment. In an open manualized intervention study Crits-Christoph et al. (1995) were able to demonstrate significant improvements in patients with generalized anxiety disorder (GAD) following psychoanalytic therapy. The pre-post effect sizes were large (anxiety: 0.95-1.99), reaching the level reported for cognitive therapies (Crits-Christoph et al. 1996; Chambless and Gillis 1993). The success rate

too was relatively high (79%). On a sample of patients mostly suffering from anxiety disorders (60%), Svartberg et al. (1995) report a considerable effect of psychoanalytic therapy in reducing symptoms and a reliable and clinically significant improvement in 75 % of the patients.

7.1.3. Stress Disorders (ICD-10 F43)

In various controlled studies psychoanalytic therapy has been shown to bring significant improvements in post-traumatic stress disorders and adaptation disorders (Brom et al. 1989; Horowitz et al. 1984; McCallum and Piper 1990; Piper et al. 2001). In the RCT of Brom et al. (1989) on treating PTSD, psychoanalytic therapy (according to Horowitz) was just as effective as comparison conditions with behavior therapy (systematic desensitization), and both forms of therapy were superior to a wait-list control condition. In the RCT of McCallum and Piper (1990) on treating pathological grieving reactions to loss, psychoanalytically oriented group therapy was significantly superior to a control group. In another RCT by Piper et al. (2001) on the treatment of complex pathological grief reactions to loss, psychoanalytically oriented group therapy proved significantly more effective than a supportive group therapy. In the study by Horowitz et al. (1984), following psychoanalytic therapy the symptoms (pathological grief reactions) lessened to the level of the control conditions (random sample after loss of one parent). In patients with adaptation disorders (as per DSM-III-R criteria) as well, Holm-Hadulla et al. (1997) report large effects clearly exceeding those of an untreated control group. In an open intervention study of the effects of psychoanalytic therapy, Jones et al. (1988) demonstrated significant effects which remained stable after treatment.

7.1.4. Dissociative, Conversion and Somatoform Disorders (ICD-10 F44, F45, F48)

In five RCTs the effectiveness of psychoanalytic therapy in somatoform disorders was shown (Svedlund et al. 1983; Guthrie et al. 1991; Baldoni et al. 1995; Hamilton et al. 2000; Monsen and Monsen 2000). Psychoanalytic therapy was significantly superior to a control condition (”treatment as usual”, TAU). Follow-up studies after 1 to 4 years showed the therapy results to be stable. Svedlund et al. (1983) and Guthrie (1991) studied patients with irritable bowel syndrome, Hamilton et al. (2000) patients with functional dyspepsia, Monsen and Monsen (2000) patients with

somatoform pain disorder (ICD-10: F 45.4, DSM-IV 307.80) and Baldoni et al. patients with urethral syndrome (somatoform autonomic functional disorder of the lower or upper gastro-intestinal tract or the urogenital system, ICD-10 F 45.32, F 45.31, F45.34). In the (manualized) studies of Guthrie and Hamilton, interestingly, the patients had previously been through treatments which had proven ineffective. In these studies, it was also possible to demonstrate a significant and substantial reduction in pain symptoms. In the study of Monsen and Monsen (2000), for example, the (pre-post) effect in pain reduction was 1.35 (1-year follow-up: 1.20).
Marked effects of psychoanalytic therapy in somatoform (F 45) and psychosomatic disorders in the narrow sense (F 54) were also found in the studies of Junkert-Tress et al. (1999, 2001). Promising results are also reported by Sifneos (1984) in patients suffering from psychosomatic (functional) symptoms in addition to psychological problems. He reports an improvement rate of 92% (13/14). However, the results of Sifneos need to be confirmed on larger samples and using a number of reliable outcome measures. Both of these studies were open intervention studies.

7.1.5. Eating Disorders (ICD-10 F50)

Bulemia: Significant and stable improvements in bulemia with psychoanalytic therapy have been demonstrated in a number of RCTs (Fairburn et al. 1986, 1995; Garner et al. 1993; Bachar et al. 1999). On central bulemia-specific measures (binging, vomiting), psychoanalytic therapy proved equally effective to CBT. On the other hand, the studies of Fairburn et al. (1986) and Garner et al. (1993) found CBT to be superior to psychoanalytic therapy on certain measures of general psychopathology. In a follow-up study on the sample of Fairburn et al. (1986) using a longer follow-up period, however, psychoanalytic therapy, CBT and interpersonal therapy (IPT) were equally effective and all were superior on several measures to exclusively behavioral therapy (Fairburn et al. 1995, S. 309, 310). For a realistic evaluation of the efficacy of psychoanalytic therapy, follow-up studies are evidently indispensable. In the RCT of Bachar et al. (1999), psychoanalytic therapy was significantly superior to purely cognitive therapy and to a control group (nutritional counseling). This finding applies to a mixed sample of anorexia and bulemia patients as well as to the bulemia patients separately.
Note: Here again the studies on interpersonal therapy of bulemia (e.g. Wilfley et al.

1993, Fairburn et al. 1993) have not been cited although this might be justified in view of the connection between psychoanalytic therapy and interpersonal therapy.

Anorexia: To date three RCTs have been conducted on this topic: In an RCT by Hall and Crisp (1987), psychoanalytic therapy in anorexia nervosa achieved significant improvements at the 1-year follow-up; it was equally effective to dietary counseling in terms of weight gain and superior to dietary counseling on measures of social and sexual adjustment. In the RCT of Gowers et al. (1994) psychoanalytic therapy achieved significant improvements in psychological, social and sexual adjustment, and at the 1-year and 2-year follow-ups it proved significantly superior to a control condition (treatment as usual, TAU) regarding weight gain and BMI. In the RCT of Dare et al. (2001), psychoanalytic focal therapy (25 sessions on average) was significantly superior to a control condition (low contact, "routine" treatment, TAU). After psychoanalytic therapy one third (33%) of the patients no longer met the DSM-IV criteria for anorexia, while in the control group (TAU) the figure was only 5%.

7.1.6 Other Behavioral Anomalies Associated with Physiological and Physical Disorders (ICD-10 F 5)

No studies have been conducted on psychoanalytic therapy in this area.

7.1.7. Psychological and Social Factors in Somatic Disease (ICD-10 F 54)

In this area 3 RCT´s have been conducted: In an RCT by Sjödin et al. (1986), psychoanalytic therapy of three months' duration, which patients with peptic ulcers received in addition to medical treatment, was significantly superior to medical treatment alone at the 15-month follow-up. In an RCT by Deter (1986), psychodynamic (group) therapy was significantly superior to an untreated control group in the treatment of patients with bronchial asthma. The treatment lasted one year, making it closer to medium-term (see below) than short-term therapy.
In an RCT by Beutel et al. (2001) on overweight treatment, analytic therapy and CBT proved equally effective. The results of the study by Junkert-Tress et al. (1999, 2001) were referred to above.

7.1.8. Personality and Behavioral Disorders (ICD-10 F 6)

Significant improvements in personality disorders and behavioral disorders treated with psychoanalytic therapy have been found in a number of studies (Woody et al. 1985; Tucker et al. 1987; Karterud et al. 1992; Stevenson and Meares 1992; Hoglend 1993; Diguer et al. 1993; Winston et al. 1994; Munroe-Blum and Marziali 1995; Hardy et al. 1995, Antikainen et al. 1995, Monsen et al. 1995; Wilberg et al. 1998; Bateman and Fonagy 1999; 2001; Guthrie et al. 2001; Svartberg et al. 2004).

Seven of these studies are RCTs: In an RCT by Woody et al. (1983; 1987; 1990), psychoanalytic therapy was equally effective to CBT in treating opiate dependent subjects, and both techniques were superior to a standard treatment (drug counseling). The authors scored the results for patients with an additional antisocial personality disorder separately and combined the results of CBT and psychoanalytic therapy since there were no significant differences. In patients with an antisocial personality disorder and comorbid depression, psychoanalytic therapy (and CBT as well) produced significant improvements, which were almost equal to those produced in opiate-dependant patients who also manifested depression but no antisocial personality disorder (effects: 0.53 vs. 0.50, Woody et al. 1985, 1084). In drug-dependant patients with antisocial personality disorder who were not also depressive, however, both forms of therapy achieved minimal effects (0.18). Hence this study demonstrates the efficacy of psychoanalytic therapy (and CBT) in the treatment of opiate-dependant patients with an antisocial personality disorder and comorbid depression. In the randomized, controlled and manualized studies of Winston et al. (1994), psychoanalytic therapy was significantly superior to a control condition, and in the RCT of Munroe-Blum and Marziali (1995) psychoanalytic therapy achieved significant effects and was equally effective to an alternative therapy (interpersonally oriented group therapy). In an RCT by Hardy et al. (1995), psychoanalytic therapy produced significant improvements in depressive patients with a comorbid personality disorder. The psychoanalytic therapy achieved large effects both at the end of therapy (1.17) and at the 1-year follow-up (1.52) (data from Leichsenring and Leibing 2003). CBT produced somewhat larger effects (1.76 and 1.85). In the RCT of Bateman and Fonagy (1999, 2001) psychoanalytic therapy was significantly superior to a standard psychiatric treatment. In an RCT by Guthrie et al. (2001) on the treatment of patients who had intentionally poisoned themselves (factitious disorder, ICD-10 F 68.1), psychoanalytic therapy was significantly superior to a control treatment (“treatment as usual”) in terms of reducing suicidal thoughts and attempts

at self-injury.

In a new RCT, psychoanalytic therapy was found equally effective to CBT in treating Cluster C personality disorders (Svartberg et al. 2004). An ongoing RCT is comparing psychoanalytic therapy with CBT and supportive therapy (Clarkin et al. 2004).

Notes: In the study by Munroe-Blum and Marziali (1995), the interpersonal group therapy with which psychoanalytic individual therapy is compared is not psychodynamic therapy (cf. Leichsenring and Leibing 2003, personal communication with the authors). Thus, a form of analytic therapy is compared with another kind of therapy. Interpersonal therapy cannot be classed as a psychoanalytic therapy here any more than it could be above when applied to depression and anxiety.

In patients with personality disorders, Holm-Hadulla et al. (1997) also report large effects (as per DSM-III-R criteria) markedly above those of the untreated control group.

Leichsenring and Leibing (2003) conducted a meta-analytic study of the effects of psychoanalytic therapy and cognitive-behavioral therapy in personality disorders. For psychoanalytic therapy they found a total effect of 1.46. Differentiated according to self- and other-rated techniques, the effects were 1.08 for self-rating and 1.79 for other-rating. Specifically in treating borderline personality disorder with psychoanalytic therapy a total effect of 1.31 was found. In self-rated techniques the effect was 1.00, in the other-rated techniques 1.45. For cognitive-behavioral therapy a total effect of 1.00 was found. In self-rating techniques the effect was 1.20, in other-rating techniques 0.87. The effects of psychodynamic and cognitive-behavioral therapy are not directly comparable, however, as they are derived from studies which differ in terms of patients, therapists, therapy, outcome measurement and other variables.

7.1.9. Dependence and Abuse (ICD-10 F 1, F 55)

A number of RCTs demonstrated the effectiveness of psychoanalytic therapy in addictions: In an RCT by Kissin et al. (1970) on the treatment of alcohol-dependence, psychoanalytic therapy was found to be significantly superior both to an untreated control group and to treatment-as-usual (drug counseling). In an RCT by Sandahl et al. (1998), psychoanalytic therapy in alcohol abuse was found just as

effective as CBT. In the RCT by Woody et al. (1983, 1987, 1990) on treating opiate dependency, psychoanalytic therapy and CBT proved equally effective and significantly superior to a standard treatment. In another RCT as well, psychoanalytic therapy was significantly superior to a standard treatment (Woody et al. 1995).
In an RCT by Crits-Christoph et al. (1999, 2001) on the treatment of cocaine dependence, psychoanalytic therapy produced significant improvements and was equally as effective as CBT (each was combined with group drug counseling). It should be mentioned that both forms of therapy were inferior to a combination of individual and group drug counseling in terms of drug use; on psychosocial outcome variables, however, this difference was not found (Crits-Christoph et al. 2001).

7.1.10 Schizophrenia and Delusional Disorder

In an RCT by Karon and Vandenbos (1972), analytically oriented therapy with an average of 42 sessions was significant superior to TAU conditions (pharmaceutical treatment). This was also the case at the 2-year follow-up.

7.1.11. Mixed Samples

Beyond these examples, a number of RCTs demonstrate the efficacy of psychoanalytic therapy in diagnostically heterogeneous samples. In quite a few of these studies psychoanalytic therapy was significantly superior to a waitlist condition (Sloane et al. 1975, 1981; Siegel et al. 1977; Piper et al. 1990; Shefler et al. 1995). In the RCTs of Sloane et al. (1975, 1981), Pierloot and Vinck (1978) and Snyder and Wills (1989), psychoanalytic therapy was found equally effective to CBT. At the 4-year follow-up of the study by Snyder and Wills, psychoanalytic therapy was superior to CBT: Significantly fewer couples had separated (Wills, Snyder and Fletcher-Grady 1991). In another RCT Guthrie et al. (1999) showed that for “high utilizers of psychiatric services,” psychoanalytic therapy was significantly superior to a control treatment (TAU) in regard to reducing psychological stress and improving social functioning. Significantly, this result is also indicates that psychoanalytic therapy can reduce the cost of illness to the health care system. In the RCT of Brill, Koegler, Epstein and Forgy (1964), psychoanalytic therapy was significantly superior to a pharmacological treatment, a placebo condition and a wait-list control group. In the study by Dührssen and Jorswieck (1965), a random sample of patients treated with analytic therapy showed a significant decrease in hospital days compared to a

random sample of untreated patients. In fact, the patients who received analytic treatment actually had a lower level of hospital days than the general insured population.

In the studies of Sifneos (Sifneos et al. 1980; Sifneos 1990) and Holm-Hadulla et al. (1997) psychoanalytic therapy was significantly superior to a wait-list condition. In the studies of Rudolf et al. (1994) and Sandell et al. (1999, 2001) long-term psychoanalytic therapy produced greater effects than shorter-term therapy.

Note: Sandell et al. (1999, 2001) attempted to assign patients randomly to the various therapies. At a certain point it became evident that this was impossible to accomplish because the patients refused to be assigned randomly to a treatment. This shows that randomization is unsuitable for long-term therapies.

Other naturalistic studies of psychoanalytic therapy with mixed samples have been conducted by Keller et al. (1997), v. Rad, Senf and Bräutigam (1998), Leuzinger-Bohleber et al. (2001, 2002), Luborsky et al. (2001), Heinzel, Breyer and Klein (1998), Hartmann and Zepf (2002), Brockmann, Schlüter, Brodbeck and Eckert (2002) and Leichsenring, Biskup, Kreische and Staats (2003).

On a critical note it must be pointed out that of the 47 controlled studies cited here, only two (4%) are from German-speaking regions (Beutel et al., 2001; Deter et al., 1986). This obviously points to a great need for research.

7.2 Studies on the Efficacy of Psychoanalytic Therapy in Children and Adolescents (E. Windaus)

In the area of psychoanalytic therapy, there have been altogether 17 controlled studies or studies with control conditions in children and adolescents and 6 comprehensive follow-up studies. In addition several studies are still in the pilot phase, including the first RCT study in this area by Target, March et al. (2002). It is the studies that cover a wide spectrum of disorders (Winkelmann/Geiser-Elze et. al. 2003; Fahrig et. al. 1996) and the naturalistic studies (Fonagy/Target 1995, Lush et. al. 1991) that best demonstrate the efficacy of psychoanalytic therapy in the clinical field.

7.2.1. Affective Disorders (F30-F39) and Stress Disorders (F43)

The studies of parent-infant/toddler therapies are to be classed in this application area. As regulatory disorders, they are not uniformly captured by the ICD-10. The stress of the birth process and adaptation to the postpartum situation qualifies them to be classified in the area of affective disorders and stress disorders. This is a special situation in which the psychological disorder extends by pathogenic interaction to at least two individuals.

In this area there are three controlled studies (Robert-Tissot et al.1996, Cohen et al. 1999, Murray et al. 2003) which demonstrate the efficacy of analytic therapy. The Robert-Tissot study (n = 75 mother/child pairs) entailed randomized assignment to comparison groups receiving psychoanalytic or interaction-based treatment. During the treatment of the mothers in the presence of their infants, the psychoanalytic focus was the relation to the mother's past and her projections onto the child. The other treatment form focused on interaction dynamics. As a result it was determined that in terms of symptom change, both procedures achieve values matching those of a clinically unremarkable sample. In the psychoanalytic process there was a particularly notable rise in the mother's sense of self-worth, which had significant effects on her manner of relating to her child.

The study by Cohen et. al. (n = 67) compares a customary form of psychodynamic therapy with a specific psychodynamic approach focusing closely on affect in the

mothers experience while generally maintaining an attitude of therapeutic abstinence (the Wait, Watch and Wonder Method (WWW)). Both comparison groups were successful in long-term symptom reduction, decrease in maternal stress and in reducing intrusive behavior on the part of the mother. The outcomes of the WWW-method could be demonstrated immediately upon termination of therapy, while the psychodynamic method attained comparably stable values after six months.

The study by Murray et al. (n = 193) is a comparison study investigating the efficacy of non-directive, cognitive-behavioral and psychodynamic interventions in a representative sample of mothers with postpartum depression in regard to early relationship disorders between mother and infant. Although the mothers benefit from all interventions in the sensitivity of their perception in the first three months of life, the results were significant only in part. It is surmised that in large part the initial disorders between mother and child quite soon resolve themselves or fade away spontaneously, so that a change in them cannot be significantly attributed to any particular form of intervention applied. All three studies can be regarded as a differentiated proof of efficacy in a still-young research area.

Affective disorders, particularly depressive disorders, form no small part of the diagnoses in a number of studies with a mixed neurotic disorder spectrum. The controlled naturalistic study of Winkelmann, Geiser-Elze et al. (2003) cites 18.2% F3 and 4.2% F43 diagnoses, the follow-up study of Winkelmann, Hartmann et al. (2000) 12% neurotic (and somatoform) disorders, and likewise the controlled naturalistic study of Fahrig et al. (1996) who also list 12% adaptive disorders. Similarly, the prospective study of Target, March et al. (2002) contains complex emotional disorders with symptoms of depression. All of these studies underscore the high comorbidity rate with other diseases. In regard to depressive disorders, the retrospective study of Fonagy/Target (1995) indicates that when children display severe and broad-spectrum symptoms, they respond well to high-frequency treatment and less well to low-frequency. The two controlled naturalistic studies (Winkelmann/Geiser-Elze et al. 2003; Fahrig et al. 1996) demonstrate the efficacy of psychoanalytic therapy in affective disorders, in particular in depressive disorders and stress disorders.

The study with the largest partial sample of F3 diagnoses is the naturalistic study of Baruch/Fearon (2002). At 52.7% depressive disorders out of n = 151, one comes to a count of around 72 patients. Using validated and reliable measuring instruments,

the study undertakes an outcome measurement on three levels (mean change, clinical change, reliable change). In all three areas significant changes are found on internal and external measures. A large portion of the subjects clinically assessed as ill attain a cut-off value in the non-clinical range. However since this naturalistic study is not an RCT, it proves the efficacy of psychoanalytic therapy in affective disorders only in a limited way.

7.2.2. Anxiety disorders (F40-F42) and emotional disorders with onset in childhood and adolescence (F93)

These disorder pictures are the object of a number of studies. The controlled naturalistic study of Fahrig et al. (1996) speaks of childhood emotional disorder (24.8%) as the most frequent diagnosis made. When the classification neurotic disorder (12%) is added to this it amounts one third of the diagnoses for this application area, which in a sample of n = 133 comes to about n = 45. The study is controlled by a wait control group (p. 388). During the waiting period the finding for the treatment group showed no improvement. The study reports a large reduction in symptoms (by 91.7%) and improvements in the manifestations of the psychological conflicts. It reaches effect sizes between 0.58 and 1.74. On the total of the BSS-K, 75.9% reach the criterion “no longer clinically ill.” When all measures of success are taken into consideration, one may speak of a successful psychotherapy in 90% of all treatment cases, which corresponds to overall good efficacy.

The controlled naturalistic study of Winkelmann, Geiser-Elze et al. (2003) reports a 33.8% proportion of F40-F42 and F93 diagnoses (n = 24). Thus it contains one third anxiety and emotional disorders. The study represents a combined study design with a wait control group design and a prospective multi-level multi-perspective approach. The study demonstrates that in short-term therapy (STT) (25 sessions) 23.9% of the children showed improvement in the BSS-K total score, but due to comorbidity and severity of disturbance the other children required LTT. After one year 45.5% of the children receiving LTT have attained values comparable to those of healthy children. What is particularly notable about this study is that many preliminary psychometric studies were conducted to standardize the assessment instruments. Overall it was possible to demonstrate the efficacy of short-term analytic therapy in a representative sample for outpatient care in the framework of a controlled test design. The effect sizes determined (between 1.1 and 1.3) rank as high.

The study of Smyrnios/Kirkby (1993) is devoted exclusively to the diagnosis "childhood emotional disorder." A comparison of three randomly assigned test groups (LTT, SST and minimal treatment) comes to the result that four years after termination of therapy, there is no longer any difference to be discerned between the children treated with STT and LTT and that all three comparison groups achieved significant improvements. This conclusion is not surprising, as in child psychotherapy the developmental factor must always be considered as well. The study demonstrates the efficacy of analytic psychotherapy with numerous validated and reliable measurement instruments, but due to the absence of a "genuine" control group, its value as proof of efficacy is limited.

The study of Muratori et al. (2002) demonstrates the efficacy of short-term psychoanalytic therapy exclusively in emotional disorders with an experimental and control group (not an RCT), reporting significant improvements in symptoms and overall condition. The treated group showed significant improvements particularly in behavioral problems and externalizing disorders. Here as well, the duration and intensity of the treatment depends on the absence of comorbid influences.

Finally, the large retrospective study of Fonagy/Target (1995) on emotional disorders (n= 352) found that 58% of the patients returned to non-clinical values and 72% displayed a reliable improvement in general functional level.

7.2.3. Dissociative, conversion and somatoform disorders (F44-F45) and other neurotic disorders (F48)

The Heidelberg studies of Winkelmann, Geiser Elze et al. (2003), Fahrig et al. (1996) and Winkelmann, Hartmann et al. (2000) deal with a minimal percentage (below 10%) of this disorder picture. The study of Baruch/Fearon (2002) also contains somatoform disorder diagnoses, however there has been no disorder-specific study on this application area.

7.2.4. Eating disorders (F50) and other behavioral syndromes associated with physiological disorders and physical factors (F5)

In this application area as well, the Heidelberg studies contain indications on smaller diagnostic groups: Winkelmann, Geiser-Elze et al. (2003) report anorexia nervosa

and bulimia nervosa at a total of 7.0%; Fahrig et al. (1996) reports eating disorders at 9% and Winkelmann et al. (2000) at the same rate.
For the 18 – 21 age group (adolescents and young adults) there have been three RCT studies (Crisp et al.1991; Gowers et al 1994, Hall/Crisp 1987), which confirm the efficacy of psychodynamic psychotherapy in eating disorders. Alongside of improved weight and resumption of menstruation, improvements are reported particularly in the areas of psychosexual identity and social adaptation.

The controlled study of Moran, Fonagy et al. (1991) on diabetes mellitus belongs in this application area even if diabetes mellitus is not mentioned in the F chapter of the ICD-10. The study demonstrated that the HbA1c value could be significantly improved with high-frequency psychoanalytic therapy (3-4 sessions per week) in the short-term therapy technique in comparison to an untreated control group. The study leaves open the question whether the result reflects improved coping skills or more profound changes affecting the disease etiology.
On a large sample of children receiving inpatient treatment (n=170), Zimprich (1980) studied the efficacy of depth psychology-based psychotherapy in children suffering from a wide spectrum of psychosomatic disorders (enuresis, encopresis, asthma, neurodermatitis etc.). The control group consisted of n=100 patients who received pharmacological treatment. This study may be seen as demonstrating in particular the efficacy of inpatient analytic therapy in children. The therapy consisted of a combination of depth psychology-based individual and family or parent therapy with ergotherapy and elements of behavior therapy customarily applied in clinical inpatient child psychotherapy. The positive effect of the therapy on the clinical symptoms and behavioral syndromes was statistically confirmed. The group receiving pharmacological treatment displayed only 30% of the effect of the group receiving psychotherapy. The study also confirms that medication use in the treatment group went down in comparison to the control group. Finally, this controlled naturalistic study is based on routine care and the normal population of a children's hospital, making its results as evidence of efficacy particularly applicable to inpatient care practice.

7.2.5 Behavioral disorders (F90-F92, F94, F98) with onset in childhood and adolescence and tic disorders (F95)

The RCT study of Szapocznik et al. (1989) and the naturalistic study of Lush et al. (1991) are two studies which demonstrate the efficacy of analytic therapy in these disorder pictures. In a comparison of a non-therapeutic play group with a family therapy group and a psychodynamic child psychotherapy group, the Szapocznik study (n = 69, approx. 35 with behavioral disorders) shows that at an average treatment duration of 18 months the total score on personality features was superior in the group receiving psychodynamic treatment. Compared to the untreated control group, the analytic therapy group displayed significant improvements. This is all the more noteworthy in that significant improvements were found in a marginalized minority population (Hispanic boys in Florida).

The naturalistic study of Lush et al. confirms the efficacy of psychoanalytic therapy in children with severe emotional deprivation. Treatment was given to foster and adoptive children with the non-specific diagnosis of “severely deprived children,” which would correspond to the ICD diagnoses reactive attachment disorder of childhood (F94.1) and disinhibited attachment disorder of childhood (F94.2). The assessment summary states that beyond improvements in relationship capacity, learning and self-esteem, structural personality changes were also achieved.

In their retrospective study (n = 763), Fonagy/Target (1995) report on a subsample of 135 children with expansive (euphoric/delusional) affect disorders. Although improvements are noted here as well, compared with those achieved in emotional disorders, expansive disorders (coding according to DSM-III-R) show a smaller degree of improvement(a fact that is attributed to the severity of this disease picture.

7.2.6. Autistic disorders (F84)

Due to the protracted nature of these disorders and the rarity of the disorder picture, no large-samples studies are available in the area of autistic disorders. This makes it all the more important to have detailed single case studies. The investigations of Alvarez (2001), Ogden (1989) and Tustin (1972, 1986) contain numerous case reports on the psychoanalytic treatment of autism, however these do not constitute proof of efficacy meeting the minimum requirements for psychotherapy studies.

7.2.7. Personality disorders and behavioral disorders (F60, F62, F68-F69), disorders of impulse control (F63), gender identity disorders and sexual disorders (F64-F66, dependence and substance abuse (F1,F55) schizophrenia and delusional disorders (F20-29)

The as yet unpublished study of Fonagy, Gerber et al. (results gleaned from Fonagy 2002), focusing on 18-24-year-old adolescents and young adults, includes both axis-II diagnoses with narcissistic disorders and borderline disorders, as well as 20% patients who received inpatient psychiatric care (including self-injury patients). With a comprehensive array of measurement instruments (SCL-90, Beck depression inventory etc.) and high- and low-frequency comparison groups, the study found the high-frequency treatment group to be superior to the low-frequency one in achieving clinically significant changes and in symptom improvements.

Similarly, the group therapy studies of Lehmkuhl/ Lehmkuhl (1992) and Lehmkuhl et al. (1982) with pre-post-measurement (not an RCT) point to symptom reduction and clinical improvements in this disorder group. The diagnoses contain mainly mixed neurotic and expansive disorders.

7.2.8. Mental retardation (F7), organic mental disorders (F0) and developmental disorders (F80-F83 , F88 and F89)

In this area there is one comparative study. Heinicke/Ramsey-Klee (1986) examined and treated children with learning difficulties and reading problems associated with hyperactive and overanxious comorbidity (diagnosed according to DSM III), which would correspond to ICD-10 diagnoses of the F81 group. In a comparison of three frequency groups (comparison groups), the study produced the result that treatment success in terms of the performance variables was significantly greater and more lasting in the group receiving high-frequency treatment. This result applies in a wide spectrum to self-esteem, frustration tolerance, adaptability, and capacity for work and relationship. After a follow-up interval these values were determined only in the group of patients who had received high-frequency treatment.

Among the older, methodologically adequate efficacy studies with multiple clearly defined disorder groups, not all are cited in the different application areas. These include the studies of Dührssen (1964), Petri/Thieme (1978), Waldron et al. (1975) and Fonagy/Target 1995. They provide indications of high long-term efficacy for

analytic therapy, since the follow-ups were conducted after very long time intervals.

7.3 Naturalistic Studies (Leichsenring)

7.3.1 Proofs of the efficacy of long-term psychoanalytic therapy under naturalistic conditions (Leichsenring)

It has been mentioned that RCTs provide evidence of how effective a treatment method is under controlled experimental conditions. Since this evidence relates to idealized conditions that differ from those of clinical practice, however, it cannot be directly applied to clinical practice. The relationship between them is similar to that between basic research and psychotherapy research (Bunge, 1967; Westmeyer, 1978): just as the evidence of basic research cannot be applied to psychotherapy research(for example, applying learning theory to behavior theory(in the same way the findings of RCTs are not transferable to clinical practice. It requires proofs of efficacy on its own terms: in order to test how effective a treatment method is in clinical practice, studies are required under the conditions of practice (e.g. Westmeyer, 1982; Leichsenring, 2004a), i.e. naturalistic effectiveness studies. As naturalistic studies relate to the conditions of clinical practice, RCTs and naturalistic studies have different “intended applications” (Westmeyer, 1989; Leichsenring, 2004a). Moreover, for a variety of reasons the design of the RCT is not applicable to long-term (psychoanalytic) therapies (e.g. Seligman, 1995): it not ethically defensible to leave patients untreated for a protracted period of time. Furthermore, plausibly comparable conditions cannot be maintained over a long time period. Attempts to assign patients randomly to long-term psychoanalytic therapy vs. shorter therapy have failed (Sandell, 1999, 2001): the patients have resisted randomization. If the attempt were made to force randomization, the object of study would be destroyed in addition: patients who choose long-term psychoanalytic therapy are those with particular personality features (not diagnoses) (Rudolf et al., 1994). They are different from the patients who choose a shorter therapy: the former are characterized by a greater tendency to dependence, for example, while the latter show more pronounced autonomy (Rudolf et al., 1994). Even if the patients accepted random assignment to therapies, the object of investigation would still be seriously altered by the randomization: we would no longer be studying the patients with the therapeutic technique which they would have chosen in practice. The results of such a study would offer no evidence for how effective the particular method is on those patients with whom it is used in practice. Furthermore, patients in clinical practice do not as a rule suffer from a single (isolated) disorder. Multiple diagnoses

are the rule. This is supported by the data of epidemiological studies (e.g. Kessler et al., 1994): in the National Comorbidity Survey (Kessler et al., 1994), 80% of persons with psychological disorders were diagnosed with at least two psychological disorders, and three or more psychological disorders were determined in more than 50% (53.9% - 58.9%) of those diagnosed. Thus if a patient has been diagnosed with a depressive disorder, an anxiety disorder, a somatoform disorder and a personality disorder, the question arises to which of these various psychological disorders his data is applicable: to depressive disorders, anxiety disorder, somatoform disorders or personality disorders? They simply apply to patients with complex (Guthrie, 2000) disorder pictures characterized by high comorbidity. Hence to study isolated disorder pictures, as is customarily done in RCTs, makes no sense and s not representative of (most) patients in clinical practice. In this sense it is also doubtful to what extent the efficacy values determined in RCTs (Westmeyer, 1978, p. 124) can claim validity for clinical practice (Leichsenring, 2004 a). For this reason naturalistic studies usually focus on patients who have complex disorder pictures and are heterogeneous in their diagnostic classification. This is not a weakness of naturalistic studies vis-a-vis RCTs, but in fact a strength in view of their representativeness of clinical practice(providing, of course, that the sample is described with adequate exactness.

The Scientific Advisory Board of the Federal Medical Union /Federal Psychotherapists Union[28] has formulated minimum requirements for the assessment of efficacy studies in the area of psychotherapy. In the altered version following the board decision of 9.15.2003, studies published after 1.1. 1990 must (among other requirements) have a control group design characterized by randomized or parallelized study groups. In other words, studies are also permitted which have employed parallelization instead of randomization of the study groups.
In the area of long-term psychoanalytic therapy a number of such controlled naturalistic studies have been conducted.

7.3.1.1. The Study of Dührssen and Jorswieck (1965)

Studying a random sample of patients who had received psychotherapeutic treatment at the Institute for Psychogenic Illnesses of the Allgemeine Ortskrankenhaus (AOK) in Berlin, Dührssen and Jorswieck (1965) found a significant reduction in hospital

[28] Bundesärztekammer/ Bundespsychotherapeutenkammer

days when comparing the number of hospital days in the 5 years prior to the end of therapy with the 5 years following it. Contrastingly, this was not the case in a wait group drawn at random from the same population and not differing from the treated patients in their initial number of hospital days. Moreover, the samples were parallelized in regard to prognostically relevant variables (Dührssen & Jorswieck, 1965, p. 168). This result also speaks against the myth of spontaneous remission in psychological illnesses. Moreover, in the five years following termination of therapy the patients who received psychotherapeutic treatment recorded significantly fewer hospital days than a random sample of patients drawn from the general insured population who had no contact with the Institute for Psychogenic Illnesses of the AOK Berlin. Accordingly, the form of psychotherapy applied here led to a reduction of costs to the health system. The treatments applied were analytic and psychodynamic therapies with a duration from 150 to a maximum of 200 hours at a frequency of 2-3 sessions per week (Dührssen, personal communication of 6. 24.1996 and Dührssen, 1962). The data published by Dührssen and Jorswieck in 1965 can be used to calculate effect sizes (Leichsenring, 2002). Patients treated with psychotherapy showed an effect size of d=0.78, which is a large effect (Cohen, 1988). The comparison group, in contrast, showed an effect of only 0.06. A further study confirmed these results (Dührssen, 1986).

7.3.1.2. The Berlin Study (Rudolf et al., 1994)

A naturalistic study by Rudolf et al. (1994; Manz et al., 1995) looked at patients for whom analytic psychotherapy, psychodynamic therapy or inpatient treatment had been indicated. As the authors report, there were no differences among the three treatment groups in terms of their disease picture or severity of pathology. Patients who received depth psychology treatment, on the other hand, displayed less favorable sociodemographic and prognostic features and differed from the patients in analytic treatment in terms of disease behavior, therapy motivation and therapeutic relationship (Rudolf et al., 1987). The analytic psychotherapy was conducted at 2-3 sessions per week for an average of 265 sessions. In the psychodynamic therapy an average of 60 sessions were conducted. The inpatient therapy lasted an average of 2.6 months. In the global final evaluation by the patients, 96% of those treated on an inpatient basis indicated that the difficulties that had prompted them to seek psychotherapeutic treatment had improved. When the criterion for success of

therapy was defined as a clinically significant improvement in self-evaluation measures, the following percentages of improved patients were found (Rudolf et al., 1994): analytic psychotherapy: 76%, psychodynamic therapy: 55%, inpatient therapy: 50%. According to patients' self-evaluation, analytic psychotherapy produced large effects ((0.80) in the areas of (physical proximity) anxiety, depression, complaints of body symptoms, and contact anxiety (Rudolf, Manz & Öri, 1994). The largest effect of psychodynamic therapy appeared in the area of physical proximity anxiety (0.50). This was also true of inpatient therapy (0.60).

7.3.1.3. The Stockholm Study of Sandell et al.

Sandell et al. (1999, 2001) studied the efficacy of analytic psychotherapy and long-term psychodynamic therapy. As was mentioned above, attempts to assign the patients to the different therapy conditions at random had failed due to the patients' resistance. Analytic psychotherapy was conducted at a frequency of 3-5 sessions per week (n=24) and long-term psychodynamic therapy at 1-2 sessions per week (n=100). The mean duration of therapy was 54 months for analytic psychotherapy (mean number of sessions: 642) and 43 months for long-term psychodynamic therapy (mean number of sessions: 233). Pre-treatment differences in patient variables between the treatment groups were statistically controlled. In regard to symptom improvement (SCL-90-GSI)[29], from an equal starting situation analytic psychotherapy produced a large effect of 1.55 and long-term psychodynamic therapy an effect of 0.60 (Sandell et al., 2001). Analytic psychotherapy improved its effects between the first and second year after termination of treatment by almost one third, while the effect of long-term psychodynamic therapy decreased slightly in this time period (Sandell et al., 1999). It was also examined how many patients met the criterion for clinical cases in the self-evaluation instruments used. It was found that three years after termination of therapy 70% of the patients treated with analytic psychotherapy were no longer classed as clinical cases, while in the group treated with long-term psychodynamic therapy the figure was 55%. Furthermore, 2 years after termination of therapy long-term psychoanalytic therapy demonstrated significantly larger effects than a group of patients who had received low-dose psychotherapy and significantly larger effects than a group of untreated patients (Sandell et al., 1999, p, 51, table 2).

[29] SCL: symptom check list; GSI: global symptom index

7.3.1.4. The Frankfurt-Hamburg Study

Brockmann, Schlüter and Eckert (2001) studied the effects of long-term psychoanalytic and behavioral therapy in patients with depressive and/or anxiety disorders (as per DSM-III-R). The therapies were conducted by licensed psychotherapists. In this study, psychoanalytic therapy with an average of 185 sessions led to significant improvements in the patient's symptoms, interpersonal problems, personal goals and sense of well-being. Large effects (pre-post) were reported for both forms of therapy both in the symptoms and in interpersonal problems: From the statistical point of view, after 3.5 years the analytically oriented therapies had achieved large (pre-post) effects of 1.59 in the area of symptoms, and 1.16 for interpersonal problems (Brockmann, personal communication of 6.22.04). Behavior therapy produced effects of 1.17 and 1.04. In both forms of therapy, improvements in interpersonal problems appeared later than symptomatic improvements. This corresponds to the results found by Lueger (1995) for short-term therapies.

7.3.1.5. Göttingen study on the efficacy of psychoanalytic and depth psychology-based therapy

The Göttingen study investigated the efficacy of psychoanalytic and depth psychology-based therapy. This is another example of a naturalistic, quasi-experimental study conducted under conditions of clinical practice. Preliminary results have now appeared on the effects of the psychoanalytic therapy studied (Leichsenring, Biskup, Kreische and Staats, 2005).

The sample studied to date consists of n=36 patients with terminated psychoanalytic therapy. Reports on the 1-year follow-up are also available for n=23 of these patients. The patients displayed the variety of disorder pictures customarily encountered in psychotherapeutic practice. On average 253 sessions were conducted (SD=74.2). This is an almost exact match to the study by Rudolf et al. (1994) with its average of 265 sessions.

The Göttingen study came to the following results: The psychoanalytic therapy employed led to significant improvements in the symptoms (symptom check-list SCL-90-R), in interpersonal problems (inventory of interpersonal problems, IIP), in satisfaction with life (life satisfaction questionnaire, FLZ), in sense of well-being

(experience and behavior change questionnaire, VEV) and in the chief issues as defined by the patients themselves (goal attainment scale, GAS). The effects are large across the board: 1.34 for the total values of the SCL-90-R (GSI), 1.28 for the total value of the IIP, 1.55 for the total value of the LSQ and 2.39 for the total value of the GAS. At the one-year follow-up all improvements proved stable or even increased (GSI: 1.38, IIP: 1.85, LSQ: 1.81, GAS 2.48). At the end of therapy, 77% of the patients were judged clinically significantly improved and at the 1-year follow-up the figure had risen to 80%.

The data of the patients who received depth psychology-based treatment is currently being evaluated. This will permit comparison with the data of those who received psychoanalytic treatment.

7.3.1.6. Clinical Practice Study on Long-term Analytic Therapy

The clinical practice study on long-term analytic therapy (PAL: Rudolf, Grande, Keller et al. 2004) is a naturalistic quasi-experimental study in which the effects of psychoanalytic and psychodynamic therapy are studied and compared. Patient groups were composed in such a way as to make the two groups comparable on prognostically relevant parameters such as age, sex, socioeconomic characteristics and disorder severity (parallelization). According to the results presently available, both forms of therapy produced significant and large effect in regard to symptoms (SCL-90-R, PSKB-Se) and interpersonal problems (IIP). The two forms of therapy were equally effective in these regards. Psychoanalytic therapy however achieved a restructuring of the personality with significantly greater frequency (Heidelberg Restructuring Scale). A more detailed account of this methodologically laborious study can be found in section 7.4 (application research).

Further comparison studies are in process at the present time: the Munich Process-Outcome-Study (Huber, Klug & v Rad, 2001) and the Helsinki Study (Knekt & Lindfors, 2004).

7.3.1.7 The DPV follow-up study (Leuzinger-Bohleber 2001, 2002)

This first representative follow-up study on psychoanalyses and long-term psychoanalytic treatments (an average of 6.5 years after termination) involved over 200 psychoanalysts and over 400 former patients. In a multi-perspective approach to

the long-term effects of therapies, patient evaluations and assessments of the treating analysts, follow-up interviewers, psychoanalytic and non-psychoanalytic experts as well as "objective data" regarding savings in health care costs etc. were compared and contrasted. A great variety of qualitative and quantitative techniques were applied both in gathering and in evaluating the data.

75% of the patients (n=282) indicated that in retrospect they would rate their overall state of health before therapy as "bad." 81% designated their overall condition at the time of the follow-up as "good." 80% reported positive changes in their overall condition, inner growth and relationships. Between 70 and 80% noted positive changes in regard to their ability to manage life, their self-esteem as well as their mood, their satisfaction with life and their capacity for work. Regarding the global symptom index (GSI), although the follow-up sample remains slightly over the values for the general population it is no longer in the clinical area and clearly below the values for inpatient and outpatient treatment. Accordingly, 76 % of the former patients and (and 64% of the analysts) were satisfied with the results of the treatment.

On a partial sample of 129 former patients, two raters assess the severity of the disorder at the beginning of treatment and at follow-up on the basis of all available information (BSS, GAF; GARF; SOFAS), as well as the initial symptoms according to the ICD-10 (adjusted kappa coefficient: 0.73). 51.2% suffered from personality disorders, 27.1% from affective disorders, 10.9% from neurotic disorders and 6.2% from schizophrenia. Among the unexpected results of the study was the observation of an aggregation of patients (62% of the interview sample) who had experienced severest actual traumas in early childhood in connection with the second World War (loss of close family members, flight, bombardment, hunger, injury etc.). For many former patients, reaching insight into the personal background of their suffering was just as important as the lessening of their symptoms (cf. Leuzinger-Bohleber, 2003).

Summary:

The studies cited demonstrate that long-term psychoanalytic therapy is effective:

(1.) Long-term psychoanalytic therapy yielded large effects, significantly exceeding the effects of comparison groups which received no treatment or low-dose treatment (Dührssen & Jorswieck, 1965; Sandell et al., 1999). (2.) Furthermore a number of studies showed that the effects of long-term psychoanalytic therapy significantly

exceed those of the shorter psychodynamic therapy (Rudolf et al., 1994; Sandell et al., 1999, 2001; Rudolf et al., 2004). The study of Rudolf et al. (2004) comes to the conclusion that this applies to precisely the outcome dimension for which a superiority of long-term psychoanalytic therapy is to be expected from the theoretical point of view, i.e. in regard to restructuring of the personality. In comparison to cognitive behavioral therapy (CBT), long-term psychoanalytic therapy manifested somewhat larger effects in improvement of symptoms (difference in effect sizes: d=0.43) and comparable effects in the interpersonal area (Brockmann et al., 2001; Brockmann, personal communication of 6. 22.04).

These results are derived from quasi-experimental studies in which the patient groups treated with long-term psychoanalytic therapy were made comparable by parallelization along relevant patient variables. In addition, the results are marked by a high clinical representativeness, since both the treatments and the patients studied conformed to conditions of clinical practice. From this point of view the treatment of patients with complex disorders which cannot be isolated as in RCTs is not a disadvantage(quite the contrary. According to the hierarchy of degrees of evidence proposed by Leichsenring (2004 a) for naturalistic studies, these are studies meeting degree of evidence 1. Such studies have the following characteristics: prospective quasi-experimental naturalistic studies, nonrandomized comparison conditions, use of matching or stratification, prediction of complex result patterns (e.g. superiority of long-term therapy in terms of personality restructuring), clear description of clinically representative treatments and patients, blind ratings, clear criteria for inclusion and exclusion, up-to-date diagnostic methods, appropriate sample size for test strength and clearly described statistical methods.

7.3.2 Surveying the Consumers – a new approach

In the United States Consumer Reports article on psychotherapy set off an interesting debate. As late as 1994 Seligman published a compilation of RCT findings (1994), yet one year later(for a variety of reasons(he had adopted a new credo, proclaiming the necessity of clinically realistic effectiveness studies, which had been given a “new look” by Consumer Reports (Seligman 1995). The data published there are hard to claim in favor of any one form of therapy, hence we refer to two further studies which unambiguously represent psychoanalytic data sets:

7.3.2.1 IPTAR study on the effectiveness of psychoanalytic psychotherapy (Freedman 1999)

This study was intended to provide validated evidence for the frequency debate; an unsatisfactory return rate (41% of 240) gives the study only a heuristic value.

Nevertheless, using the same CR instrument the study shows that increasing the frequency from one to two sessions resulted in a marked improvement in satisfaction with therapeutic outcome.

Under the influence of the great response to the Consumer Reports study, two similar studies were conducted in Germany.

7.3.2.2 The Constance study: A German Consumer Reports study - (Breyer 1997)

Using the membership lists of two German therapeutic associations (DGPT and DGIP), a random sample of 20% of the members was drawn to take part in a survey regarding their patients. 50% of them responded, and of these again 50% (therapists as well as patients) expressed willingness to participate (5% of the members-not a very representative sample). The results of the questionnaires showed that the most important changes took place during therapy but continued after termination. According to patients' own evaluation, the most important changes were in overall well-being and capacity for relationship (two-year follow-up).

7.3.2.3 The Saarbrücken CR study (Hartmann and Zepf 2002)

This study employs a German translation of the original Consumer Reports questionnaire:

a) How much improvement was there in the psychological problems which led you to seek treatment? 0-100

b) How satisfied were you with the treatment? 0-100

c) How much did your overall emotional state improve with the treatment? 0-100

This generates a total score of 000-300. The subjects were recruited by psychotherapists (68%), the Stiftung Warentest[30] (11%), by internet (11%) and by friends/acquaintances (10%). From June 1, 2000 to February 28, 2001, 1896 questionnaires were returned, of which 1426 were usable and 468 were excluded.

[30] "Foundation Product-Test"

The socio-demographic characteristics of the sample are said to match those of psychotherapy patients in Germany, 58% of whom have passed their abitur.[31]

a) Depth psych.-based psychotherapy N=469 (33%)
b) Psychoanalysis N=284 (20%)
c) Behavior therapy N=238 (17%)
d) Client-centered N=119 (09%)
e) Other N=290 (21%)

It would appear to be particularly problematic that 67% of the patients were still in ongoing treatment. The duration data show 49% >2 years, 29% 1-2 yr., 22% <1 yr.
In terms of effectiveness, the following results are reported:
Slight superiority of psychoanalysis over depth psych.-based psychotherapy.
No difference between psychoanalysis and behavior therapy.
No difference between depth psych.-based psychotherapy and behavior therapy.
Psychoanalysis markedly better than conversational therapy and other modalities.
Depth psych.-based psychotherapy markedly better than conversational therapy.
The breakdown on duration is also quite interesting:
More than two years duration

Psychoanalysis	74%
Depth psych.-based psychotherapy	50%
Conversational Therapy	42%
Behavior therapy	29%

Conclusion: Clear influence of treatment duration.
The first significant improvement in efficacy appears after 7 months, the second after 1 year and a third highly significant one after 2 years.
The preliminary assessments correspond to those of the U.S. Consumer Reports study.
Methodological problems lie particularly in the questionable representativeness of the sample.

7.3.2.4 The follow-up study of the Stuttgart-Sonnenberg Psychotherapeutic Clinic (Teufel andVolk 1988)

The Stuttgart-Sonneberg Psychotherapeutic Clinic is an exclusively psychoanalytic institution which since 1967 has provided 102 beds and treated around 300 patients

[31]Qualifying examination for prospective university students

per year. A follow-up study identified 248 patients, of whom 147 could be interviewed an average of 3.9 years after termination of therapy. Four dimensions were studied: (a) attainment of therapeutic goals, (b) reduction of symptoms, (c) overall emotional state and (d) capacity for work. The results show that capacity for work and attainment of therapeutic goals as defined at the beginning of treatment showed the greatest change. In terms of overall emotional state and symptom reduction the results were quite modest. It is important to bear in mind that the study was conducted at a time when pharmacological treatment did not yet lead to rapid successes.

7.4 Descriptive Process Research (H. Kächele)

Clinical course research – process research

This topic was a central focus of psychoanalysis at one of the last significant German-language congresses held before the war (1936 in Marienbad), and it has remained a clinical priority in the field ever since. Clinical process research revolves around the central question of psychotherapeutic action: “What justification or foundation can be found for a given therapeutic action?” (Westmeyer 1978). A source of answers to this question can be found particularly in single case studies which, although highly esteemed in the world of psychoanalytic therapy, are not so numerous as might be desirable. A survey of thorough and systematic clinical-empirical studies of this kind is provided by Kächele (1981) (cf. chap. 7.3), and Leuzinger-Bohleber (1995) offers an up-to-date position statement. Much more frequent have been group studies, comprehensive results of which are documented in one chapter of the Handbook of Psychotherapy and Behavior Change in each of its five editions (Bergin and Garfield 1971; Garfield and Bergin 1978; Garfield and Bergin 1986; Bergin and Garfield 1994; Lambert 2003). Ideally, complete clinical course descriptions would both objectify changes in the patient(the results of treatment(as well as provide a step-by-step explanation of how they came about through the therapeutic interventions. In the attempt to approach this goal, a great variety of preliminary methodological work has been accomplished. Over many years the details gleaned from thousands of single case studies were repeatedly compiled and prepared by Orlinsky and Howard (1972, 1978, 1986), making it possible for a “generic model of psychotherapy” (Orlinsky and Howard 1987) to take form. In the next-to-last edition of the Handbook, K. Grawe was brought into the process as a German-speaking therapy researcher so that German-language results could also be taken into account (Orlinsky 1994). Of course not all the findings derive from psychoanalytically oriented therapy studies, but(this much can be said(a considerable portion of this literature was contributed by psychoanalytically oriented therapy researchers such as L. Luborsky (1988a), M. Horowitz (1991), H. H. Strupp (1997), C. Perry (1993), W. Piper (1998) and R. Wallerstein (1989). Among the German authors who have enriched the field of therapy process research one thinks particularly of A.E. Meyer (1962b, 1981b), F. Heigl (1977), G. Rudolf (1991, 1997), H. Kordy (1990, 1995), B. Strauß (1995, 2000), V. Tschuschke (1993, 1996), H. Faller

(1998) and H. Kächele (1981, 1988).

In psychoanalytic therapy research a great variety of descriptive evaluation methods have been explored over the years, and these require further development. Since beyond realizing the unspecific factors required of any helping interpersonal relationship (Kächele 1988), psychoanalysis places a premium on the effects of specific technical interventions (clarification, confrontation, interpretation (Koenigsberg 1985)), it is particularly concerned with their reliable and contentually relevant assessment.

In its need to approach the psychoanalytic dialog, research is confronted with a great quantity of new data. Before testing hypotheses, it seemed advisable to leave ample room for phenomenological description (Grawe 1988b) and the inductive process. This is also where the chances lie for qualitative research approaches in psychoanalysis (Streeck 1994; Buchholz and Streeck 1994, Stuhr 1997, 2001), by orienting interpretation to the actual text of the dialog, i.e. to the verbatim transcript (Faller and Frommer 1994).

The largely conversational nature of the therapeutic process opens the door to research approaches ranging from linguistic, conversation-analytic text analyses (Flader 1982) to computer-assisted studies (Dahl 1974, Kächele 1976, 1988, Spence 1993, Mergenthaler 2002) and enabling a differentiated apprehension of therapeutic processes. These new methodological approaches have been explored in short-term therapies (Mergenthaler and Kächele 1996) as well as in individual psychoanalytic treatments (Leuzinger-Bohleber and Kächele 1990, Leuzinger-Bohleber 1987, 1989).

As part of a special research area supported by the DFG□, beginning in Germany a systematic collection of therapeutic dialogs in tape-recorded, video-recorded and particularly in written form has been established as a text corpus (Mergenthaler and Kächele 1994). Since then further data banks have been formed internationally. With interregional cooperation and the implementation of modern computer technology, a new dimension in psychotherapy research has been opened in this way (Luborsky et al. 2001).

Specifically, the following areas of intensive ongoing research can be highlighted (Henry 1994):

a) the therapeutic alliance

This is by far the best-studied area (Horvath and Greenberg 1994). It may well be

the most important technical principle not only for psychodynamic forms of therapy but(as is generally acknowledged today(for all treatment modalities. How is this to be understood?

The helping relationship embraces a number of related phenomena which reflect the extent to which the patient experiences his or her relationship with the therapist as helpful in attaining the therapeutic goals. It corresponds to Freud's (1912b) conception of mild positive transference as the "vehicle of success" (ibid. 371). The mere presence of the psychotherapist creates a helpful relationship, but it is strengthened by "helping interventions" (see below).

The therapeutic relationship requiring such helping attention is the best studied phenomenon in the field. Commonalities with the attitudes that have been declared the pillars of conversational therapy are no mere accident. General agreement exists that the concept is a multidimensional construct in which four aspects can be distinguished:

a) the patient's capacity to work in a goal-oriented way in the therapy;
b) the affective bond of the patient to the therapist;
c) the empathic understanding and involvement of the therapist;

the agreement of patient and therapist on tasks and goals of treatment.

In regard to manner of action, Horvath and Greenberg (1994) speak of a) direct effect, b) a mediated effect and c) an interactive effect.

The available survey studies indicate that the relationship which the therapist offers is more important for therapeutic change than the technique employed. By use of the elements "bonds," "tasks" and "goals," the therapeutic alliance becomes a "helping environment" which makes it possible to effectively solve therapeutic tasks.

Horvath summarizes the results of a metaanalysis of 15 years of research on the therapeutic alliance as follows:

Alliance (established in early sessions of therapy) is a predictor of therapeutic outcome, independent of psychotherapeutic technique, diagnosis or patient characteristics.

Therapist and patient generally do not agree in their evaluation of the alliance.

A detailed study on the significance of the therapeutic alliance in low- and high-frequency psychoanalytic treatments was conducted by Rudolf (1991). Among further studies one may point to those conducted by Bassler in various clinical

settings (Bassler 1995).

b) Transference or the core relationship pattern

On the interpersonal plane(between themselves and their patients(psychodynamic therapists recognize and make use of relationship patterns which, according to a time-tested clinical conception, have resulted from interaction patterns among family members that were often repeated in the child's early experiential world. This analysis of the relationship between patient and therapist is the psychoanalytic-psychodiagnostic instrument par excellance (Strupp and Binder 1984, Luborsky 1984, Thomä and Kächele 1985) (cf. chap. 5 and 6). Recurrent dysfunctional relationship patterns are considered as an object of treatment and thus of research. The explicit formulation of relationship patterns assumes central importance in psychodynamic and cognitively oriented individual and group therapy as well as in family therapies.

From the psychodynamic perspective, these relationship patterns can be understood as the result of conflicts between personal needs and wishes, anxieties and defense processes on the one hand and the reactions of interaction partners on the other. The patient's psychological symptoms are embedded in characteristic dysfunctional relationship patterns: the wish, the anxiety associated with wish-fulfillment and the corresponding defense of the wish or anxiety also configure interpersonal relationships. From the psychodynamic point of view, conflicts are to be understood as contradictory or even mutually exclusive wishes and other motives which evoke anxieties about the consequences of wish-fulfillment and corresponding defense reactions on both the intrapsychic and the interpersonal planes.

Transference, the central construct of psychoanalytic theories of disease genesis (etiology) and treatment, means such repetitive relationship patterns.

Methods of measuring relationship patterns

Direct measurement of conflictual interpersonal and/or intrapsychic relationship patterns from the material of therapeutic dialogs has found acceptance in the last twenty years as a successful research strategy. A number of measurement instruments have been developed for this purpose. Among the best known of these are:

Luborsky, L. (1977): Core Conflictual Relationship Theme Method (CCRT), (Luborsky

et al. 1992) (Luborsky and Crits-Christoph 1998).

Horowitz, M. (1979): Configurational Analysis.

Dahl, H. (1988): Frames Method.

Gill and Hoffmann (1982): Patient's Experience of the Relationship with Therapist (PERT).

Strupp and Binder (1984): Dynamic Focus.

Weiss and Sampson (Weiss 1986): Plan Diagnosis/Plan Formulation Method.

OPD Working Group (2001) Operationalized Psychodynamic Diagnosis. Axis II: interpersonal relations (Grande et al. 1997).

All of these measurement instruments capture relationship patterns that occupy a high position motivationally (i.e. they are judged to be relatively important) and may be applied to cognitive as well as to expressive forms of psychotherapy (Albani 2003). The connection of the therapeutic working through of these repetitive relationship patterns with the therapeutic outcome has been demonstrated in particular for the method of the Core Conflictual Relationship Theme (CCRT) (Albani 2003). Using the Penn Collection of Psychoanalytic Cases (Luborsky 2001), the CCRT was also applied to a relatively large number of psychoanalyses.

Another now widely employed instrument for measuring transference tendencies is that of Plan Diagnosis/Plan Formulation conceived by Weiss and Sampson (1987); it has been tested on a long-term case (Weiss 1986) and on short-term psychoanalytic therapies (Silberschatz 1986; Silberschatz 1986a; Curtis 1988; Silberschatz 1989; Silberschatz 1991; Silberschatz 1997). A German version of Plan Diagnosis has also been created (Albani 2000).

The connection between transference and resistance was explored in detail by Herold based on verbatim transcripts using the reworked German version of the method of Gill and Hoffman (Herold 1995). Another single case study also analyzes the connection of relationship, resistance and insight based on formal and contentual text features (Michal 2001).

The method of FRAME analysis was demonstrated by Dahl on the model American psychoanalytic case of Mrs. C. (Dahl 1988); a German version of this method has also been tested (Hölzer 1998).

c) Countertransference

Measurement methods for the clinical concept of countertransference remain rare

(Singer and Luborsky 1977). It is possible that linguistic indicators will lead us on the right track towards identifying these subtle phenomena of clinical practice in an empirically reliable way (Dahl et al. 1978).

The concept of emotional insight, though highly valued therapeutically, has been little studied (Roback 1974). However one can point to Hohage's empirical measurement method, whose value as a process-related outcome criterion was demonstrated in a single case study of a long-term psychoanalytic treatment (Hohage and Kübler 1987, 1988).

d) Mastery

Introduced relatively recently, the empirical concept of mastery operationalizes the therapeutic concept of working through (Grenyer and Luborsky 1996); studies on high-frequency treatments with this concept are presently underway Gange (Grenyer, oral communication 2003).

e) Free Association

Regarding the clinically prized method of free association there are few naturalistic studies; however the concept has been investigated experimentally by a number of authors (Bordin 1966, Colby 1960, Kris 1982, Kroth and Forrest 1969, Kroth 1970, Teller and Dahl 1986, Hölzer et al. 1988, Heckmann 1987, Bucci 1995). A recent study of the verbatim material of a psychoanalysis empirically validates the connection between the analyst's interpretative activity and the patient's productivity of associative materials (Spence et al. 1993).

f) Interpretive work and patient reaction

The processual connection between interpretive activity and patient reaction has been a repeatedly studied theme in psychoanalytic process research. A review of the (then) current state of research on this connection was provided by Crits-Christoph (1998).

Currently a working group of the New Psychoanalytic Institute is conducting a detailed investigation of the connection between interventions and the patient's subsequent productive reaction (Waldron et al, 2001, Waldron 2003).

g) Structural changes

Among the hard-to-measure themes of empirical therapy research is the assumption that psychoanalytic treatment leads to structural changes and not only to symptomatic improvements. Various recently developed methods support this assumption. Thus, the analysand's reaction to interruptions as an indicator of structural changes has been studied (Jimenez and Kächele 2002). The value of change in the cognitive features of dream reports and related associations as an indicator of change was demonstrated by Leuzinger-Bohleber and Kächele on five single cases; the structural changes found could be parallelized with the clinical outcome of the treatment (Leuzinger-Bohleber 1987; Leuzinger-Bohleber and Kächele 1988; Leuzinger-Bohleber 1989; Leuzinger-Bohleber and Kächele 1990).

Methodological developments such as the Heidelberg Structural Change Scale (Rudolf et al. 2000, Grande et al. 1997) round out the available methodological arsenal. This instrument makes it possible to measure changes in the processing of intrapsychic conflicts and structural impairments (Grande et al. 2001, 2003). In addition the psychoanalytically significant concept of "structural change" finds an operationalization in the scale, so that the specific effects of pychoanalyses in contrast to psychotherapies become measurable (Rudolf et al. 2002, Grande et al. 2003, Rudolf et al. 2003).

A great deal of interest has also been drawn to the Scales of Psychological Capacities (SPC, Wallerstein 1991), which have been applied in the Munich psychotherapy study (Huber 2001) on low-frequency and high-frequency analytical treatments. These techniques represent important steps towards identifying short-term and long-term changes that are compatible with the clinical concept of structural change.

There has been increasing use of the Adult Attachment Interview as a method of measuring change. Fonagy et al. (1996) also demonstrate the extent to which customary psychiatric diagnoses covary with attachment status and which changes can be expected from long-term treatments (Bateman and Fonagy 2001). A single case study on this question is reported by Buchheim and Kächele (2003).

7.5 Experimental and basic science studies in the field of psychoanalysis (S. Hau)

The extensive clinical knowledge that has been gathered by psychoanalysts over the years has given rise to a rich body of hypotheses, theoretical concepts and models. This has motivated a great number of psychoanalysts to investigate specific phenomena and their theoretical explanations in the framework of experimental studies. As a result, empirical as well as experimental research in the field of psychoanalysis has a long tradition. However, this tradition is not well known.

The term “off-line research” was introduced by Moser (1991) to describe this broad field of research outside of the clinical arena, in which different research questions, models and specific phenomena are investigated with non-psychoanalytic methods (e.g. experimentally controlled laboratory conditions). This type of psychoanalytic research has been discussed and justified with respect to theory of science by Leuzinger-Bohleber (1995, 2002).

As far as experimental laboratory research is concerned, its results cannot be directly connected to the psychoanalytic therapeutic situation. However, the data it provides enhance our general basic knowledge and at the same time help relate psychoanalytic models to those of other disciplines such as the cognitive and neurosciences. In addition, interdisciplinary dialogue with other sciences as well as the clinician’s own empirical and experimental research offer a broad basis for critical self-reflection. This is useful as a form of individual quality control regarding one’s own clinical work.

Within this framework, several areas of basic science can be mentioned in which intensive experimental empirical research relating to psychoanalytic concepts has been conducted:

- Experimental studies in dream research and the preconscious processing of information.
- Developmental psychology and early childhood research (Spitz, Mahler, Stern, Emde, Popousek, etc.).
- Research into affect development (Krause, Bänninger-Huber and others)

- Studies of attachment development.
- Psychoanalysis and cognitive science (cf. overview in Moser and v. Zeppelin 1991).
- Neurophysiological research (cf. International Society of Neuro-psychoanalysis, Journal of Neuro-psychoanalysis).

In order to illustrate how experimental and empirical basic research can contribute to external validation of psychoanalytic concepts, two areas are examined below as examples.

Experimental dream research

Since the discovery of REM (rapid eye movement) sleep by Aserinsky and Kleitman (1953), the processes of sleep and dreaming have been investigated in detail in numerous experimental laboratory studies (cf. Hau 2003, p.32ff). In the process, experimental dream research has confirmed as well as modified psychoanalytic dream theory(demonstrating, for example, that dreaming is essential to maintaining mental as well as physiological health. Here a quasi-therapeutic function of dreaming becomes apparent. Dreams help to regulate emotions, resolve problems and stress, assimilate and contextualize affects (Hartmann 1998, Fiss 1995) and create new associations serving a relief function. In addition, dreams are an important component of the so-called “signal detection system” (Fiss 1993), which operates parallel to conscious perception (Leuschner and Hau 1995, Leuschner et al. 1998, Hau 1999). Dreams incubate corrective judgments and experiences. Dreams serve the functions of information processing and the amplification and consolidation of knowledge; they help maintain homeostatic psychological equilibrium and participate in the development of the central nervous system. Research on the ontogenesis of dreams (i.e. dreaming in children of different ages) contradicts Freud’s hypothesis that wish-fulfillment is depicted directly in children’s dreams (Foulkes 1985, Hamburger 1987). On the contrary, investigations of children’s dreams reveal that children have far more nightmares than adults. Their capacity to generate dreams develops in the course of early childhood and increases in relation to their developmental age. The amount of dreaming and its narrative structures correlate with developmental level and with the given cognitive capacities. Language capacities also play an important role.

At the same time dream research is also research on perception and memory. In our

age it is no longer possible to deny the existence of unconscious psychological processes. At the same time the universal concept of an unconscious has been differentiated by the proof of many different unconscious processes. There is hardly a single psychological phenomenon for which so much empirical and experimental evidence has been found as for the existence of unconscious processes. To speak of "unconscious processes" instead of "the unconscious" is not an arbitrary choice here: an extensive body of research on "cognition without awareness", implicit memory and the concept of the "hidden observer" has shown again and again that these phenomena must be conceptualized as complex processes that serve very different functions and affect attention and perception as well as decision-making, affect regulation, motivation and drive-related processes. In order to stress the dynamic of these occurrences they are conceptualized as processes. This at the same time takes account of the fact that associative networks play a decisive role in unconscious processing. The same is true of primary process features that can be found in both unconscious and preconscious processes (cf. the comprehensive descriptions by Westen 1999, Dixon 1971, 1981, Erdelyi 1985, Schacter 1992, 1995, and by Shevrin et al. 1997).

Alongside of research on unconscious cognitive processes, there are a great number of proofs for the existence of unconscious affective processes (Gazzaniga 1985, LeDoux 1995, Erdelyi 1985, Dixon 1971, 1981, Shevrin et al. 1997, Westen et al. 1995, Pennebaker 1997). The same is true of motivational processes (McClelland et al. 1989, Bargh 1997, Wilson et al. 1993, Shevrin et al. 1997, Glasman & Andersen 1999).

Neurophysiological research

In the past decade psychoanalysts have become increasingly interested in the progress of neurophysiological research, especially in the area of imaging processing (cf. Beutel, Stern & Silbersweig 2004). Their hope is that observations and experiences in the clinical situation might be conclusively related to their (neuro-) physiological basis. Meanwhile, an intensive interdisciplinary discourse between psychoanalysis and the neurosciences has been established (cf. Society for Neuro-Psychoanalysis, Journal of Neuro-Psychoanalysis, overview in Koukkou et al. 1998, Solms 1998, 1999, 2000, Kaplan-Solms & Solms 2000, 2003).

Based on syndrome analyses of patients with brain lesions, Solms (1999, Kaplan-

Solms & Solms 2003) proves that REM-activity and dream activity are not causally connected but are correlative phenomena. Kaplan-Solms & Solms (2003) report different effects on dream activity in their patients depending on the type of brain tissue lesions. When the right or left inferior parietal lobe of the brain or the bilateral white-matter in the ventromesial frontal region was damaged, a complete cessation of dream activity was reported. With damage to the ventromesial occipito-temporal region, patients reported non-visual dreams. On the other hand if the frontal limbic region was damaged, patients were no longer able to distinguish surely between dream experiences and reality (loss of reality control).

These results of current neurophysiological research appear to be compatible with Freud's assumptions about the dream process. Solms as well sees dream processes as stimulated by an arousal stimulus which must be of sufficient strength or duration. This arousal impulse may also come from the pons region in the brain stem(the region thought to be responsible for triggering REM-activity. Finally there is a triggering of motivational processes in the brain which are normally responsible and necessary for the creation and performance of goal-directed actions. Only after this activation of motivational mechanisms does the dream process proper begin. During sleep the performance of goal directed actions is blocked and during REM-phases motor activity is extremely reduced. Hence no transformation of arousal impulses into actions is possible and arousal takes a different (regressive) course. According to Solms, first more highly organized parts of the perceptual system are activated, serving to a large extent the functions of memory and abstract thinking. In a second step the less highly developed parts of the perceptual system are involved, creating concrete visual pictures. At the same time reflective thought processes are inhibited. Thus the dreamer cannot distinguish between the regressive process with its perceptive experiences (in which no action is possible) and external reality. The imaginative experiences are uncritically accepted as real perceptions because the frontal region of the limbic systems seems to be inactive.

In the course of this interdisciplinary dialogue, interesting and promising convergences with psychoanalytic dream theory are becoming apparent. The example examined above is intended to cast light on how modern evaluative methods may help test important psychoanalytic concepts and at the same time raise new questions.

The dialogue with the neurosciences is already finding direct applications in

psychoanalytic psychotherapy research. In a recently published study, Beutel and his colleagues evaluated affective and behavioral dysfunctions of patients with borderline personality disorders and investigated the associated specific arousal patterns in the brain. Different interactive patterns were observed in the brain in the course of psychodynamic treatment. In addition, the interplay of behavioral control by functions of the prefrontal cortex and reactive systems based in the limbic system were investigated in specifically described groups of patients (Beutel et al. 2004).

Encouraged by interesting and important findings in neurophysiological research, researchers turned their attention to psychoanalytic treatment in patients with cerebral damage (Solms 1995, 1998, Kaplan-Solms & Solms 2000, Röckerath et al. 2003). Their aim was to make visible the unconscious psychological structures and processes that are affected by the brain lesion and the associated symptoms. One of the findings was that good object relations were helpful for transient improvement of symptoms. This was true e.g. for the alleviation of anxieties, coherent thinking, memory performances as well as for temporal-spatial orientation. This means that in the context of stable object relations, a patient is able to compensate to some extent for functional breakdowns resulting from circumscribed anatomical lesions of the forebrain. These results demonstrate that psychological experiences cannot be defined as anatomical processes of the brain alone but also involve other factors relating to the outer world, to relationships and interactions with other objects.

In this connection research was conducted to measure attachment representation using the fMRI technique (Buchheim et al., in press). The purpose of this exploratory study was to combine for the first time two methodological approaches: the AAP (Adult Attachment Projective) and functional magnetic resonance imaging (fMRI). The results of this study confirm that the AAP is a feasible measure for use in a neuroimaging environment, demonstrating that it is possible to analyze cerebral activation during continuous speech and that this yields results consistent with the literature. Brain activation was demonstrated in the expected visual and semantic regions of the brain. The results of theoretically derived attachment hypotheses regarding organized vs. unresolved/disorganized attachment representations showed a significant interaction effect between sequence of pictures and attachment category. These results can be interpreted as a confirmation of the a priori hypothesis linking unresolved attachment to emotional dysregulation of the attachment system. This is an ongoing study. Based on the results presented here,

we now plan to investigate the neural correlates of attachment patterns relating to specific linguistic and content markers of the AAP, in particular comparing patients with borderline personality disorder with non-patient healthy controls using our fMRI-adapted attachment paradigm.

Different techniques are also used(electroencephalogram (EEG), positron emission tomography (PET), magneto-encephalogram (MEG), magnetic resonance imaging (MRI)(to study brain activation patterns with respect to psychotherapeutic processes (e.g. Baxter et al. 1992, Schwartz et al. 1996). Psychodynamic psychotherapies of borderline patients are currently under investigation in an ongoing study by Beutel, Posner, Kernberg and Clarkin at Cornell. They are looking for possible neurophysiological substrates of clinically important features. In a preliminary analysis the authors report “increased amygdala activation associated with affective dysregulation in borderline subjects versus control subjects” (Beutel et al. 2004, 20). The authors suggest that “studying and assimilating neuroscience results should aid psychoanalysts in reflecting on and reformulating treatment decisions, strategies” (Beutel et al. 2004, 21) as well as treatment plans.

Several authors have fostered a more active role for psychoanalysts in the neurosciences (Kandell 1999) and demonstrated the effects of neuroscientific research on the development of psychodynamic models (e.g. Beutel 2003, Westen & Gabbard 2002). However, this research adventure is also faced with many challenging problems and questions. Basic methodological problems and aspects of philosophy of science are affected and it still seems to be as much of an exciting challenge as well as a tightrope walk for psychoanalysis as ever before: On the one hand it seems necessary for the results of psychoanalytic research and psychoanalytic theories based on them to attain "external coherence" (Strenger, 1991) and to participate in a discourse with the scientific community. On the other hand there also seems to be the danger for psychoanalysis of overhasty adjustment to viewpoints which are culturally and "scientifically" accepted but foreign to the profession itself. In this respect clinical psychoanalytic research cannot be replaced by any other form of research. Nevertheless, interdisciplinary or empirical research can be helpful in adding dimensions to the understanding of complex unconscious psychic functioning such as dreaming and remembering. Therefore difficult but open scientific discussions within the psychoanalytic community and with the scientific world at large will be of great importance for the future of psychoanalysis as a

creative clinical theory as well as an innovative science.

8. Clinical Relevance (A.Gerlach, P.L.Janssen)

Indications for Psychoanalytic Therapy

The chief indication areas for psychoanalytic therapy are: psychoneuroses (e.g. anxiety neuroses, phobias, neurotic depressions, conversion neuroses); vegetative-functional and psychosomatic disorders with a confirmed psychological etiology; personality disorders and psychological impairments in which psychodynamic aspects play a significant role (e.g. dependence on alcohol, drugs or medications); psychological impairments due to emotional deficiencies in early childhood; psychological impairments resulting from severe chronic illnesses; psychological impairments due to extreme traumas; and psychological impairments resulting from psychotic illnesses (cf. Faber et al. 2003).

Prevalence of Illness with a Treatment Indication for Psychoanalytic Therapy

A point-prevalence field study conducted in rural Bavaria by Dilling et al. (1984) found a 40.9% overall frequency for psychological disorders. When milder forms were discounted, the remainder requiring treatment came to 18.6%, 12.0% of these being neuroses and personality disorders. Additional epidemiological data can be found in the Mannheim Study by Schepank (1987) and his coworkers, who conducted a study focusing specifically on the incidence of psychoneurotic and psychosomatic syndrome. An initial longitudinal study on a sample of 600 subjects of an urban population between the ages of 25 and 45 found 22.8% in need of psychotherapeutic treatment. In a follow-up study on the same sample (cohort study, Schepank 1990), the initial findings proved to be relatively stable, with only 11% new cases and 11% inactive cases. From this Schepank derived an estimate of needs, according to which short-term therapy was required for 10% of the sample, intensive ambulatory psychotherapy for 15% and inpatient psychotherapeutic treatment for 4%. It must be considered that the great majority of psychogenic illnesses become chronic and have no appreciable tendency to spontaneous remission (cf. Franz, 1999).

For Germany there are as yet no country-wide studies that would permit a more reliable estimate of the prevalence of the indication areas described (Tress 1990).

Further data on the prevalence of psychological disorders and associated comorbidity can be expected from a study by the Max-Planck-Institut für Psychiatrie in Munich (Wittchen et al. 1998). As a preliminary result in 1999 it was possible to ascertain that affective (6.3%), anxiety (9%) and somatoform disorders (7.5%) are widespread in all age groups between 18 and 65 (Wittchen et al. 1999).

These epidemiological findings alone, however, are not sufficient to determine direct treatment needs. There are indications that in the area of psychotherapy more complex indication models are needed than those customarily employed in medicine: "As a rule, indication decisions in psychotherapy are the result of complex negotiation processes in which agreement on goals, consideration of available resources and the 'fit' between therapeutic offerings and patients' ideas and wishes play a significant role" (Strauss 2000). Further study of this is required from the point of view of medical sociology, e.g. on disease behavior in psychological disorders.

Outpatient Care with Psychoanalytic Therapy

The question of prevalence also plays a role in a study aimed at determining outpatient psychotherapeutic care needs, which was conducted by the Central Research Institute of Ambulatory Health Care[32] on behalf of the Federal Ministry of Health and the Federal Association of Statutory Health Insurance Physicians[33] (Löcherbach 2000). According to their surveys the frequency of psychoneuroses and personality disorders in the Federal Republic varied between about 7% and 15%, depending on the study. Differentiated according to age group, disorder rates came to between 16.2 and 18.4% in children and adolescents, 11.3 and 26.4% in adults and around 23% in seniors. In the opinion of the authors, however, these prevalence data from epidemiological field studies are not immediately convertible into care requirement categories. These are based on an apportionment of the treatment indication, quantified as 15% analytic therapy, 50% depth-psychology-based therapy and 35% behavioral therapy.

Since 1967 applications of psychoanalytic therapy in outpatient care have been integrated into the statutory health insurance system under the designations "analytic psychotherapy" and "depth-psychology-based psychotherapy." Since then, physicians and psychologists with requisite professional training have been able to

[32] Zentralinstitut für die kassenärztliche Versorgung
[33] Kassenärztliche Bundesvereinigung

offer psychotherapy (initially, limited forms thereof) to suitable patients in treatment of ongoing unconscious conflicts—since 1976 also analytic psychotherapy aimed at structural change—at the cost of the statutory health insurance. Treatments provided by therapists in training under supervision were also integrated into this system, while at the same time high qualitative standards for professional further training were set down in the guidelines and agreements on psychotherapy. In this way psychoanalytic treatment of patients in the area of psychotherapy became an important component of the health system in both outpatient and inpatient care. Around 150,000 applications for psychotherapy in the analytically based techniques are presently filed each year, approximately one third of these being specified as "analytic psychotherapy."

Inpatient Treatment with Psychoanalytic Therapy

According to calculations based on the epidemiological studies of Franz (1999), approximately 14.1% of patients with neuroses, psychosomatic illness and personality disorders will at times require inpatient psychotherapeutic treatment.

Particular emphasis has been placed on development of inpatient psychotherapy in the hospital and in psychosomatic rehabilitation in Germany. At present psychoanalytic therapy is offered alongside of behavior therapy in the following wards and clinics:

1. Large specialized clinics for psychotherapeutic medicine (psychosomatic medicine, psychosomatics and psychotherapy) designed for the treatment of neurotic illnesses, personality disorders as well as psychosomatic or somatopsychic illnesses, but above all illnesses in the realm of personality disorders. Most such clinics are designed to provide cross-regional specialized care and some are divided into separate units.
2. Wards for psychotherapeutic medicine (psychosomatics, psychotherapy) in general hospitals, e.g. central hospitals providing priority care), most of them with low bed capacity but offering consultation/liaison and outpatient services. From the diagnostic point of view most such wards are primarily focused on psychosomatic and somatopsychic illnesses.
3. Purely consultative and liaison wards at general hospitals without beds.

4. Wards for psychotherapy at specialized psychiatric clinics designed to provide psychotherapeutic treatment of psychiatric illnesses.
5. Specialized clinics for psychosomatic rehabilitation, of which there are a number of different types with different focuses (internistic psychosomatic, neurological psychosomatic, orthopedic psychosomatic etc.).

According to a recent survey (lecture by H. Schulz, Hamburg 2003), in the Federal Republic of Germany there are about 75 hospital wards for psychosomatic medicine and psychotherapy with a total of 3,196 beds and 158 clinics for psychosomatic rehabilitation with 13,930 beds. Two-thirds of these take a depth-psychology-analytic concept as their basis. According to data gathered by the Federal Chamber of Physicians[34] (2003), there is an overall trend towards reallocating internistic and psychiatric beds as beds for psychosomatic medicine and psychotherapy. The number of psychiatric clinics maintaining separate psychotherapeutic stations is not known, nor is the number of beds they provide.

A considerable portion of the patients with diagnoses requiring psychotherapy are evidently treated in clinics that do not provide specialized psychotherapeutic care (misallocation of hospital beds). Furthermore a large portion of patients receiving inpatient care are released with an indication for outpatient psychotherapy. There is a proven need for integration of psychotherapeutic-psychosomatic care and psychosomatic-psychotherapeutic consulting and liaison services in inpatient wards equipped for specialized psychotherapy.

[34] Bundesärztekammer

9. Training (G.Bruns, P.L.Janssen)

Training in psychoanalytic therapy takes place at psychoanalytic institutes, some of them associated with psychoanalytic-psychotherapeutic departments at clinics and universities. Present membership in the German Society for Psychoanalysis, Psychosomatics and Depth Psychology (DGPT)[35], an umbrella organization of psychoanalytic associations and institutes, includes 52 institutes graduating approximately 2,200 candidates from a training or further training program. The majority of the institutes also belong to one of the four psychoanalytic societies - Deutsche Gesellschaft für Analytische Psychologie (DGAP), Deutsche Gesellschaft für Individualpsychologie (DGIP), Deutsche Psychoanalytische Gesellschaft (DPG), Deutsche Psychoanalytische Vereinigung (DPV) - by whom they were founded and nurtured.

Training at the psychoanalytic institutes is governed by various rules and regulations. These are, in the case of physicians, the further training regulations of the responsible state chamber of physicians; for psychologists and future child and adolescent psychotherapists, the law governing the professions of psychological psychotherapist and child/adolescent psychotherapist (PsychThG) as well as the training and examination ordinance for psychological psychotherapists (PsychTh-APrV); for all candidates at DGPT institutes, the initial and further training ordinance of the DGPT; and for candidates at institutes connected with specialists associations, the initial and further training regulations of the particular specialists association. As to the structural quality of the training, comprehensive information is available regarding content, scope and structure of the training for future training candidates and interested members of the public (Sasse 2000, 2003a).

Training in psychoanalysis is open to licensed physicians and trained psychologists. For physicians, strictly speaking this represents further training as they have already gained certification to practice with their physician's license; for psychologists and future child/adolescent psychotherapists it is a training program leading to licensing as a psychological psychotherapist or child/adolescent psychotherapist, i.e. providing access to the practice of a profession. Psychoanalytic training for physicians is conducted by physicians authorized to provide professional further training by the

[35] Deutsche Gesellschaft für Psychoanalyse, Psychotherapie, Psychosomatik und Tiefenpsychologie.

state chambers of physicians to which the institutes belong, by recognized training analysts, supervisors and docents. Psychoanalytic training for psychologists and future child or adolescent psychotherapists is conducted by training analysts, supervisors and docents who are recognized by the state authorities as experiential learning guides and supervisors in accordance with PsychTh-APrV. As a rule, planning and organization of training and further training at the institutes are coordinated by a training director and a training committee.

The training is composed of four main elements: a practical clinical activity in a psychiatric and psychotherapeutic institution as required in the physicians further training ordinances for the domain “psychoanalysis” and in PsychThG (§ 8) and PsychTh-APrV (§ 2); theoretical training; experiential learning (training analysis); and practical training in providing treatment under guidance or supervision.

The training or further training in medical and psychological psychoanalysis proceeds essentially as a training in psychoanalytically-based techniques as defined in the psychotherapy guidelines (section B I. 1.1.), i.e. it comprises depth-psychology-based psychotherapy (B I. 1.1.1.) and analytic psychotherapy (B I. 1.1.2.). Some of the institutes also provide training in depth psychology-based and analytic group psychotherapy.

Professional training in psychodynamic/depth psychology-based psychotherapy is also provided as part of the further training for specialists in psychotherapeutic medicine (future designation “specialist physicians in psychosomatic medicine and psychotherapy”). In addition to providing theoretical training and experiential learning and cultivating knowledge, experience and capacities in psychodynamic psychotherapy and cognitive-behavioral psychotherapy, the professional training in guideline-conforming psychotherapy also covers other psychotherapeutic techniques, such as psychoeducation, psychotrauma therapy and knowledge and experience in internal medicine, psychiatry and psychotherapy. The training also develops knowledge, experience and capacities in long-term, short-term, couples and family therapies and group psychotherapies. The scope and nature of the practical training (a total of 1,500 treatment hours in 40 cases under supervision) are defined in the physicians’ further training ordinance. Some of the long-term cases are conducted in the framework of additional training towards the designation of “psychoanalyst,” some in the practices of authorized licensed specialist physicians, some in institute

outpatient clinics and polyclinics at the training centers and others at the psychoanalytic institutes.

According to current data (as of 2003), in the Federal Republic there are 75 wards for psychosomatic medicine and psychotherapy with 3,196 beds and 158 clinics for psychosomatic rehabilitation with 13,130 beds. According to a survey by the Deutsche Gesellschaft für Psychotherapeutische Medizin[36] of June 2002, around 80% of those authorized to provide professional training have a psychodynamic depth-psychology orientation. Specialist physicians authorized to provide further training are active in the inpatient area, in medical practices as well as in polyclinics, outpatient clinics and consultation and liaison services. The statutory further training period is longer in the inpatient area and lasts at least three years, while in the outpatient area it is generally one year.

At the time of the survey about 600 assistant physicians were in further training.

70% of the authorized physicians indicated that they perform further training in association with clinics, with certified physicians, with psychoanalytic institutes, etc. Two-thirds of these authorized physicians were also able to provide further training towards the supplementary designation “psychotherapy” and 1/3 were authorized to provide further training towards the supplementary designation “psychoanalysis.” These data show the autonomous development of further education in the field of psychotherapeutic medicine and its pronounced cross-linkage with other structures for initial and further training.

[36] DGPM, German Society for Psychotherapeutic Medicine

10. Quality Control (A.Springer, A.-M.Schlösser)

For quality control in psychoanalytic therapy, essential and coordinated tasks have been assumed in past years by DGPT (Deutsche Gesellschaft für Psychoanalyse, Psychotherapie, Psychosomatik und Tiefenpsychologie) and the specialists associations cooperating with it: DPG (Deutsche Psychoanalytische Gesellschaft), DPV (Deutsche Psychoanalytische Vereinigung), DGIP (Deutsche Gesellschaft für Individualpsychologie) and DGAP (Deutsche Gesellschaft für Analytische Psychologie). These responsibilities apply to practice and training in the area of analytic treatment techniques for adults. In the area of analytic child and adolescent psychotherapy, planning, development and coordination has been assumed by an association of professional specialists, the VAKJP (Vereinigung analytischer Kinder- und Jugendlichenpsychotherapeuten).

As a member society of the Association of Scientific Medical Societies (AWMF)[37] the DGPT participates in the processes of certification and recertification of relevant specialty-specific disease- and setting-related scientific guidelines. In this work it collaborates with the specialist associations AÄGP (Allgemeine Ärztliche Gesellschaft für Psychotherapie), DGPM (Deutsche Gesellschaft für Psychosomatische Medizin und Psychotherapie), DKPM (Deutsches Kollegium für Psychosomatische Medizin) and the leading specialist authorities in psychosomatic medicine and psychotherapy at the universities. To date the following guidelines have been certified in collaborative work with the DGPT:

- Posttraumatic Stress Disorders
- Personality Disorders
- Somatoform Disorders
- Depression (recertified 2002)
- Couples and family therapy
- Psychosomatics in reproductive medicine
- Assessment of psychosomatic disorders
- Artificial disorders

[37] Arbeitsgemeinschaft wissenschaftlich-medizinischer Fachgesellschaften

Collaborative work is in its initial stages on a guideline for:

- Psychosocial care of breast cancer patients.

The working group for quality control and management (see above), founded in 2002, has prepared a summary of all activities and considerations to date in order to prepare for framework planning for quality control of the DGPT.

At the request of the executive board the results have been systematized in the paper “Quality Management of the DGPT” (Piechotta 2002, unpub. manuscript, see appendix).

This working concept assesses the existing situation and identifies areas for development. It addresses the following planes: 1. members, 2. institutes and 3. cooperating specialist associations, from the aspects of 1. structural quality, 2. process quality and 3. result quality.

Regarding the activities of the members in patient care, a paper was prepared (also at the request of the executive board) on “Certification of the practices of analytic psychotherapists” (Piechotta 2001, unpub. manuscript), which follows such protocols as the “basic documentation for outpatient psychotherapy,” which was developed in 2000/2001 in the working group on quality control for private practitioners (see above).

All measures and planning for quality control and management in the area of psychoanalytic therapy are guided by the following essential criteria:

- Acceptability to members, institutes and cooperating specialists associations by assurance of freedom from legal etc. repercussions
- In the present context, this means the guaranteeing of data security for patients, members, institutes and cooperating specialists associations.
- Orientation to the method-specific working conditions required by each form of psychoanalytic therapy.
- Compatibility with quality control and management concepts (non-method-specific) presently being developed for psychotherapy by the federal chambers: the (Federal Physicians’ Chamber[38], the Federal Psychotherapists

[38] Bundesärztekammer, BÄK

Chamber[39] and the Federal Association of Statutory Health Insurance Physicians.[40]

The actual quality control of the training centers, the content of the training and the trainers takes place primarily within the training centers themselves under the oversight of the responsible state[41] authority. Regular meetings of the training centers are devoted to this both under the auspices of the DGPT and in the specialists associations. At these, common standards for the training are developed and agreed upon.

The training, testing and appointment of docents, supervisors and training and control analysts are conducted in the training centers in accordance with these binding standards. The trainers additionally place themselves at the disposal of the state examination offices to serve as examiners at the state examinations of psychological psychotherapists.

As provided by the German Social Law and in accordance with the psychotherapy guidelines, the majority of the experts in the expert reviewing procedure are trainers at the state accredited training centers.

The Expert Review Procedure as an Instrument of Quality Control

To the extent that it is covered by the statutory health insurance, psychotherapy in Germany is subject to the conditions of the psychotherapy agreements. According to these, the precondition for any benefit obligation on the part of the health insurance funds is implementation of an expert review procedure.

In this procedure, an expert examines an anonymous therapist's report to determine:

- if a psychological pathology is present,
- if this can be understood as cause-determined by means of an etiologically oriented diagnostic process,
- if acceptable improvement can be expected within the framework of the planned treatment, and
- if the planned use of the specified procedure to the specified extent is

[39] Bundespsychotherapeutenkammer, BPtK
[40] Kassenärztliche Bundesvereinigung, KBV
[41] I.e. the given German *Land.*

economical.

Based on his or her insight, the expert then submits a recommendation regarding assumption of costs to the insurance fund that has commissioned the procedure.

According to data of the Federal Association of Statutory Health Insurance Physicians, in 2002 in the area of analytically based therapies almost 137,000 expert reviews were submitted (Dahm A 2003, written communication). The average rejection rate was 4%, slightly below the preceding year. In higher-level (conclusive) expert review procedures, however, the rejection rate of applications for assumption of costs showed a slight rise from the preceding year, reaching 25%.

Criticism of the expert review procedure has intensified in recent years. Certain critics—those in the majority—blame what they see as a too low rejection rate on the procedure's poor capacity to distinguish applications that meet the conditions from those that do not. Others, however, speak of a too high rejection rate. Their central objection is that the procedure employed (an assessment based on written reports) is a wholly inadequate instrument for quality control because of its low reliability and validity (e.g.: Köhlke 1998).

In the meantime, however, studies have become available which prove the opposite (Rudolf, Jakobsen, Hohage and Schlösser 2002; Rudolf and Jakobsen 2002; Rudolf and Schmutterer 2003). In the first study a list of 10 criteria was developed with 3 gradations for each. In the judgment of the participating expert reviewers, if these criteria came out positive, they would confirm conformance with the psychotherapy guidelines and result in a recommendation for assumptions of costs.

In a study of interrater reliability in the decision-making behavior of reviewers using this list, a high rate of reviewer agreement was found in assessing positive reports. On the negative reviews the agreement rate was somewhat lower, with one third of the reviewers in such cases deciding for limited approval alongside of the rejections. This supports the case for reliable distinguishing of positive and negative cases. Furthermore certain criteria on the list could be isolated which were associated to a high degree with endorsement or non-endorsement. Thus there is good evidence that the criterion list contains decision-making criteria that are relevant to the expert review process.

In another study (Rudolf and Jakobsen 2002) the findings regarding the selectivity of the criteria based on a small number of reports was reviewed with a larger sample

(40 expert reviewers, 452 cases) and assessed as to their significance as a basis for expert evaluation. Here is the result:

“In their assessment of written reports and their way of dealing with the criterion list developed by the expert review commission, the expert reviewers show an unexpectedly high rate of agreement. In their assessment behavior the reviewers base themselves on the criteria derived from the psychotherapy guidelines. In the case of approval on average 80% of the criteria are met, in a limited approval an average of only 30 %, and in non-approval under 10 %. When a total of 9 criteria are used, the critical threshold between approval and non-approval lies at 6 out of 9. In approved cases 7, 8 or 9 out of 9 criteria are unambiguously met, while in non-approved cases a total of 6 or less are met.

It appears that certain criteria, such as degree of pathology and psychodynamics, tend to be the precondition for the actual judgment while others, such as correctness of treatment procedure, prognostic outlook of the treatment concept and prognostic assessment of the course, form the necessary basis for endorsement of coverage. These single features correlate highly with the collective decision of the expert reviewers. The feature that correlates most highly is economy, which is probably less a single feature than it is a reflection of a concluding synthesis. Thus the list of criteria developed appears very highly suited to reflect the content of the expert review process. Many of the experts participating in the study expressed a positive impression of it, finding that consulting the list made it easier for them to form a judgment. They were also in favor of putting this transparency to use in order to make their position plausible to the therapist by use of the expert review criteria list.

In summary, “use of the criteria list in the routine process of expert review can further enhance quality control for a well-functioning process.” (Rudolf and Jakobsen 2002).

Conclusion:

The decision process by expert review can be standardized and operationalized by use of the review criteria list, which has been established as a reliable and valid instrument. In this way transparency and quality control of the expert review procedure can be markedly optimized. Moreover the expert review process can be made more transparent for the therapist if he or she receives the review criteria list filled out by the reviewer as feedback.

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11. APPENDIX

11.1 Overview of studies and follow-up studies in psychoanalytic child and adolescent psychotherapy

Controlled studies (with control groups or control conditions)

11.1.1 Moran, G.S., Fonagy, P., Kurtz, A.M. and Brook, C. (1991). A controlled study of the psychoanalytic treatment of brittle diabetes.

Sample: 22 children and adolescents; *Diagnoses*: diabetes mellitus; *Measurement instruments*: checking of diabetes value HbA1c; *Control group*: control group with diabetes not treated with psychotherapy; *Treatment:* psychoanalytic therapy at 3-4 sessions per week, chiefly as a short-term technique.

Results: In comparison with the untreated control group, significant improvements in blood sugar values were found in the group receiving psychoanalytic treatment.

11.1.2 Heinicke, C.M. and Ramsey-Klee, D.M. (1986). Outcome of child psychotherapy as a function of frequency of sessions.

Samples: children in latency (between 7 and 10 years), n = 12; *Diagnoses*: learning problems, reading weaknesses, some hyperactive and all overanxious (as per DSM III); *Measuring instruments:* Diagnostic Profile according to A. Freud, reliability checking by ratings of the Wide Range Achievement Test (WRAT, validated); *Control group:* high-frequency (4 sessions per week), low-frequency (1 session per week) and frequency-change group (from 1 to 4 sessions); *Treatment:* psychoanalytic treatment of about 2 years.

Result: All treatments led to an enhancement of self-esteem, frustration tolerance, adaptability, capacity for work and relationship capacity. However, the outcomes were significantly greater and more lasting in the groups treated four times a week for more than one year.

After the follow-up interval the values remained stable only in the high-frequency treatment group.

11.1.3 Szapocznik, R., Murray, S., Rivas-Vasquez, Hervis, Posada and Kurtines (1989). Structural family versus psychodynamic child therapy for problematic Hispanic boys.

Sample: n = 69, boys aged 6-12 years; *Diagnoses:* clin. relevant disorder, DSM-III *Diagnoses:* 48% behavioral disorders, 30% anxiety disorders, 12% adjustment disorders and 10% other disorders; *Measuring instruments:* 27 comparisons on clinical symptoms, personality characteristics and family traits were conducted among the three groups, follow-up study; *Control group:* 1. non-therapeutic play group (n = 17; 14 in follow-up study), 2. comparison group treated with structural family therapy (n = 26; 23 in follow-up study), 3. psychodynamic treatment group (n = 26 and 21); *Treatment:* psychodynamic child psychotherapy at one session per week with average treatment duration of 18 months.

Result: On the total score of the test battery for determination of personality features, the group receiving psychodynamic treatment proved superior, but on the item “intrafamilial structure” it was inferior to the family therapy group. The analytic therapy group displayed significant improvements as compared with the control group of untreated children.

11.1.4 Lush, D., Boston, M. and Grainger, E. (1991). Evaluation of psychoanalytic psychotherapy with children: Therapists' assessments and predictions.

Sample: Out of 203 foster and adoptive children, 51 were recommended for PT, n = 38 began the PT (at ages from 2-18 years), n = 35 remained in the sample, foster and adoptive children; *Diagnoses*: ”severely deprived children,” reactive attachment disorders of childhood and disinhibited attachment disorders of childhood (F 94.1 and F 94.2); *Measuring instruments:* rating scales, independent clinical ratings, checking of validity, semi-structured questionnaire; *Control group*: control group of 13 children who had not begun any kind of therapy, comparison treated/untreated; *Treatment:* psychoanalytic psychotherapy.

Result: Therapist and independent clinicians report that the treated children improved, appearing “to make good use of psychoanalytic psychotherapy.” Improvements in their relationship capacity with adults, in the peer group, in learning and in self-evaluation.

The assessment demonstrates that in these particularly unreachable children it was actually possible to attain changes in personality structure.

11.1.5 Fonagy, P., Gerber, A., Higgitt, A. and Bateman, A. (2002). The comparison of intensive (5 times weekly) and non-intensive (once weekly) treatment of young adults

Sample: 30 young adults (18 - 24 years), 20% previously in inpatient psychiatric treatment; *Diagnoses:* axis II diagnoses with narcissistic disorders and borderline disorders and axis I diagnoses with affective disorders, significantly high number of self-injuries; *Measuring instruments:* SCL-90, Beck Depression Inventory, Spielberger State and Trait Anxiety Inventory, Social Adjustment Scale, National Adult Reading Test, Eysenck Personality Questionnaire, Adult Attachment Interview, SADS-L and SCID II (500-item checklist of a weekly rating scale); *Control group:* comparison between low- and high-frequency treatment groups; *Treatment*: high- and low-frequency psychoanalytic psychotherapy with an average duration of 3.5 years.

Result: The study demonstrates that the high-frequency treatment group was superior in attaining clinically significant symptom changes.

11.1.6 Fahrig, H., Kronmüller, K.-H., Hartmann, M. and Rudolf, G. (1996). Therapieerfolg analytischer Psychotherapie bei Kindern und Jugendlichen. Die Heidelberger Studie zur analytischen Kinder- und Jugendlichen-Psychotherapie. [Therapeutic outcome of analytic psychotherapy in children and adolescents. The Heidelberg study on analytic child and adolescent psychotherapy.]

Sample: n = 133 children aged from under 5 to 14 from a sample of 519 children; *Diagnoses*: diagnosed according to MAS and ICD-10, main diagnoses of this naturalistic study were emotional disorder of childhood (24.8%), disorder of social behavior (23.8%), enuresis (17.3%), adjustment disorder (12.0%) and developmental disorders (12%), neurotic and somatoform disorders (12%), eating disorders (9,%) and encopresis (6.8%). 41% had comorbidity of two disorders, 10.5% comorbidity of three disorders; *Measuring instruments:* BSS-K[42]; *Control group*: comparison sample of 67 healthy children, who were introduced but had no diagnosis in the sense of the

[42] Bildertest zum sozialen Selbst-Konzept (pictorial self-image test).

ICD-10. From this sample the comparison values for the BSS-K were determined; *Treatment:* the average number of treatment hours was 66.

Result: symptom reduction of 91.7%, improvements of 94.7% in manifestation areas of psychological conflicts, improvement of 89.1% in intrapsychic conflicts, improvement of 84.8% in conflicts worked through in parent conversations, effect sizes between 0.58 and 1.74, on the total value of the BSS-K 75.9% reached the criterion of clinical significance, i.e. values in the "non-case" range. Taking all outcome measures into account, one can speak of a successful psychotherapy in 90% of all treatment cases.

11.1.7 Winkelmann, K., Geiser-Elze, A., Hartmann, M., Horn, H., Schenkenbach, C., Victor, A.D., Kronmüller , K.-T. (2003), Heidelberger Studie zur analytischen Langzeitpsychotherapie bei Kindern und Jugendlichen [Heidelberg study on long-term analytic psychotherapy in children and adolescents}

Sample: n= 71 treatment cases; *Diagnoses:* the most frequent diagnoses were emotional disorder of childhood F 93.0 and disorder of social behavior F 92.0 (10.1% each). The second most frequent diagnosis was emotional disorder of childhood with sibling rivalry F 93.3 (8.7%). Overall, emotional disorders of childhood with additional issues comprised the main diagnoses (26%). Behavioral and emotional disorders with onset in childhood and adolescence (F 9) made up a total of 60.5% of the cases treated. Affective disorders (F 3) made up 20.2% of cases followed by F 4 diagnoses (neurotic stress and somatoform disorders (11.3%)); *Measuring instruments:* Test of Self Conscious Affects (Tosca), Psychischer und Sozialkommunikativer Befund (PSKB-KJ) für Kinder und Jugendliche (Psychological and social communication findings for children and adolescents), Fragebogen zur therapeutischen Beziehung (FTB-KJ = questionnaire on therapeutic relationship), Fokusbearbeitungsskala (FBS-KJ = focus assessment scale), Skalen zum therapeutischen Prozeß (STP-KJ = scales on therapeutic process), BSSK; *Control group:* combined study design with wait group design and a prospective, multi-level, multi-perspective approach; *Treatment:* short- and long-term psychoanalytic therapy, 25 – 100^{+} sessions using a therapy guide.

Results: Short-term treatment is unable to produce changes in ego-structure features such as attachment style, ego strength and defense structure. After 6 months of treatment it was possible to lower the mean severity of impairment by an

average of 2 points, but it did not reach the cut-off value for healthy children and adolescents, and longer treatment is necessary for symptom reduction as well. After one year of therapy 45.5% attain values comparable to those of healthy children (reliable and valid reduction).

11.1.8 Target, M., March, J., Ensik, K., Fabricius, J. and Fonagy, P. (2002). Prospective study of the outcome of child psychoanalysis and psychotherapy (AFC5).

This study is still in its pilot phase. It is expected to be completed in five years. *Sample*: 160 children aged from 6-12 years; *Diagnoses:* severe and complex emotional disorders with symptoms of anxiety and depression; *Measurement instruments*: application of the usual measurement instruments for the given therapeutic method with new development of specific instruments for measuring developmental outcomes in children. Measurement on five planes (symptom/diagnosis, psychosocial adjustment, cognitive and emotional capacities, relationship capacity and capacity to make use of the therapy); *Control group:* prospective randomized study with three comparison groups: psychoanalysis (high/low-frequency), cognitive behavioral therapy and usual child psychiatric treatments (TAU); *Treatment:* psychoanalysis in comparison with weekly psychotherapy, cognitive behavioral therapy, manualized treatments.

Results: still in pilot phase.

11.1.9 Smyrnios, K.S. and Kirkby, R.-J. (1993). Long-term comparison of brief versus unlimited psychodynamic treatments with children and their parents.

Sample: n = 30 children; *Diagnoses*: emotional disorders of childhood; *Measurement instruments*: Goal Attainment Scale (validated and reliable), Target Complaints Scales (recommended by Kazdin, reliable), Van der Veen Family Concept Inventory (validated and reliable), Bristol Social Adjustment Guides (validated and reliable); *Control group:* comparison of LTT and STT with a minimally treated control group. “Randomly assigned” to the three groups; *Treatment:* psychodynamically oriented psychotherapy.

Results: Four years after termination of therapy no difference was found between children receiving STT and LTT; LTT does not necessarily promise greater efficacy.

11.1.10 Lehmkuhl, G., Schieber, P.M. and Schmidt, G. (1982). Stationäre Gruppenpsychotherapie bei Jugendlichen im Spiegel von Selbst- und Fremdbeurteilung und Behandlungserfolg. [Inpatient group psychotherapy in the mirror of self- and other-evaluation and treatment outcome.]

Sample: n = 10, adolescents; *Diagnoses:* neurotic and expansive disorders, postpsychotic status; *Measurement instruments*: PSKB according to Rudolf; c*ontrol condition*: pre-post measurement according to PSKB; *Treatment:* analytic group psychotherapy in a weekly frequency setting over a period of 12 weeks.

Results: In nine clinical problem areas the problems are reduced by about one half (e.g. on symptom, attachment and contact planes).

11.1.11 Lehmkuhl, G. and Lehmkuhl, U. (1992). Gibt es spezifische Effekte der stationären Gruppentherapie mit Jugendlichen? [Are there specific effects of inpatient group therapy with adolescents?]

Sample: adolescents, n = 30; *Diagnoses:* neurotic diseases (n = 18), psychoses (n = 5) and expansive disorders (n = 7); *Measurement instruments*: psychological and social communication finding (PSKB according to Rudolf) as an instrument for standardized measurement of neurotic findings, performed by 2 independent raters, 13-item questionnaire according to Speierer, evaluation of treatment outcome using a modified version of Malan values by independent raters; *Control group:* comparison groups: video group, one- and two-session (per week) conversation groups; *Treatment:* analytic group psychotherapy in three different group settings over a period of 9 weeks.

Results: Rapid initial improvement of symptoms. The group with more frequent sessions is experienced as more helpful.

11.1.12 Robert-Tissot, C., Cramer, B., Stern, D., Rusconi Serpa, S., Bachmann, J.P., Palacio-Espasa, F., Knauer, D., De Muralt, M., Berney, C., Meniguren G. (1996). Outcome evaluation in brief mother-infant psychotherapies: report on 75 cases.

Sample: 75 mother-child pairs (about 60% referred by their pediatricians), children no older than 30 months; *Diagnoses:* regulation disorders (sleep, behavior and eating disorders), problems in parent-child interaction; *Measurement instruments*: Beck Depression Inventory for Mothers, Symptom Check-List (body functions, behavior disorders, anxiety and separation issues), R-interview for maternal representations, video-recorded mother-baby interactions, KIA/KIDIES profile; *Control group:* randomized assignment to two treated groups receiving psychodynamic mother-child psychotherapy (PD) conducted by psychoanalysts or interaction-centered psychotherapy carried out by psychologists and conversational therapists (IG) without reference to the mother's past or her projections. Evaluation before therapy, one week after termination and at a six-month follow-up; *Treatment:* up to 10 sessions of psychoanalytically oriented mother-child PT and interaction-centered PT.

Results: Tendency towards the values of a clinically unremarkable sample. Mothers' sensitivity to their children's signals continued to grow after termination of therapy. In the IG method, the mother's sensitivity grew solely in dealing with playthings; the mother's self-esteem also increased after PD.

11.1.13 Cohen, N.J., Muir, E., Parker, C.J., Brown, M., Lojkasek, M., Muir, R. and Barwick, M. (1999). Watch, wait and wonder. Testing the effectiveness of an new approach to mother-infant psychotherapy

Sample: 10 - 30 month-old infants and children, n = 67; *Diagnoses:* early childhood regulation disorders (attachment disorders, behavioral disorders, sleep and feeding disorders, emotional disorders of parent behavior and developmental disorders); *Measurement instruments*: Ainsworth Strange Situation test, Chatoor Play Scale, Mental Scales of the Bayley Scales of Infant Development, Parenting Stress Index, Beck Depression Inventory (BDI), Working Alliance Inventory; *Control groups:* therapy comparison of the "Watch, Wait and Wonder" approach with psychodynamic psychotherapy techniques; *Treatment:* see control groups.

Results: The two therapeutic techniques were equally successful in long-term symptom reduction, reduction of maternal stress and reduction of intrusive maternal behavior. The outcomes of the "WWW method" could be demonstrated immediately at termination of therapy, while the PD method did not attain comparable values until six months following termination.

11.1.14. Murray, Lynne, Cooper, Peter J., Wilson, Anji, Romaniuk, Helena (2003) Controlled trial of the short- and long-term effect of psychological treatment of post-partum depression

Sample: representative sample with n = 193 of a local clinical population. *Diagnoses*: DSM-III-R 'major depressive disorder'. *Measurement instruments*: measurements were taken at three measurement points (4-5 months, 18 months and 60 months), videotapes of face-to-face sessions 8 - 18 weeks, global rating scales, Behavioral Screening Questionnaire, Ainsworth Strange Situation test, Rutter A Scale, Pre-School Behavior Checklist. *Control group*: routine primary care is compared with non-directive supportive counseling, cognitive-behavioral therapy and short-term psychodynamic therapy. *Treatment*: the methods named above represented the forms of treatment and intervention. For a description of these, refer to Cooper 2003.

Results: Compared with routine care, all three techniques improve the mother's ability to deal with early relationship disorders in mother-child interaction. However on the parameters of attachment, intelligence and relationship dynamics, no long-term differences can be discerned between the control group and the treatment forms applied. The essential effects are described as 'short-term benefits' in the first year of life. Statistically significant differences could not be found either in comparison to the control group or in comparing the applied treatment forms among themselves. This may also have to do with the fact that the sample is described as a 'relatively low-risk population.'

11.1.15 Baruch, Geoffrey, Fearon and Pasco (2002). The evaluation of mental health outcome at a community-based psychodynamic psychotherapy service for young people: A 12-month follow up based on self report data.

Sample: n = 151 out of 720 adolescents (12-18 years) and young adults; *Diagnoses*: depressive disorders (F 3) (52.7%), neurotic, adjustment and somatoform disorders (F 4), (F 9.3) (20%), personality disorders F 6 (8%), hyperkinetic and behavior disorders (F 9.0, F 9.2) (5.3%); *Measurement instruments*: Global Assessment of Functioning Scale (GAF), Severity of Psychosocial Stressors Scale of Children and Adolescents (SPS); C*ontrol condition*: outcome is measured on three planes: 1. change in "mean scores," 2. change from clinical to non-clinical, 3. statistically

reliable change of the "level of adaptation"; *Treatment*: psychodynamic psychotherapy conducted by child, adolescent and adult psychoanalysts.

Results: In the outcome areas of internal and external measurements as well as in the total values, significant changes are found at all three measurement points. Effect sizes of 0.27 to 0.50 are attained; a large portion of the clinically ill reach non-clinical values at a cut-off of 60 (according to Achenbach).

11.1.16 Muratori, F., Picchi, L., Casella, C., Tancredi, R., Milone, A. and Patarnello, M.G. (2002). Efficacy of brief dynamic psychotherapy for children with emotional disorders.

Sample: n = 30 (between 6 and 10 years); *Diagnoses*: "emotional disorders" as per F93 and F92, determined by child psychiatrists; *Measurement instruments*: Children's Global Assessment Scale and Child Behavior Checklist; *Control groups*: experimental and control group (no treatment or another treatment) of 15 each; *Treatment*: Brief Psychodynamic Psychotherapy (BPP) following Fraiberg, Luborsky and Malan.

Results: Experimental group shows stronger improvement on two outcome variables, although only the mean value of the experimental group moved into the normal range. Significant improvements were attained in symptoms and overall emotional state. This outcome depended more on the absence of comorbid elements than on the duration or intensity of treatment.

11.1.17 Zimprich, H. (1980). Behandlungskonzepte und -resultate bei psycho-somatischen Erkrankungen im Kindesalter [Treatment concepts and results in psychosomatic illnesses of childhood]

Sample: n=270 patients of both sexes between 3 and 14 years of age; *Diagnoses*: mixed psychosomatic diagnoses, the chief leading symptoms (about 60%) being bronchial asthma, adiposity, anorexia, recurrent vomiting, eczema, dermatitis and (about 30%) enuresis, encopresis, constipation; *Measurement instruments*: psychosomatic status assessment, interview model with 29 variables, psychological testing procedure, linear logistical model LLRA, likelihood-quotient test; *Control group*: 100 patients of a control with psychosomatic symptoms not receiving psychotherapeutic treatment; *Treatment*: inpatient depth psychology-based, non-

interpretive play therapy for the patient (several times weekly) supplemented by analytically oriented family therapy interventions.

Results: To equate the observable change in symptom manifestation with the effectiveness of the therapy is made problematic by the fact that behavioral syndromes with weakly developed symptoms are disfavored in the symptom measurement process. A statistically verified positive effect of psychotherapy on the clinical symptoms and behavioral syndromes is found in comparison with the control group. Reduction of medication use in the group receiving psychotherapeutic treatment.

Follow-up studies

11.1.18 Dührssen, Annemarie (1964), Katamnestische Untersuchung bei 150 Kindern und Jugendlichen nach analytischer Psychotherapie. [Follow-up studies of 150 children and adolescents after analytic psychotherapy.]

Sample: infants and toddlers (14), school-age children (80) and adolescents (35), n= 129; *Diagnoses* (as defined by leading symptoms): productivity disorders, stuttering, enuresis and symptoms of anxiety are the most frequent diagnoses; *Measurement instruments*: follow-up period of 5 years following termination, questionnaire and follow-up interview with parents, child or adolescent; *Treatment*: analytic psychotherapy.

Results: "...these findings do not represent the results of a scientific study." 53% received the result "very good to satisfactory improvement and 26% the result "adequate improvement."

11.1.19 Petri, H. and Thieme, E. (1978). Katamnese zur analytischen Psychotherapie im Kindes -und Jugendalter. [Follow-up study on analytic psychotherapy in childhood and adolescence.]

Sample: children and adolescents at the Kinder- und Jugendpsychiatrischen Poliklinik of the Freie Universität Berlin, n = 78; *Diagnoses*: 43 are assessed as incipient and 35 as pronounced neurotic developmental disorders. 32 have the following additional diagnoses: suspected brain damage in early childhood, puberty

crisis, atrophy syndrome, retarded intellectual development, legasthenia, neglect, substance abuse, grand mal, disorders of psychosexual identity or development; *Measurement instruments*: follow-up period of up to five years, multi-perspective outcome assessment from the points of view of the patient, parents and therapists; *Treatments*: long-term analytic therapies, less than 80 sessions for adolescents.

Results: Satisfaction scores were between 57-66%. The neurotic disorders gave more satisfied assessments (54%), compared to 36% for more complex and comorbid disease pictures (e.g. neglect).

11.1.20 Fonagy, P. and Target, M. (1995). Kinderpsychotherapie und Kinderanalyse in der Entwicklungsperspektive: Implikationen für die therapeutische Arbeit. Prediktoren des Therapieerfolges in der Kinderanalyse: eine retrospektive Studie aufgrund 761 Fälle am Anna Freud Center. [Child psychotherapy and child analysis from a developmental perspective: implications for therapeutic work. Predictors of therapeutic outcome in child analysis: a retrospective study based on 761 cases at the Anna Freud Center.]

Sample: n = 763 (= 90% of the children treated at the Anna Freud Center); *Diagnoses*: ICD-10 and DSM-III diagnoses (retrospective, but good reliability assessments by external child psychiatrists who checked the diagnoses independently of one another; *Measurement instruments*: Hamstead Psychoanalytic Index, Hamstead Child Adaptation Measure (HCAM) with high reliability values; *Treatments*: 76% received intensive treatment (4-5 sessions per week), 24% were treated at 1 - 2 sessions per week.

Results: Clinically significant improvements were determined in 62% of the children receiving intensive treatment (effect size of 1.00) and in 49% of the children receiving low-frequency treatment (effect size = 0.64); in expansive disorders the disorder severity was reduced with LTT to the level of improvement as in emotional disorders. In emotional disorders (largest sub-group with n = 352), 58% moved into the normal range and 72% showed reliable improvement in functioning.

Summary of results according to Fonagy/Target:

1. Younger children show greater improvement in psychodynamic treatments and benefit from 4-5 sessions per week.
2. Non-generalized anxiety disorders are associated with good prognosis, even when the initial diagnosis was an expansive disorder.

3. Children with profound developmental disorders do show comparatively poor outcomes (only 28% improvements), including with LTT.
4. Children with emotional disorders respond well to LTT even with comorbidity, but not with low-frequency treatment.

“Our data suggest that given sufficiently long and intensive treatment most (but not all) child psychiatric disorders can be meaningfully treated with this application of the psychoanalytic technique, which has been somewhat extended (by providing developmental help)” (181).

11.1.21 Target, M. and Fonagy, P. (1998). The long-term follow-up of child psychoanalysis.

This study, which has not yet been completed, is a retrospective long-term study addressing the question whether psychoanalytic interventions in childhood represent a protective factor.

Sample: 200 persons, half of whom displayed disorders at age 10-11 and are today between 24 and 35 years old; *Diagnoses*: disorders in childhood, including psychiatric disorders; *Measurement instruments*: 1. depth interviews based on objective measurements of life events, on present level of personality functioning as well as on psychiatric and personality disorder diagnoses; 2. symptom measurement scales (SCL-90, SF-36, IQ and EPQ); 3. psychodynamic measurement of attachment capacity and object relation representations; *Control group*: 1. group receiving intensive psychoanalytic treatment, 2. group receiving low-frequency treatment (1 session per week), 3. group of siblings of those receiving treatment, 4. group of untreated persons with disorders in childhood; *Treatment*: high- and low-frequency psychoanalytic treatment.

Result: Successfully treated children have acquired a protective factor for their adult life.

11.1.22 Winkelmann, K., Hartmann, M., Neumann, K., Hennch, C., Reck, C., Victor, D., Horn, H., Uebel, T. and Kronmüller. K.T. (2000). Stabilität des Therapieerfolgs nach analytischer Kinder- und Jugendlichen-Psychotherapie - eine Fünf-Jahres-Katamnese [Stability of therapeutic outcome after analytic child and adolescent pyschotherapy – a five-year follow-up.]

Sample: n = 131; *Diagnoses*: emotional disorders of childhood (24.8%), disorders of social behavior (23.3%), enuresis (17.3%), adjustment disorders (12.0%), developmental disorders (12%), neurotic and somatoform disorders (12%), eating disorders (9%) and encopresis (6.8%) (as per ICD-10 and MAS); *Measurement instrument*: BSS-K according to Schepank (1995), CBCL, Giessen problem questionnaire for children and adolescents; *control condition*: pre-post comparisons; *Treatment*: analytic child and adolescent psychotherapy.

Results: On all BSS-K scales and total score, highly significant changes were found between the beginning and end of therapy. After termination (41%) and at the follow-up (45%) unremarkable on all BSS-K scales. According to the criterion of clinical significance the effect size and improvement rates remain largely stable at 70-80%.

11.1.23 Waldron, S. et al. (1975). School phobia and other neurosis. Systematic study of the children and their families

Sample: n = 42 out of n = 627, young adults (17-22 years) who were under 13 years old at the time; *Diagnoses*: neuroses and school phobia; *Measurement instrument*: Health-Sickness Rating Scale (HSR) according to Luborsky, Current and Past Psychopathology Scales (CAPPS), semi-structured clinical interview with rating scales, interrater reliability; *Control group*: 42 former patients treated with short-term therapy are compared with patients remaining in long-term analysis; *Treatment*: unspecific STT compared with analytic LTT.

Results: No patient of the control group was clinically ill, while the former STT patients fall within a wide spectrum of psychopathology. It follows that these children were in need of effective treatment. No former patient received appropriate standard psychoanalytic treatment.

11.2 Classification of the studies by application area for psychotherapy in children and adolescents.[43]

The following compilation attempts to classify the various studies by application area. In accordance with the specifications of the Scientific Advisory Board for Psychotherapy, controlled studies or studies with control conditions are recognized

[43] (published in Deutsches Ärzteblatt 97, Heft 33, 13. August 2000)

as a demonstration of efficacy. Follow-up studies demonstrate that the treatment outcome is appropriately stable for the clinical problem. Naturalistic studies are given particular consideration in assessment.

Chief application areas of psychotherapy for children and adolescents in accordance with the resolution of the Scientific Advisory Board

11.2.1. Affective disorders and stress disorders (F 30 – F 39 and F 43)

- Infant studies dealing with both affective disorders in the mothers and with elements of posttraumatic stress and adjustment disorders are to be classified under this application area. Three efficacy studies fit in this category: Robert-Tissot et al. (7.3.12), Cohen et al. (7.3.13) and Murray (7.3.17).
- The study of Baruch and Fearon (7.3.15) contains over 52.7% F 3 diagnoses. It contains outcome measurements according to validated and reliable instruments in three important measurement areas. Thus the study fulfills the requirement "control condition" by pre-post measurement.
- The prospective study of Target et al. (7.3.9), still in its pilot phase, can be classified here due its focus on depressive symptoms.

Summary: There are **four studies** in this area. It is a weakness that the studies in this area are mainly parent/infant studies inasmuch as the Advisory Board requires them "to cover various age levels up to age 18"; on the other hand, this requirement applies to the total assessment, not to a single application area.

11.2.2. Anxiety disorders and emotional disorders with onset in childhood and adolescence (F 40 – F 42 and F 93)

- The study of Fahrig et. al. (7.3.6) with its predominant symptoms of emotional disorders can be placed in this category. It is true that this study is not controlled by a control group but by a comparison sample, but this does represent a "control condition."
- The study of Winckelmann et al. (7.3.8) focusing chiefly on symptoms of emotional disorders may be classified here. With its combination of a controlled study section and a naturalistic design, this study carries double weight in view of the Advisory Board's determination that "studies which make it possible to

translate proofs of efficacy into clinical care practice will be given particular weight in assessment."

- The study of Smyrnios et al. (7.3.9) can also be assigned to this category because of its predominant focus on symptoms of emotional disorders. The measurement instruments employed are validated and reliable. The STT treatments were more successful than the minimal contact treatments.
- The study of Muratori et al. (7.3.16), being exclusively devoted to F 92 and F 93 ICD diagnoses, falls in this category as well. The experimental group demonstrates improvements in all functions.

Summary: There are **four demonstrations of efficacy** for this application area.

11.2.3. Dissociative, conversion and somatoform disorders and other neurotic disorders (F 44 – F 45 and F 48)

In the studies of Fahrig (7.3.6), Winkelmann, Geiser-Elze et al. (7.3.7) and Winkelmann, Hartmann (7.3.22), these diagnoses are treated as well but to a smaller extent. These studies are already counted in other application areas.

Summary: There are **no studies** for this application area.

11.2.4. Eating disorders and other behavioral syndromes associated with physiological disturbances and physical factors (F 50 - 52 and F 54)

- The study of Moran and Fonagy (7.3.1) is to be categorized here since diabetes mellitus is not mentioned in the ICD-10. Since the commentary mentions examples of other psychosomatic illnesses such as asthma, dermatitis and colitis and since F 54 deals with psychological factors and behavioral factors in diseases classified elsewhere (under chapter E), this seems to be the appropriate category.
- The study of Zimprich (7.3.17) fits in this category in view of its broad spectrum (around 60% of 170 patients) of predominantly psychosomatic disorders (asthma, eating disorders, dermatological symptoms), even though the study includes enuresis and encopresis.

Summary: There are **two** studies.

11.2.5. Behavioral disorders (F 90 – F 92, F 94, F 98) with onset in childhood and adolescence and tic disorders (F 95)

- Szapoznik et al. (7.3.3) can be classed in this application area based on its aggressive disorders of social behavior. The study is well controlled, having three comparison groups.
- The study of Lush et. al. (7.3.4) includes combined disorders of social behavior and emotions as diagnoses, but its diagnoses are predominantly reactive attachment disorders of childhood (F 94.1) and disinhibited attachment disorders of childhood (F 94.2)—disorders which may be expected in foster and adoptive children. The study is controlled.
- The studies of Lehmkuhl and Lehmkuhl (7.3.11) and Lehmkuhl, Schieber and Schmidt (7.3.10) belong in this category due to the pronounced disorders of social behavior.
- Fonagy and Target (7.3.6) can be classed here since the term “childhood disturbances” also implies behavioral disorders. This study remains unpublished and is available only in the form of a congress paper.

Summary: There have been **four studies** in this category.

11.2.6. Autistic Disorders (F 84)

Summary: No studies have been conducted in this application area.

11.2.7. Personality disorders and behavioral disorders (F 60, F 62, F 68 – F 69, disorders of impulse control (F 63), disorders of sexual identity and sexual disorders (F 64 – F 66), dependency and abuse (F 1, F 55), schizophrenia and delusional disorders (F 20 – F 29)

- The study of Fonagy and Gerber et al. (7.3.5) can be classed in this application area due to its focus on personality disorders. However, it has not been completed and is not published.

Summary: One study can provisionally be counted in this area.

11.2.8. Mental retardation (F 7), organic mental disorders (F 0) and developmental disorders (F 80 – F 83; F 88 and F 89)

- The study of Heinicke and Ramsey (7.3.2) belongs in this category due to its learning and reading disorders. It is not a controlled study.

Summary: One study has been conducted in this area.

In addition, the older, methodologically adequate follow-up studies of Dührssen (7.3.18), Petri/Thieme (7.3.19) Fonagy/Target (7.3.20), Target/Fonagy (7.3.21), Winkelmann et. al. (7.3.22) and Waldron et al. (7.3.23) should be counted. Together they make five further studies, devoted to various clearly defined groups of disorders, which serve to cover an application area.

Thus altogether there have been 17 controlled studies or studies with control conditions and 6 comprehensive follow-up studies with a total of approx. 1350 patients. It is particularly noteworthy that many studies are based on a clinically naturalistic design and so provide testimony to their efficacy in the context of routine care—a fact which deserves special consideration according to the provisions of the Scientific Advisory Board.