Kächele H, Richter R, Thomä H, Meyer AE (1999) Psychotherapy Services in the Federal Republic of Germany. *In: Miller N, Magruder K (eds) Cost-effectiveness of psychotherapy. Oxford University Press, New York Oxford, pp 334-344*

Psychotherapy Services in the Federal Republic of Germany

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Historical Development of the field of Psychotherapy

For historical reasons, the field of psychotherapy in the Federal Republic of Germany has largely developed independently from psychiatry, and presently has achieved the status of a medical specialty (psychotherapeutic medicine) and of a field of applied clinical psychology. The differentiation of psychotherapy from psychiatry began in the second half of the last century with Griesinger's insistence that "mind diseases are brain diseases".This biological focus had a strong opposition within German psychiatry to the developing field of psychotherapy (Alexander & Selesnick 1969).

Thus the development of psychoanalysis as the leading theoretical and practical movement in psychotherapy after the turn of the century largely took place outside of academia. During the Third Reich psychoanalysis was destroyed. Following closure of the distinguished Berlin Psychoanalytic Institute which had established the first functioning low-fee outpatient psychotherapy clinic the few remaining, non-jewish psychoanalysts sought ways to maintain their professional existence. On the one hand, they turned to private practice; on the other, they retained a measure of independence with the German Institute for Psychological Research and Psychotherapy, founded in 1936. The training of young psychoanalysts continued there, although the Institute's goals exerted considerable pressure on them. The aim of bringing all schools of depth psychology under one roof was to promote Aryan

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psychotherapy and create a standard psychotherapy. Cocks (1984), in his historical studies, concluded that the gathering of the different schools at one institute had longterm consequences which, in his estimation, are on the whole positive[5].

The incorporation of all psychotherapists employing depth psychology into one institue led to the development of communities of interests, and to consensus on various issues between advocates of different approaches. The founding, in 1949, of the German Society for Psychotherapy and Depth Psychology had considerable positive consequences right up to the present day.

The subsequent recognition of psychoanalytic therapy by public health insurance organizations also began in Berlin. The Institute for Psychogenic Illnesses (Institut für psychogene Erkrankungen) founded in Berlin in 1946, was the first psychotherapeutic outpatient clinic to be financially sponsored by a semi-state organization, the General Communal Health Insurance (Allgemeine Ortskrankenkasse). This represented a first step for the eventual acceptance of psychoanalytic therapy by all public health insurance organizations: Nonmedical psychoanalysts were always active at this clinic, and were able later, following the introduction of professional standards for practising psychologists, to fully participate in the clinicl treatment of patients.

Another forceful influence promoting in the establishment of psychoanalysis as a key treatment modality in West-Germany was the Psychosomatic Hospital of the University of Heidelberg, which was founded in 1950 with support from the Rockefeller Foundation. Under the direction of A. Mitscherlich, it grew into an institution in which psychoanalytic training, treatment, and research were united under one roof. There for the first time in the history of German universities, psychoanalysis was able to establish itself in the way Freud (1919) had envisaged.

Many of the first generation of postwar psychoanalysts in Germany began as self-taught practitioners without public support. The slow recovery of the psychoanalytic profession - there were no behavior therapists in those years - was markedly supported by help from German speaking psychoanalysts living abroad putting aside personal feelings and offering their assistance. Further support came from the German Research Foundation (Deutsche Forschungsgemeinschaft) which provided financial support for training and supervisory analyses, as the result of recommendations from a report it had commissioned. (Görres et al. 1964).

This report documented the separation of psychotherapy from psychiatry in the postwar Germany, and also made clear that in Germany psychosomatic medicine had become part and parcel of psychotherapy; the field of psychotherapy served many patients who were not adaequately treated, either by psychiatric, or other somatic, interventions.

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[5]for further critical comments see Thomä & Kächele 1987, p. XIX

The founding of the Berlin Central Institut for Psychogenic Illnesses in 1946 represents "the first step in the recognition of neurosis as illness by a German public institution: For the first time, one of the institutions in the social insurance system paid the costs of psychoanalysis and other psychotherapeutic treatments" (Dräger 1971, p. 267). The Central Institute thus made a significant contribution to overcoming the resistance of the social insurance system to psychodynamic treatment. It "provided the German Society for Psychotherapy and Depth Psychology with many of the arguments which, after long and weary years of negotations, finally led to success" (Baumeyer 1971).

The recognition of neuroses as illnesses represented a precondition for the inclusion of psychotherapy as a benefit in the programs of major health insurance companies in 1967, and the programs of other public organizations, in 1971 (Haarstrick 1976; Faber 1981).

Parallel to the recognition of psychodynamic and psychoanalytic therapies as part of the health insurance officially funded service delivery system, German medical faculties changed the curriculum in 1970 to include "psychosomatic medicine and psychotherapy" as an independent field, to be mandatorily taught to all medical students. This necessitated the establishment of departments for psychosomatic medicine and psychotherapy. The first and second generation of chairs at these 33 departments are all psychoanalytically oriented. These institutions had considerable impact on the further establishment of psychotherapy as an acknowledged form of treatment in medicine.

The slightly later development in academic clinical psychology to integrate psychotherapy as a field of research and training, developed mainly in behaviorally and client-centered orientations. Many of the professors and lecturers in clinical psychology, however, are not clinically experienced psychotherapists, but more qualified as empirical researchers. Although psychotherapy is considered as applied clinical psychology, its standing within academic psychology is rather poor.

Health Insurance in Germany

In Germany, the health insurance system ensures that necessary outpatient and inpatient medical treatment are available at the time of need, for individuals from all strata of society, regardless of financial situation. With few exceptions, the patient pays no more than his regular insurance premium (approximately 14% of his income). Health insurance companies are legally constrained from demanding any direct

contribution toward the costs of either analytic or behavior therapy[6]. As nearly all patients consulting a psychotherapist in the FRG have medical insurance covering the officially admitted forms of psychotherapy,[7] these regulations have a powerful impact on the psychotherapy service delivery system.

The system of providing psychotherapy is regulated by a set of agreements between the *Kassenärztliche Bundesvereinigung* (KBV; the national corporate organization of physicians regulating matters of public health and payment of medical care) and the health insurance companies. The system of third-party payment is explicit about the fact that the patient make no direct payment; instead he requests, by way of the therapist writing a detailed report, that the KBV cover costs for treatment. A body of peer reviewers examines the claim and if approved, the therapist recives his fee via the local branch of the KBV.

It should be emphasized the patient's right of legal redress is directed not at the state but at the health insurance company, an arrangment dating back to insurance regulations implemented by Bismarck. The German social insurance system is supervised by the state, but it is not a national health service.

The patient knows how much is deduced from his salary or wages as his health insurance contribution, and he can calculate how much he has paid in over the years, and how often he has availed himself of services. He has a free choice of doctor. Just as the public health insurance companies together form a corporate entity, nearly all doctors (and psychotherapists) are members of the KBV.

The fees for psychotherapists' services, as for all doctors' services, are negotiated between these two corporate organizations. Obviously, the agreement on rates for medical services involves compromises in which political and economic factors play a part. In many respects, the specific regulations covering the analytic and behavioral psychotherapies, including the guidelines on payment, represent such a compromise.

The Guidelines (Psychotherapie-Richtlinien)

[6]To qualify for inclusion in the health insurance system only those forms of psychotherapy are admitted that provide an etiological theory and provides specific methods of treatment with demonstrated effectiveness

[7]There are also non officially recognized forms of psychotherapy, e. g. client-centered or other forms of humanistic psychotherapy, that can be reimbursed based on case-specific decisions by local insurance companies. This "grey market" is quite substantial, accounting for at least17% of the costs of official psychotherapy (Meyer et al. 1991, p. 38)

To direct the practitioner and to assure quality of care, clinical guidelines called *Psychotherapie-Richtlinien* are continuously monitored by the KBV, which bases its judgments on input from peer reviewers elected from the field.

Guidelines Indications for Psychodynamic Therapy and Psychoanalytic Therapy:

1. Psychoreactive psychic disturbances (e.g. anxiety neuroses, phobias, neurotic depression)
2. Conversion neuroses
3. Autonomic functional disturbances with established psychic etiology
4. Psychic disturbances consequent on emotional deficiencies in early childhood; exceptionally, psychic disturbances related to physical injuries in early childhood or to malformations
5. Psychic disturbances resulting from severe chronic illness, as long as they offer a basis for the application of psychodynamic or psychoanalytic therapy (e.g. chronic rheumatic conditions, particular forms of psychosis)
6. Psychic disturbances due to extreme situations which evoke grave personality disturbances (e.g. a long prison sentence, severe psychic trauma)

The guidelines specify that psychotherapy provided by health insurance is restricted to those illnesses whose course can be influenced for the better. Thus, the patient officially requests insurance coverage, and the psychotherapist is called upon to provide the peer reviewer with evidence suggesting that the intended therapy has the potential to alleviate, improve, or cure the neurotic or psychosomatic disease in question.
The psychotherapist is obliged to review his chosen therapy, and to justify it, in terms of the triad of necessity, effectiveness, and economy, which governs a doctor's diagnostic and therapeutic action in Germany, to the insurance company.

Complications inevitably ensue if therapist and patient forget that they are only two sides of a triangle. One cannot behave as if the reviewer were not there; whether therapy is extended or not depends on his assessment. In making his decision, heeds guidelines pertaining to treatment duration: "Psychonalytic therapy should as a rule achieve a satisfactory result in 160 sessions, in special cases, up to 240 sessions". Extension to 300 sessions is possible under exceptional circumstances, but must be sup-

ported by detailed arguments. Even 300 sessions is not an absolute limit, in the event that valid, convincing reasons are presented by the therapist to the peer reviewer. The unlike eveent that therapist and peer reviewer do not agree, a patient may go to court, and in some cases, successfully claim more sessions[8].

The health insurance companies are obliged to take over the costs only when the symptoms constitute an illness, and the triad of necessity, effectiveness, and economy is also satisfied. Both in diagnosis and in treatment, the German psychotherapist - be he or she a medical doctor or a psychologist - must maintain these criteria in mind. He or she must also remember that neuroses are on a continuum with characterologically determined disturbances, the latter of which, however, are not covered by health insurance. Psychodynamic therapy and psychoanalytic therapy are not covered by public health insurance if they do not have the potential to bring about cure or amelioration of a disease, or lead to medical rehabilitation. This applies especially to interventions intended exclusively for professional growth and development, social adjustment, child-rearing guidance, or other similar measures.

The Two Branches of the Psychotherapy Service Delivery System

A) The Inpatient System

The German psychotherapy delivery system consists of two branches: outpatient and inpatient psychotherapy. Historically, the development of the inpatient psychotherapy system began with some local experimentation by Simmel in Berlin, and Groddeck in Baden-Baden in the twenties. After the war, the joint influence of psychosomatics, as established within university departments of internal medicine (Freiburg, Hamburg, Heidelberg), and some early, successful efforts to re-establish the tradition of Simmel, led to inpatient psychotherapy as an accepted clinical method paid for by insuraance, long before out-patient psychotherapy became accepted[9].

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[8]Kächele et al. (1995) recently have presented a methodology of retrospectively reviewing such a controversial case which led a court to rule that the patient should be paid 420 sessions of psychoanalytic therapy.

[9]A psychosomatic-psychotherapeutic hospital for internal medicine, was established in Lübeck in 1946;
A hospital for analytic psychotherapy was instituted in Göttingen in 1949,
a hospital for psychogenic disorders in Berlin was established in 1948,
a special psychotherapy ward was added to the university hospital for internal medicine in Hamburg in 1950;
The Psychosomatic Hospital in Heidelberg was established the same year;
Inpatient treatment facilities were also established at universities in Freiburg (1957), Giessen (1962) and Mainz (1965).

As Schepank (1988) makes clear, this trend has been increasing since the 1970s, when hospitals established for the treatment of chronic somatic diseases like tuberculosis had to find a new clientele. Psychosomatic medicine turned out to be a comparatively inexpensive treatment modality and thus financially attractive for owners of rehabilitation institutions. There is a steeply rising numbers of beds for psychotherapy/ psychosomatics in the so called "Rehabilitation" segment of medical care, as well as the less pronounced growth of psychosomatic beds in community and university hospitals (Lachauer et al. 1991).

The more than 8000 beds for short term inpatient psychotherapy are officially provided for rehabilitative aftercare for somatic conditions like cardiac, pulmonary, orthopaedic, dermatologic complaints etc. Given the large percentage of patients suffering from functional somatic complaints, the system of inpatient rehabilitation over the years has been transformed into a system of inpatient psychodynamic therapy. In recent years, behavioral approaches also have successfully moved into that field, and today about 25 % of hospitals operate within a behavioral framework. Most of these inpatient facilities are still officially working under the adminstrative-financial regime of rehabilitation, and provide up to six weeks of intensive multimodal psychotherapy. However some institutions, officially recognized as psychotherapeutic hospitals, are able to provide quite intensive psychoanalytic inpatient treatment with duration of stay lasting up to nine months (e. g. Psychotherapeutic Hospital Stuttgart (Schmitt et al. 1993)). The patients taking advantage of these inpatient care facilities tend to be more severely ill than outpatients, and/or their motivation for change would not lead them to seek help as outpatients. Typically, these are chronically ill psychosomatic and psychoneurotic patients requiring some form of integrated psychosomatic, holistic treatment. A key problem of this inpatient system is the absence of continuity of care, post-discharge. Because these patients are admitted to therapeutic institutions from all over Germany, it has been difficult to integrate a suitable aftercare system.

Though this system of care, unique in its extension per capita of the population, offers intensive treatment for a segment of the population that otherwise clearly would be not cared for, scientific questions have been raised with regard such a system of inpatient care represents a strategy of treating patients too late and too often. Some have argued that it would be possible to treat all these patients as outpatients, if the system of outpatient care were in a position to really draw these patient into treatments. The point of Meyer et al. (1991) the inpatient system decrying as a "mis-allocation of public means" (p.41) might be too strong a statement, given that the development of inpatient psychotherapy also represents the outgrowth of wide public ac-

ceptance of psychotherapy (Kächele & Kordy 1996).

Inpatient psychotherapy is more than just psychotherapy in a hospital. Its general goals are based on the assumption that a convenient composition of a variety of therapeutic factors in a suitable structured institutional setting will allow for the optimal treatment of those patients who, when treated in an outpatient setting, are said to have little chances of success.

The sheer amount and diversity of psychotherapeutic and psychosomatic hospitals to be found all over Germany [10] as a well established part of the mental health care system may come as a surprise to the anglo-american reader; nevertheless, it is an established fact that in present day Germany nearby 40 % of all patients receive their psychotherapy as inpatient psychotherapy (Meyer et al 1991).

The outpatient delivery system in the FRG (1990) comprises a total number of 6,492 trained psychotherapists for adult patients and 740 child and adolescent psychotherapists that were licensed to practice within the German health insurance system.
The present system of funding psychotherapy allows for the following regimes that are detailed in the aforementioned guidelines (Kommentar Richtlinien Psychotherapie, Faber & Haarstrick 1991):

[10]We are deliberately omitting a description of the former East-German psychotherapy system which has disappeared now and is replaced by the West-German system.

Table 1

Insurance Coverage for Outpatient Psychotherapy Treatment Modalities:

			Number of Sessions Allocated
I	initial interview and evaluation		5-8
II	short term psychodynamic therapy a crisis intervention b focal therapy c dynamic psychotherapy d supportive therapy		25
III	short term behavior therapy		25
IV	psychodynamic therapy	1. phase 2. phase 3.phase	50 50+30 50+30+20
V	psychodynamic group therapy	1. phase 2. phase 3.phase	40 40+20 40+20+20
VI	behavior therapy	1. phase 2. phase 3. phase	45 45+15 45+15+20
VII	psychoanalytic therapy	1. phase 2. phase 3. phase	160 160+80 160+80+60
VIII	psychoanalytic group therapy	1. phase 2. phase	80 80+40

The psychotherapists and the population

The ratio of psychotherapists to people is 1 to 8695 persons, or 11.5 psychotherapists per 100,000 population. Tze data show also a linear increase in number of psychotherapists within the past decade. About half of the trained psychotherapists are physicians, the other half are clinical psychologists. Neither professional group is qualified to conduct psychotherapy by virtue their academic degree per se, but ruther must undergo intensive structured courses of post-graduate education and training.

Table 2

Training Schemes

Physician	Psychologist
Psychodynamic Psychotherapy	
Analytic Psychotherapy	Analytic Psychotherapy
Behavior Therapy	Behavior Therapy

Training is provided by private institutions certified by the *Kassenärztliche Bundesvereinigung* (KBV) to provide the necessary qualifications for serving within the medical system. As noted in the historical outline previously, psychotherapy training for long time was only provided in psychoanalytic/depth-psychological orientations. Training in behavior therapy was initiated in the 1970s, but only in 1987, after a recommendation from peer reviewers to the *Kassenärztliche Bundesvereinigung* (KBV) and to the insurance companies, was behavior therapy was covered by insuraance. Since then, the number of institutes providing behavior oriented training has been increasing rapidly, with a strong preponderance of psychologists seeking that kind of training. In psychoanalytic training institutions, the number of psychologists and physicians is fairly equal.

A recent review commissioned by the German government estimates that the total number of 7,232 psychotherapists does not cover the actual need for outpatient psychotherapy (Meyer et al. 1991). This estimate is supported by epidemiological data on the prevalence of neurotic, psychosomatic and personality disorders (Schepank 1987).
The one week prevalence of mental disorders ascertained from a representative sample drawn at random from a middle-aged municipal population when screened by an expert group, 25% of the sample received a diagnosis of neurotic, psychosomatic or personality disorder using ICD 9 criteria. Clearly, not all these individuals were motivated to seek out treatment. In a follow-up study, Schepank et. al. found that only 35 percent of diagnosed cases accepted out-patient individual or group psychotherapy when it was offered. (Franz et al. 1990).

The report commissioned by the German government following a review of data

from German epidemiologic studies, estimated that 5.3 percent of the F.R.G is in need of out-patient psychotherapeutic care, and would accept such treatment if covered by the health care system. This estimate of need can not be met by the 7,232 insurance-funded practitioner.

Using official data from the health care system, the review estimated that only one of seven for whom outpatient psychotherapeutic treatment is indicated, is treated in the official health care system. From these studies, it can be deduced that approximately 60 psychotherapists are necessary to cover the needs of 100,000 people, which corresponds to a ratio of one psychotherapist for 1,700 people. Estimates suggest the German health system needs six to seven times more psychotherapists than are presently available.

Although the number of psychotherapists is small relative to the need, it is actually great relative to availability in some other industrial countries. In addition, the budget for out-patient psychotherapy allocated by the health insurance companies is quite small, amounting to only 2.1 percent of the overall budget for out-patient health care by physicians, or to 0.39 percent of the total budget of the German health insurance companies.
The allocation of the psychotherapy budget to different service components is quire remarkable:
Not taking into account psychiatric outpatient services here, one-third of the budget is allocated to basic psychosomatic care - a recently introduced service provided by general practioners with some training in psychological medicine, 43 % are allocated to psychodynamic or psychoanalytic treatments, 13 % to behavior therapy, 6.4 % to psychoanalytic oriented child and adolescent psychotherapy, and almost 2 % to initial evaluative interviews. These data reflect the predominance of the psychodynamic orientation within the German psychotherapeutic health care system, and even the service of basic psychosomatic care is based on psychodynamic principles of training. As noted previously, the reasons for this preponderance reside in the special development of psychoanalysis within the German post-war culture. There is strong societal consensus pertaining to the effctiveness of psychoanalytic psychotherapy. Initial approval for this treatment was based on an empirical study that turned out to be decisive in the process of societal recognition of psychotherapy.

<u>The Berlin cost-effectiveness study</u>
As noted above, the Institute for Psychogenic Illnesses (Institut für psychogene Erkrankungen) founded in Berlin in 1946, was the first psychotherapeutic outpatient clinic to be financially sponsored by a semi-state organization. From early on, there

was strong interest in evaluating treatment outcomes.

In 1958 a major follow-up study was launched, in which retrospective case histories on 1427 patients were reviewed. The majority of treatments were individual analytic psychotherapies, at once or twice a week frequency, with an average length of 100 sessions. Five years post-termination, follow-up interviews with the 1004 successfully terminated cases were conducted by independent experts[11]. The data analysis constisted of systematic scaling of outcome criteria along the dimension of more or less improved. From 1004 successful cases they were able to interview 845 patients. The outcome data revealed that two thirds of patients remained improved. The more interesting findings of this follow-up study concerned data on successfully treated patients' stay in general hospital, both before and after treatment. This led to a subsequent study that deserves to be reported in some detail as it turned out to be the cost-effectiveness study that convinced the insurance companies.

Dührssen & Jorswieck (1965) drew a randon sample of 125 cases from all psycho-analytic oriented individual treatments that had been terminated in 1958. In addition, they also drew a random sample of 100 patients from the waiting list. They then checked for the distribution of prognostically favourable and unfavourable cases, and balanced the two samples. In addition they drew another random sample of 100 non-patients, from the general population of the insurance files. Based on these data, they were able to exactly count the number of days spent in a general hospital - for any kind of diagnosis - in the five years preceding, and the five years following, treat-ment.

Table 3: Number of days in a general hospital, in the five years preceding and the 5 years following psychoanalytic psychotherapy

group	**N**	**mean number of hospi-tal days**	**stan-dard devia-tion**
Ia patients before treatment	125	26.1	26.9
Ib patients after treatment	125	5.9	14.2
IIa patients waiting before 1958	100	25.6	30.4
IIb patients waiting after 1958	100	23.9	28.7
IIIa normal subjects before 1958	100	10.0	18.2

[11]Why the 152 non successful cases were not also approached remains a mystery (see Dührssen 1972, p.397; for a detailed discussion see Kächele 1992)

IIIb normal subjects after 1958	100	11.7	19.5

Patients on-the-waiting-list group required hospitalization for approximately 25 days within the time span of the first and second 5 year evaluation. In the psychotherapy group, however, the number of days of hospitalization decreased from 26 days in the five year pre-treatment period, to only 6 days, in the 5 year period following the termination of treatment. The so-called healthy members of the insurance company spent an average of 10 days in the five year period before 1958, and 11.7 days in the five year period after 1958. This finding was impressive, and it helped support the argument that psychoanalytic therapy should be implemented into the public health system of care.

On the other hand, true cost-effectiveness or cost-benefit analysis studies of psychotherapy appear rarely in the German literature. The following two studies are mentioned representatively: Deter (1986) studied the effectiveness of psychodynamic group-psychotherapy in bronchial asthma. In this controlled study, 57 patients suffering from moderate to heavy bronchial asthma, participated in a one-year outpatient group-therapy which was systematically monitored. A randomly selected sub-sample of 12 patients vs 10 matched control was further studied. All the differences between the one-year-pre- and one-year-post-treatment period, taken into account in the cost-benefit-analysis, were found to be statistically significant.

Three items underscored the benefit of the psychotherapeutic treatment. These included:

> Number of workday absences were found to increase in the control group from 44 to 62 days per year, whereas in the treatment group absences decreased from 58 days during the pre-treatment-year, to 27 days during the year-period following therapy. This difference in temporary work disability expressed as a benefit, was due to a direct and indirect decrease in labor costs, in the amount of to $ 2,070 per patient. Additionally, while number of days of hospitalization per year increased in the control group from 11 to 19 days per patient, it decreased from 24 to 3 days, in the treatment group. The decrease in costs of hospitalization, amounted to $ 4,410 per patient. Finally, psychotherapy patients were found to visit their GP less often.

The authors concluded that a savings of $ 5,330 per patient was achieved via psychodynamic group-therapy.

Zielke (1993) studied 148 patients and calculated the difference between the costs incurred by a chronic psychosomatic disease (treatment costs and labor costs due to temporary work disability) before and after a 60 day inpatient course of behavioral treatment, comparing work disability decreases with treatment costs. He reported a cost-benefit-ratio of 1 : 3.5 for working patients, i.e. a direct benefit of $ 8,871 per patient.

Economic arguments will become increasingly prominent in the German medical literature in the years to come. The health insurance companies and the health administration will increase pressure on the psychotherapy delivery system to offer treatments which have been proven cost-effective. Accordingly, important new aspects of the evaluation of psychotherapeutic techniques can be expected in the near future.

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