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Do psychoanalytic treatments have positive effects on health and health care utilization? Further findings of the Stockholm Outcome of Psychotherapy and Psychoanalysis Project (STOPPP)

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Abstract
Effects of psychoanalytic treatment on subjective health and health care utilization were studied in a sample of 420 patients in various stages of psychotherapeutic treatment. Outcome measures, based on a self-report questionnaire taken for three consecutive years, included the Self-Rated Health Scale (SRH), General Symptom Index (GSI) from the Symptom Checklist-90 (SCL-90), and Sense of Coherence Scale (SOCS) as well as self-reports on health care utilization during the past 12 months. The study had a quasi-experimental, accelerated longitudinal design. Individual raw scores of the dependent variables were regressed, one by one, on an eight-step treatment stage scale. Sex, age, and education level were entered in a first block to partial out their possible effects. In contrast to the significant positive developments found on the subjective health measures (SRH, GSI, and SOCS), no significant change was found on the health care utilization variables. The complications in interpreting psychotherapy effects on health and health care utilization are discussed.

A number of studies have accumulated that suggest that even very limited psychological interventions can reduce health care costs (Beutel, Rasting, Stuhr, Rüger, & Leuzinger-Bohleber, 2004; Breyer, Heinzel, & Klein, 1997; Chiles, Lambert, & Hatch, 1999; Dührssen, 1962; Dührssen & Jorswieck, 1965; Follette & Cummings, 1967; Gabbard, Lazar, Hornberger, & Spiegel, 1997; Keller, Westhoff, Dilg, Rohner, & Studt, 2001; Keller, Westhoff, Dilg, Rohner, Studt, & Study Group on Empirical Research in Analytical Psychotherapy, 1997; Mumford, Schlesinger, Glass, Patrick, & Cuerdon, 1984). Where shrinking health care budgets lead to an increased demand for less expensive treatment alternatives in public health care, this type of outcome information is welcomed. However, the interpretation of these seemingly positive findings is hampered by complications, the most important of which are discussed next.

Direct versus indirect aims of psychological interventions

In their meta-analytic review on the impact of psychological interventions on medical cost offset, Chiles et al. (1999) underscored the difference between psychological treatments, in which medical offset is the primary goal, and treatments in which medical offset is rather a side effect. They found clear support for the direct effects of behavioral medicine interventions but only weak support for medical cost offset as an indirect consequence of outpatient psychotherapy, with improvement of the patients' psychological state as the primary goal. The difference between these contexts is obvious if one considers, for example, the use of behavioral medicine to "pretreat" or "posttreat" surgical inpatients in contrast to psychotherapy with patients with interpersonal relation problems.

Psychological interventions are not always psychotherapy

In their meta-analysis, Mumford et al. (1984) used the terms *mental health treatment* and *psychotherapy* as though they were interchangeable or synonymous. Yet only two of the 58 studies involved long-term psychotherapeutic treatments (Dührssen & Jorswieck, 1965; Follette & Cummings, 1967). The same restriction applies to the review by Gabbard et al. (1997). In the majority of studies, the interventions were brief and typically educational–in-

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structional in nature, in some cases approximating supportive counseling but seldom psychotherapy. Although impressive, their effects, as measured, were often circumscribed and short term. As Chiles et al. (1999) argued, one cannot generalize from such interventions to psychotherapy proper. Furthermore, showing that instruction and emotional support before surgical treatment may reduce the subsequent number of inpatient days has quite different implications than showing that long-term psychotherapy may reduce future health care utilization in general.

Health care does not exactly reflect ill health

Because sick leave and other sickness-related variables are multifactorial, they cannot be taken as mere reflections of ill health. Changes in governmental health care policy, reimbursement rules and conditions, and general attitudes and morale in the population (Englund, 2000) are examples of other factors that may contribute to changes in health care consumption. Hence, a patient's health status and his or her use of health care must be sharply distinguished.

Furthermore, health and ill health have both objective (e.g., laboratory test results) and subjective (e.g., the feeling of being in good health) referents, and these may be equally valid without being in any close correspondence. Subjective, self-rated health has been shown to be a powerful predictor of mortality, often more powerful than medical diagnoses (Bue Bjorner et al., 1996). This underscores the importance of also taking into account patients' perception of their own health.

Medical and psychiatric health care effects have different social impact

Regarding psychological interventions and their impact on health care, it is important to distinguish between psychiatric and medical (somatic) health care. A reduction in psychiatric health care utilization after psychotherapy (Gabbard et al., 1997) has different implications than a reduction in medical health care utilization. In the former case, the positive finding may be taken as evidence that psychotherapy, itself a kind of psychiatric treatment, is a viable alternative to other forms of psychiatric care. A negative finding would be a setback to psychotherapy proponents. In the latter case, a positive finding is a bonus, beyond the promises of psychotherapy, whereas a negative finding may be regretable but should not be detrimental to the image of psychotherapy on the market.

Different health care variables apply to different populations

Health care variables are heterogeneous. They reflect ill health at different degrees of severity and in different patient populations. Thus, it is important to carefully define the relevant population for each variable. For instance, outpatient visits with medical doctors apply only to a nonhospitalized population, whereas hospitalization applies to a comparatively sick population. As another example, sick leave as a measure of ill health is only applicable to patients employed and working full or part time over the whole follow-up period. This excludes all patients who were not in the labor force during the follow-up period (e.g., the unemployed, students, homemakers, and persons on parental leave).

Cost measures are differentially sensitive to different health care variables

Hospitalization accounts for a large share of health care costs but is relatively infrequent both generally and in the psychotherapy population. Thus, health care costs are more sensitive to hospitalization than to outpatient visits. On the other hand, outpatient visits are more sensitive to variations in "normal" ill health, whereas hospitalization is insensitive to other than severe pathology. Still, many studies focus on inpatient stays or days. For example, the reduction of health costs after psychological interventions, which Mumford et al. (1984) found in 85% of the 58 studies reviewed, was primarily due to fewer inpatient days. In the "normal" psychotherapy population, outpatient visits would probably better reflect improved health but have relatively little consequences for the costs.

Cost-effectiveness is very difficult to estimate

It is difficult enough to make a thorough inventory of the various types of costs and savings that can be related to psychotherapy but far more difficult to estimate the costs and savings in dollars or euro. The cost of psychotherapy should include not only the fee or reimbursement and work loss of the patient but also such remote costs as, for instance, those for psychotherapist supervision. Savings should include not only the patient's own reduced health care consumption but also that of the patient's family members, increased productivity (not only or necessarily measurable in days of sick leave) of the patient and his or her family, and so on, if possible in a lifetime perspective. Beutel et al. (2004), Breyer et al. (1997), and Zielke (1999) are well aware of these difficulties. The exactness of the figures they report

may nonetheless lead to a false impression of precision.

Thus, a number of complications make health care utilization variables questionable as measures of psychotherapy effects. The aim of this article is to illustrate this complexity using data that were collected with the purpose of studying whether long-term psychoanalytically oriented psychotherapy and psychoanalysis have any positive effect on patients' health and health care utilization variables.

In 1989 the Swedish national health insurance and health care authorities agreed on a program to subsidize long-term psychotherapies and psychoanalyses with private practitioners in Stockholm County. One of the main goals was to reduce the incapacity rate (mean number of days per year reimbursed by national health insurance) and the number of long-term sick leaves and disability pensions. Follow-up was required as part of the deal. The Stockholm Outcome of Psychotherapy and Psychoanalysis Project (STOPPP) was designed partly in response to this.

Method

Design and Procedure

The STOPPP study design was quasi-experimental, partly cross-sectional and partly longitudinal. It was based on a three-wave panel survey in which the panel members' treatment status in each panel wave was uncontrolled, some patients being in treatment, some waiting to start, and some having already terminated. In analyzing the observations in the panel, we "unfolded" the panel along a time scale, distributing the panel members on the time scale in accordance with their treatment status each wave. Thus, we created what Bell (1953) referred to as an "accelerated longitudinal design." Because we have noticed that our design is not easily understood, we give a rather detailed account even though similar accounts have been published before (Sandell et al., 2000, 2001).

First, a sample of 756 persons was selected to ensure that it consisted of people who had terminated their treatments as well as those who were in the midst of it and those who had not yet started. Thus, we selected all persons who had received national health insurance–funded subsidization for psychotherapy or psychoanalysis with private practitioners in Stockholm County for the periods 1991–1993 and 1992–1994 ($n = 202$, some having terminated and some being still in treatment). Additionally, we selected the first 554 persons on the waiting list for this subsidization because we anticipated that a number of these were not yet in treatment.

Second, a questionnaire was distributed to these 756 persons in 1994 and again in 1995 and 1996 to all who had responded the first year, each year with four reminders. With returns of 78%, 86%, and 88%, respectively, for each year, this produced a panel of 445 persons, which was 59% of the initial sample of 756. An analysis of the attrition showed that patients with higher educational level and higher current level of functioning tended to respond significantly more often. However, the pattern of attrition did not differ between patients in different modalities of treatment.

Third, the panel was quasi-experimentally split in subgroups to compare different treatment modalities. Of the 445 persons in the panel, 344 had long-term psychotherapy and 76 patients had psychoanalysis as their treatment or, in case they had been in more than one, their main treatment, in terms of number of sessions (see Treatments section). In the current study, we chose to compare these two treatments. Thus, the remaining persons in the panel, 13 patients who had various kinds of so-called low-dose treatments (e.g., low-frequency or brief individual therapy, group therapy, family therapy) and 12 who had not commenced treatment in any of the three waves, were excluded.

Fourth, a relative time scale was constructed based on the three possible treatment states (pretreatment, treatment, and posttreatment) and the three panel waves. The nine steps of the scale correspond to stages of the treatment process: three before treatment, three during treatment, and three after treatment. The exclusion of those who did not commence treatment at all effectively reduced the scale from nine to eight positions. On the basis of their treatment status at each wave, the patients were distributed along this scale. By pooling observations from different waves who were in the same relative stage of treatment (i.e., relative to earlier and later stages), we had the observations distributed along the stage scale, from before (about two years) treatment to late (about three years) after treatment termination. Table I shows the resulting distribution of the 1,260 observations from the 420 persons remaining in the panel across the treatment stage scale.

Fifth, the basic analytic strategy was to regress the dependent variables (subjective health or health care), one by one, on the treatment stage scale. Of the regression coefficients, the slope parameter reflects the mean change rate across the treatment stages and the intercept the level of the last year before treatment. To control for patient factors that may also influence the dependent variables, sex, age,

Table I. Number of Observations of Patient Outcome at Different Stages in the Treatment Process.

	Treatment stage							
Variable	Before	Late before	Early during	During	Late during	Soon after	After	after
Cases ($N = 420$)								
1	1	1	1					
3[a]		3		1	2	3		
31		31	31	31				
152			152	152	152			
26				26	26	26		
52					52	52	52	
155						155	155	155
Total observations	1	35	184	210	232	236	207	155
Treatment groups								
Psychotherapy	1	27	147	167	188	197	174	131
Psychoanalysis		8	37	43	44	39	33	24

[a]Because of the brevity of their psychotherapies (10–16 months), these patients did not fit three consecutive steps of the time scale. The observations were assigned to the treatment stages that best fit the starting and ending dates of the treatments.

and education level were entered in a first block before testing the regression of the dependent variable on treatment stages.

Sixth, a number of preliminary tests of the data and the design were performed. Obviously, the variation across time was partly within patients and partly between patients, yielding a mixed design. We, therefore, tested whether the regression of our outcome variables on the time scale came out consistently within and between patients. Next, for all dependent variables, we tested whether nonlinear components of the regression on the time scale made any significant contributions. Also, to ensure that possible trends across the time scale were treatment dependent, we tested the independence of the time scale in relation to possible confounds. Furthermore, to test the validity of the self-reports, we compared the self-reported data with data from official records that had been collected for the whole initial sample of 756 persons, including number of health care visits and number of sick leave days reimbursed by the national health insurance system from 1987 to 1996. To investigate lower bound test–retest reliability of the outcome variables, bivariate correlations were computed between the panel waves. Finally, we also tested the associations between sex, age, and education level and the outcome variables in the patient and norm groups.

Assessment Procedures

Patients' pretreatment status. Various diagnostic and assessment procedures were applied to the patients' referrals. These pretreatment assessments were not used in this study and are, therefore, not specified here (but see Blomberg, Lazar, & Sandell, 2001).

Patient outcome measures. The Well-Being Questionnaire (WbQ) was designed to explore the patients' symptoms, social relations, and morale. The following standard self-rating scales were included:

The Symptom Checklist-90 (SCL-90; Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974) contains 90 items representing various psychological and somatic signs of distress. Using a scale ranging from 0 (*not at all*) to 4 (*very much*), respondents rate the extent to which they have been troubled with each during the last seven days. The ratings are scored in various combinations. In this study we used the General Symptom Index (GSI), which is calculated as the mean rating across all 90 items. Internal consistency estimates in the three waves varied between .83 and .96.

The Sense of Coherence Scale (SOCS; Antonovsky, 1987) is a 29-item self-rating instrument designed to measure sense of coherence, the feeling of confidence that life is manageable, comprehensible, and meaningful. The items are questions or phrases about life experiences, and the ratings are made on 7-point bipolar scales, the poles of which are contrasting, alternative responses to the item. Following Antonovsky's recommendations, a general score was calculated as the mean across all items. Internal consistency estimates in the three waves varied between .81 and .92.

Besides these instruments, the WbQ contained standard items or questions on (a) demography and socioeconomy, familial, vocational, and financial situation; (b) ongoing psychotherapy; (c) previous treatments, including psychotherapy, for psychological distress; (d) current health status and health care utilization over the past 12 months; (e) current and prior severity of psychological problems; (f)

occupational activities (including studies) over the past 12 months.

The section on current health status and health care utilization, on which the current study focuses, included on a number of health care variables and questions the Self-Rated Health Scale (SRH), a single-item indicator of subjective health, designed as a Faces Scale (Andrews & Withey, 1976; McDowell & Newell, 1996). The 7-point scale, ranging from 1 (*very bad*) to 7 (*very good*), is presented as a row of seven stylized faces with different facial expressions, with the endpoints also verbally defined. Respondents check the face that best corresponds with their experience of physical and mental health taken together during the past 12 months. Because it is a single-item scale, internal consistency is not applicable as a reliability estimation method. As a lower bound, the test–retest correlations across 1-year intervals, with treatment intervening, was .51 (between Years 1 and 2) and .59 (Years 2 and 3).

The following health care variables were selected on the basis of our assumption that they represent different degrees of ill health severity and sensitivity to change:

Psychiatric health care utilization during the past 12 months: number of consultations with psychiatrists; number of consultations with psychologists, social workers, and so on; level of medicine consumption, rated on a 5-point ordinal scale from 0 (*not at all*) to 4 (*regular consumption of several drugs over the whole year*); checklist of type of medication: soporifics, sedatives, antidepressants, neuroleptics; a yes–no question on any current psychoactive medication; number of weeks of inpatient treatment in hospital, nursing home, and so on.

Medical health care utilization during the past 12 months: number of consultations with medical doctors; number of consultations with physiotherapists, district nurses, and so on; level of medicine consumption, rated on a 5-point ordinal scale ranging from 0 (*not at all*) to 4 (*regular consumption of several drugs over the whole year*); the medication type checklist also included medication for somatic affliction, including pain; number of weeks of inpatient treatment in hospital, nursing home, and so on.

Number of days, weeks or months absent from work or other occupation because of ill health during the past 12 months, including disability pension. Psychiatric or medical (somatic) causes were not differentiated. Weeks and months were transformed into workdays.

Treatments

In the referrals, psychotherapy was defined as once- or twice-weekly treatment with a licensed psychotherapist, and psychoanalysis as three- to five-times/week treatment with a fully trained psychoanalyst. The psychotherapy group had a mean frequency of 1.5 sessions per week ($SD = 0.52$), whereas the psychoanalysis group had a mean of 3.6 sessions ($SD = 0.70$). Mean length of the psychotherapies was 3.9 years ($M = 46.6$ months, $SD = 24.29$) and 4.5 years for psychoanalyses ($M = 53.7$ months, $SD = 23.39$). The difference in length between these two treatment modalities was significant ($p < .01$).

The treatments were not manualized or standardized with respect to duration, session frequency, technique, and so on. However, all therapists in the STOPPP treatment provider sample claimed to have a psychoanalytic or psychodynamic theoretical orientation, and the average length of therapeutic experience was about 20 years (mean number of years in the psychotherapeutic profession after licensing was 9.6 years and before licensing 10.7 years). Further details on the treatment providers are given in Blomberg et al. (2001).

Patient Characteristics

The typical patient was a woman (77%) in her late 30s ($M = 38.7$ years at the first panel wave, $SD = 8.3$). Almost half of the patients (45%) were cohabiting with a partner (58% were unmarried, 24% married, 17% divorced). Half had children (52%). The majority (79%) had some post-high school education (64% held a university degree) and typically worked in the health care, education, or social sectors. Half of the patients (56%) had at least one *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.; *DSM–III–R*; American Psychiatric Association, 1987) Axis I diagnosis (typically mood or anxiety syndromes), 11% had an Axis II personality disorder (5% of the patients had both a personality disorder and at least one Axis I diagnosis), and V codes were assigned to 33% of the patients. The average Global Assessment of Functioning Scale (GAF) score ($M = 59.8$, $SD = 5.5$) indicates a moderate dysfunction level. More than half of the patients (66%) had some kind of previous experience with psychotherapy. When patients in psychotherapy and psychoanalysis were compared, there were relatively more men in the psychoanalysis group. Analysands were also somewhat older, had higher education, and were more often married or divorced. There were no differences between the two groups with respect to *DSM* diagnoses. The GAF score, however, was lower in the psychotherapy group ($p < .05$). In terms of previous experience of psychiatric treatments, more of the analysands had prior psychotherapeutic experiences, whereas psy-

chotherapy patients had more often been hospitalized. Further details on the patient sample are given in Blomberg et al. (2001).

Norm Groups

To establish a standard for evaluating patient outcome in relation to "normality," the WbQ was also distributed in two nonclinical groups: (a) a random community sample of 400 persons between 20 and 69 years of age in Stockholm County and (b) a sample of 87 psychology students, demographically very similar to the clinical sample, according to pilot analyses of the referrals. The norm groups took the questionnaire only once, in May 1994. Without any reminders, the response rates in the two groups were 37% and 79%, respectively. The responders in the two groups had almost identical mean values on the self-rating scales, and they were, therefore, collapsed into one group ($N = 214$). Women were overrepresented in this collapsed group (63%), and the mean age was 39.2 years ($SD = 12.2$). More than half (61%) were cohabiting with a partner (42% were unmarried, 41% married, 15% divorced) and had children (56%). Half (55%) had some post-high school education (33% held a university degree). We had no diagnostic data on the norm group. However, 14% had some kind of previous psychiatric experience, 15% had previous psychotherapeutic experience, and, in fact, 5% reported being in ongoing therapy. We chose not to discard these. When demographic data were compared with the patient group, there were relatively more men in the norm group. Persons in the norm group more often cohabited with a partner and were married. Their education level was lower. The associations of these variables with the health care variables were tested (see following discussion).

Preliminary Tests of the Data and the Design

To address the issue of dependencies as a result of the mixed within- and between-patients design, we compared the within-patients and between-patients components of the total regression of the outcome variables on the time scale. No significant differences were found, and we concluded that the mixed design did not compromise the change rate estimates. We also tested whether nonlinear components of the regressions on the time scale made any significant contributions. Because this was not the case, we decided to analyze only the linear component.

The independence of the time scale in relation to other factors is a critical assumption that should be tested as far as possible. If, for instance, patient sex, age, diagnosis, or any other characteristics were unequal among cases in earlier and later stages of treatment, different outcomes for early and late stages might as well be produced by that factor. We, therefore, tested (two-tailed) the associations between the time scale and a number of variables. For instance, patient sex correlated .02 with time; age, .06 ($p < .05$); *DSM–III–R* Axis I diagnosis, .04; Axis II diagnosis, –.01; GAF score, –.01; number of sessions per week, –.08 ($p < .01$); and length of treatment, –.14 ($p < .01$). In fact, testing more than 30 variables for their correlations with time, we found only three with significant, yet low, correlations: age, session frequency, and length of treatment. Some degree of relation between age and time was, of course, expected, because patients naturally aged two years from the first to the third panel wave. We, therefore, concluded that our time scale was free of obvious strong confounds.

To test the validity of the WbQ self-reports, these were compared with official records from the corresponding 1-year time periods. We did not expect perfect agreement between the two data sources, partly because the official records do not include health care by private practitioners or sick leave periods of two weeks or less, which were reimbursed by the employer. The official records turned out to be far from flawless and included strange entries. The correlations varied greatly across variables and years. The overall number of psychiatric consultations correlated .18 for Year 1, .27 for Year 2, and .43 for Year 3 between self-reports and official records, whereas number of medical consultations correlated .41 for Year 1, .43 for Year 2, and .30 for Year 3. In spite of all complications, the number of reimbursed days of absence correlated .57 for Year 1, .66 for Year 2, and .73 for Year 3 with self-reported days of absence from work. Considering the difficulty in comparing the different measures, the latter levels are impressive.

To investigate the test–retest reliability of the outcome variables, bivariate correlations were computed between the panel waves (Year 1–2; Year 2–3; Year 1–3). In view of the length of the test–retest intervals, it should be recognized that the correlations offer lower bound estimates of the reliabilities. Correlations varied greatly across the different variables. Regarding days of absence coefficients were high ($.91 < r < .94$). This was true also for the GSI ($.75 < r < .85$), SOCS ($.77 < r < .83$), and general level of medicine consumption ($.59 < r < .70$). Number of consultations with medical health care providers and with psychiatrists yielded moderate coefficients ($.40 < r < .67$), as did the third self-rated variable, SRH ($.44 < r < .59$). Weaker correlations were found regarding psychiatric inpatient weeks ($.29 < r < .56$) and consultations with psychiatric

paramedics ($.07 < r < .38$). Regarding somatic inpatient weeks, only nonsignificant correlations were found between panel waves.

We also tested (two-tailed) the associations among sex, age, and education level and the outcome variables in the patient and norm groups. In general, correlations were weak, only occasionally significant, and no common pattern was found between the patient group and the norm group. The highest correlation found in the patient group was .16 ($p < .01$) between age and somatic medication level. Despite these low correlations, sex, age, and education level were entered as independent variables in all regression analyses so as to partial out their possible effects. Thus, after these preliminary tests, we proceeded with our substantial analyses.

Data Analyses

In the analyses, individual raw scores, for each outcome variable separately, were first regressed on sex, age, and education level (Block 1). In the next step, the time scale was added (Block 2). By comparing these two models, we tested whether, and to what extent, the addition of treatment stage would explain significantly more of the variance than the sociodemographic variables alone. Because our aim was to study the effect of psychotherapeutic treatment, only results concerning the treatment stage variable are reported. Furthermore, because the Block 1 variables, which can be regarded as covariates, deprived the intercept and the unstandardized regression coefficient of their natural metric, only the standardized regression coefficient (β) in the second block and the change in R^2 from the first to the second block model ($\triangle R^2$) are presented. These were tested with one-tailed z and incremental F tests, respectively. Change rate differences between the treatment groups were tested with two-tailed z tests. Dichotomous variables were analyzed by logistic regressions with sex, age, education level (entered in Block 1), and treatment stage as predictors.

In addition to these tests, nonadjusted (i.e., with no control for sex, age, or education level) mean score growth curve plots[1] are presented to enable an evaluation of the actual levels of health care utilization, using the norm group mean and a "caseness" criterion as references. The caseness criterion, which separates the 10% worst scoring from the 90% best scoring persons in the norm group, corresponds to 1.28 *SD*s above (or, for SOCS and SRH, below) the norm group mean. Derogatis and Lazarus (1994) proposed it as the most appropriate division between clinical and nonclinical cases for the SCL-90. For comparison purposes, we have used the same criterion for the other variables as well.

The SPSS software package (Version 10.0.5) was used for all analyses. A liberal Bonferroni adjustment, dividing $p = .05$ by the number of outcome measures, set the significance criterion at $p < .003$. This criterion was applied in all the following analyses.

Results

Subjective Health Measures

Plotting the mean trajectories of the SRH across the treatment stages yielded the growth curves in Figure 1. The horizontal lines indicate the norm group mean and the caseness criterion.

As Figure 1 shows, subjective general health (SRH) increased at about the same rate during long-term psychodynamic psychotherapy and psychoanalysis, and the positive trend persisted during long-term follow-up. This impression was supported by the regression analyses, as can be seen in Table II, along with the corresponding positive trends with decreasing symptom distress (GSI) and increasing morale (SOCS), which have been reported previously (for further details see Blomberg et al., 2001; Sandell, Blomberg, & Lazar, 2002).

On the basis of these findings, it was quite reasonable to expect correspondingly benign developments in the health care variables.

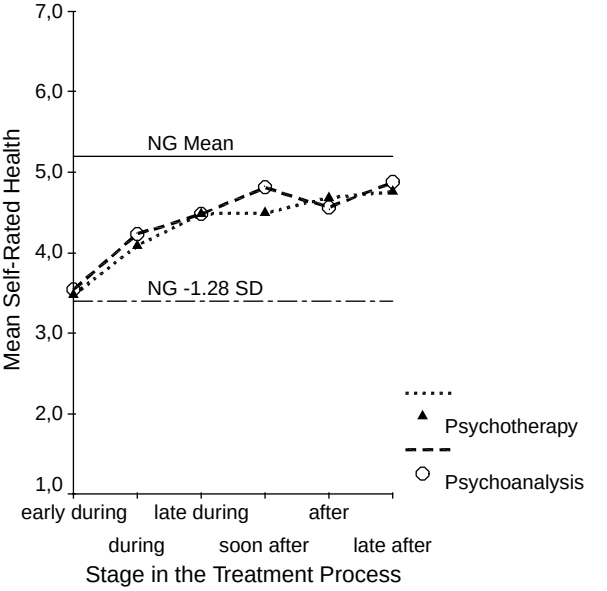

Figure 1. Changes in Self-Rated Health Scale across stages in the treatment process for patients in psychotherapy and psychoanalysis, in comparison with the norm group (NG) mean and the caseness criterion (NG -1.28 *SD*).

Table II. Subjective Health Measures Slopes (Standardized β) Across Treatment Stages With Patients' Sex, Age, and Education Level as Covariates and Increase in R^2 (ΔR^2)

	Psychotherapy ($n = 344$)		Psychoanalysis ($n = 76$)	
Variable	β	ΔR^2	β	ΔR^2
SRH	.250***	.062***	.252***	.059***
SCL-90, GSI	−.190***	.036***	−.373***	.129***
SOCS	.192***	.037***	.332***	.102***

Note. Slopes were tested one-tailed. Differences between Models 1 and 2 (ΔR^2) were tested against the F distribution. Differences between treatment groups were tested two-tailed and found to be nonsignificant (Bonferroni adjustment applied) on all variables. SRH = Self-Rated Health Scale; SCL-90 = Symptom Checklist-90; GSI = General Symptom Index; SOCS = Sense of Coherence Scale.
***$p < .001$ (Bonferroni adjustment applied).

Psychiatric Health Care Utilization

In line with our previous discussion of different social impact of medical–somatic and psychiatric health care effects, we had our highest expectations of positive effects for the psychiatric health care variables. However, as can be seen in Figure 2, the curve plot of the mean number of consultations with psychiatrists indicates no clear trend across the treatment stages.

In contrast to the relative smoothness of the subjective health variables, the zigzag form of the curves proved to be representative of the patterns of the health care variables in general and, therefore, represents an interesting finding in its own right. There was, however, no periodicity in these zigzag patterns.

As Table III summarizes, the only significant change in psychiatric health care utilization was an increase in number of consultations with psychologists, social workers, and the like in the psychotherapy group.[2] The curve plot in Figure 3 suggests that this increase began soon after treatment and continued through the posttreatment stages.

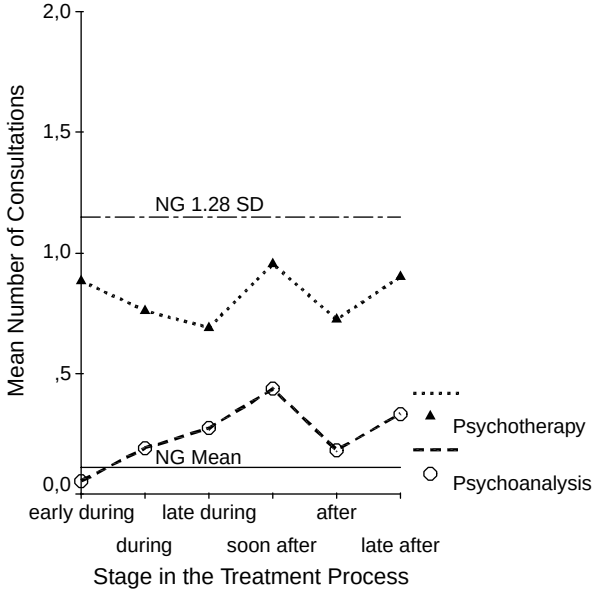

Figure 2. Changes in mean number of consultations with psychiatrists across stages in the treatment process for patients in psychotherapy and psychoanalysis in comparison with the norm group (NG) mean and the caseness criterion (NG 1.28 *SD*).

Medicine consumption was also measured in terms of concurrent psychiatric medication. The proportions of patients currently using any medicine for psychiatric reasons showed different patterns between the treatment groups.[3] The psychotherapy group held a fairly stable level with a slight reduction from about 17% during treatment to about 15% across the follow-up stages. In the psychoanalysis group, on the other hand, consumption increased from about 3% during analysis to 13% at the "soon after" stage and showed a continuing increasing trend during the follow-up period. These levels may be compared with the norm group, in which 1% reported ongoing use of psychiatric drugs. To further analyze the proportions, logistic regressions were conducted, with sex, age, education level (entered in Block 1), and treatment stage as predictors.

As Table IV shows, stage in the treatment process was not a significant predictor in any of the groups. However, the analyses confirmed the impression given by the consumption levels. In the psychoanalysis group, the estimated odds ratio of 1.41 suggests an increased use of unspecified psychoactive medicines over the treatment stages. This impression is also supported by the increased use, albeit nonsignificant, of specified medication types which was found in the psychoanalysis group (see Table III).

Medical Health Care Utilization

We assumed that the variable most directly related, and sensitive, to general ill health would be the rate of outpatient consultations with doctors in somatic care. The other variables were selected in analogy with the psychiatric health care variables to represent different degrees of severity and sensitivity to change. The mean levels of the medical health care variables did not exceed the norm group caseness

Table III. Psychiatric Health Care Utilization During the Last 12 Months: Slopes (Standardized β) Across Treatment Stages with Patients' Sex, Age, and Education Level as Covariates and Increase in R^2 (ΔR^2)

	Psychotherapy ($n = 344$)		Psychoanalysis ($n = 76$)	
Variable	β	$\triangle R^2$	β	$\triangle R^2$
Consultations				
Psychiatrists	−.030	.001	.064	.004
Paramedics	.094⋆	.009⋆	.166	.026
Medication level				
Antidepressants	.050	.002	.025	.001
Soporifics	−.058	.003	.130	.016
Sedatives	−.017	.000	−.048	.002
Neuroleptics	−.029	.001	—[a]	—
Inpatient weeks	.034	.001	—[a]	—

Note. Slopes were tested one-tailed. Differences between Models 1 and 2 ($\triangle R^2$) were tested against the F distribution. Differences between treatment groups were tested two-tailed and found to be nonsignificant (Bonferroni adjustment applied) on all variables.
[a]Not computed, variable constant (zero).
⋆$p < .05$ (Bonferroni adjustment applied).

criteria (1.28 *SD*) at any stage of the treatment process. As can be seen in Table V, we found no significant changes in any of the variables.

Sickness Absence

For a meaningful analysis of absence from work as a result of illness, we decided to use only data from patients belonging to the labor force, according to a definition similar to that of the national health insurance system. This included those who (a) worked at a minimum level of 75% of full-time activity, (b) were on disability pension or temporary

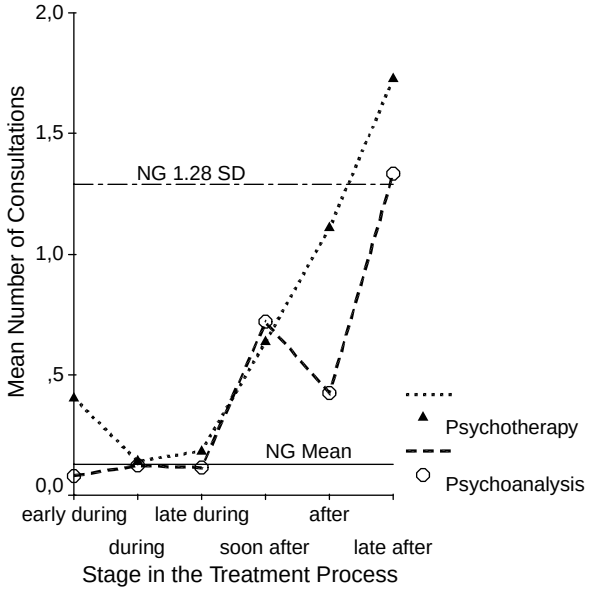

Figure 3. Changes in mean number of consultations with psychiatric paramedics across stages in the treatment process for patients in psychotherapy and psychoanalysis in comparison with the norm group (NG) mean and the caseness criterion (NG 1.28 *SD*).

disability pension, or (c) had been sick-listed over the last 12 months in any or all of the three panel waves. This yielded a group of 216 persons ($\times 3 =$ 648 observations). We set the minimum working level at 75% because we assumed that a substantial workload was necessary for sick leave to reflect ill health, and that part-time workers could more easily cope with ill health without letting it intrude on their working ability. Thus, among those who were excluded because they worked less than 75%, their part-time work was not due to partial sick leave. Split on treatment types, 49% ($n = 168$) of the psychotherapy patients and 63% ($n = 48$) of the psychoanalysis patients were included in the labor force subgroup. This difference was significant ($p < .05$) and may itself be regarded as an important finding of modality differences.

As mentioned, one of the main goals of the subsidization program was to reduce the incapacity rate, which refers to the mean number of days reimbursed by national health insurance per year. It is computed with number of persons covered by the national health insurance as the denominator and includes long-term sick leaves and disability pensions but not short-term sick leaves, because the first 14 days were covered by the employer. When evaluating the level of absenteeism, we compared our data with incapacity rate data from the Stockholm County population from approximately the same time period. To match the format of the health insurance data, patients were split on sex and age groups, and means were plotted across treatment stages (Figure 4). The horizontal lines indicate the average population incapacity rate for each Sex × Age group. Younger and older age groups (including 50- to 59-year-old male patients) were excluded because of small sample sizes. Avoiding too small

Table IV. Stage in the Treatment Process as Predictor of Concurrent Psychiatric Medication for Patients in Psychotherapy and Psychoanalysis, With Patients' Sex, Age and Education Level as Covariates.

	Psychotherapy ($n = 344$)				Psychoanalysis ($n = 76$)			
Variable	b	Wald $\chi^2(df)$	p	Exp(b)	b	Wald $\chi^2(df)$	p	Exp(b)
Medication	−0.039	0.545 (1)	.461	0.962	0.343	4.410 (1)	.036	1.409

Note. b = covariate predictor coefficient; Exp(b) = exponentiated value of b.

sample sizes was also the reason for not splitting the Sex × Age groups on treatment modalities.[4]

Figure 4 suggests that the average level of absenteeism for both the female and male patients in the 30- to 49-year age span was well above the incapacity rate of their peers in the Stockholm County population across all treatment stages. Measures are not exactly comparable, however, because the patient means also included short-term sick leaves. On the other hand, the absence level of the 50- to 59-year-old female patients was below the incapacity rate of their peers. The curves suggest a decreasing trend. This was not confirmed, however, when days of absence was tested with our regression analysis model. As Table VI shows, we found no significant changes in work absenteeism. On the other hand, we did find a significant difference between treatment groups regarding the intercepts (which are not included in the tables), indicating a significantly lower pretreatment level of absenteeism in the psychoanalysis group.

Whereas the arithmetic mean best corresponds to the national health insurance incapacity rate, the positively skewed distribution of the variable (skewness = 1.93 computed over all observations in the labor force subgroup) in fact requires other methods of analysis. We chose to add the following alternative test: Taking the norm group's days of absence as the starting point, we found that the 90th percentile was 21.66 days. In analogy with our previous analyses, defining the 90th percentile of the norm group as the caseness criterion, the days-of-absence-variable was dichotomized into high (>21.66 days) and low (≤ 21.66 days) work absenteeism. Then logistic regression analyses were conducted on treatment group proportions of high level absenteeism, with sex, age, education level (entered in Block 1), and treatment stage as predictors.

As Table VII shows, treatment stage had no significantly predictive value for high-level work absenteeism. However, albeit nonsignificant, the predictor coefficients together with the estimated odds ratios of 0.86 and 1.09, respectively, suggest a decrease in the psychotherapy group and an increase in the psychoanalysis group.

To summarize our significant findings, in line with our expectations, we found an increase in subjective general health (SRH), decreasing symptom distress (GSI), and increasing morale (SOCS) in both groups. Furthermore, we found an unexpected increase in psychiatric consultations with paramedics in the psychotherapy group.

Table V. Medical Health Care Utilization During the Last 12 Months: Slopes (Standardized β) Across Treatment Stages with Patients' Sex, Age and Education Level as Covariates and Increase in R^2 (ΔR^2)

	Psychotherapy ($n = 344$)		Psychoanalysis ($n = 76$)	
Variable	β	ΔR^2	β	ΔR^2
Consultations				
MDs	−.081	.007	.003	.000
Paramedics	−.068	.005	.005	.000
Medication level	−.044	.002	−.118	.013
Inpatient weeks	.022	.001	−.073	.005

Note. Slopes were tested one-tailed. Differences between Models 1 and 2 (ΔR^2) were tested against the F distribution. Differences between treatment groups were tested two-tailed. All were nonsignificant (Bonferroni adjustment applied).

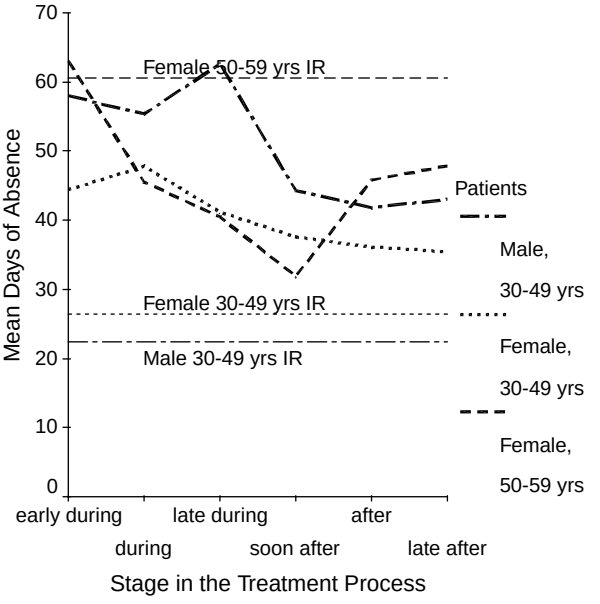

Figure 4. Changes in mean number of days of absence from work across stages in the treatment process for female and male patients in comparison with the Stockholm County population incapacity rate (IR).

Table VI. Days of Absence From Work During the Last 12 Months: Slopes (Standardized β) Across Treatment Stages With Patients' Sex, Age, and Education Level as Covariates and Increase in R^2 (ΔR^2)

	Psychotherapy ($n=168$)		Psychoanalysis ($n=48$)	
Variable	β	ΔR^2	β	ΔR^2
Days of absence	−.069	.005	−.007	.000

Note. Computed on labor force subgroups. Slopes were tested one-tailed. Differences between Models 1 and 2 (ΔR^2) were tested against the F distribution. Differences between treatment groups were tested two-tailed. All were nonsignificant, with one exception: Intercepts (not presented) differed significantly between treatment groups ($p < .01$, Bonferroni adjustment applied).

Discussion

As our brief summary bluntly demonstrates, the most striking finding of our study is the lack of significant change in the health care variables to match the positive changes in the subjective well-being measures. Considering the amount of testing done, the only significant difference found, using the present adjusted alpha level, would be dismissed as a Type I error had we used a more conservative Bonferroni adjustment.

Our results indicate that psychoanalytic treatments do have positive effects on patients' health in terms of how it is subjectively experienced and rated (SRH, GSI, and SOCS). In contrast, we could not discern any effects of psychoanalytic treatments on health care utilization variables. A clear setback was our failure to demonstrate decreasing trends even in psychiatric health care utilization, the area of our highest expectations. Regarding medical health care, we had assumed that consultations with medical doctors would be the variable most sensitive to decreasing somatic ill health, but this was not confirmed either. Because our results differ from the conclusions of much previous research, the question one must ask is where the differences lie.

Methodological Considerations

Some recent studies, all with positive results, have used long-term retrospective self-reports after termination of treatment (Beutel et al., 2004; Breyer et al., 1997; Keller et al., 1997, 2001). The latter two studies also used health insurance data. Intuitively, retrospection is a weak design, the more so the longer the time interval. First, as Beutel et al. (2004) exemplified when correlating self-reports with health insurance data, it is not easy to remember an exact number of days or visits several years in retrospect. Second, the implicit comparison between before and after treatment may influence the patients, making their estimates dependent on treatment satisfaction. We believe our data, albeit also retrospective self-reports but on a relatively short-term basis, are closer to the truth.

Patient Population Differences

Do Swedish psychotherapy patients differ from patients in other countries? For instance, do criteria for advising, or referring to, psychoanalytic treatment differ, or can differences be found in pretreatment health care utilization levels?

Regarding possible diagnostic differences, comparison is difficult because few studies referred to previously include diagnostic data. Beutel et al. (2004) and Keller et al. (1997, 2001), however, reported comparatively higher rates of personality disorders than in our sample. Turning to other, more general studies, Westen (1997), in a study of U.S. clinicians, reported that many of their patients had significant difficulties functioning "in work and love" yet did not meet Axis I or II criteria. The rather large proportion of V codes in our patient population is in line with this finding. In a study of a patient population in Ontario, Canada, with data from the same time period and a setting comparable to ours (i.e., with psychoanalysis covered by national health insurance plans), Doidge, Simon, Gillies, and Ruskin (1994) reported a pattern of Axis I–Axis II comorbidity in which the typical patient had a personality disorder and one or more Axis I diagnoses. In a more recent study, Doidge et al. (2002) compared U.S. and Australian psychoanalysis patients with the Canadians of the previous study and found no significant differences across countries. Mood or anxiety disorders, sexual dysfunction, and personality disorders were the most common pro-

Table VII. Stage in the Treatment Process as Predictor of High-Level Work Absenteeism for Patients in Psychotherapy and Psychoanalysis With Patients' Sex, Age, and Education Level as Covariates.

	Psychotherapy ($n=168$)				Psychoanalysis ($n=48$)			
Variable	b	Wald $\chi^2(df)$	p	Exp(b)	b	Wald $\chi^2(df)$	p	Exp(b)
>1 mo absence	−0.156	6.018 (1)	.014	0.855	0.088	0.308 (1)	.579	1.092

Note. Computed on labor force subgroups. b = covariate predictor coefficient; Exp(b) = exponentiated value of b.

blems. Thus, compared with German, Canadian, U.S., and Australian studies, personality disorders appear to have been less frequent among the STOPPP patients. This may confirm our belief that in the diagnosing procedure of the STOPPP patients' personality disorders were, in fact, underestimated, but it may as well indicate population differences.

Furthermore, differences exist regarding criteria for psychoanalysis. Chronicity is required by the American Psychoanalytic Association and the American Psychiatric Association as a necessary indication for analysis, and met by a vast majority of patients in the United States, Canada, and Australia (Doidge et al., 2002), but such a criterion is not obligatory for psychoanalysis in general in Sweden or for the subsidized treatments of the current study.

When pretreatment levels of health care consumption are concerned, all comparisons indicate higher pretreatment levels in the German studies, especially regarding hospitalization. Days of absence are, however, an important exception; the German studies report lower pretreatment levels, which nonetheless decrease after treatment. In sickness absence research, about 60 different more or less inclusive measures of sick leave are currently used (K. Alexanderson, personal communication, October 15, 2004; see also Hensing, Alexanderson, Allebeck, & Bjurulf, 1998), and these yield very different results in terms of absence levels. Thus, comparison between studies is further complicated when seemingly similar measures can, in fact, be incompatible. However, there may also be sociocultural factors contributing to these differences.

Sociocultural and Socioeconomic Differences

A particular strength of our design is that the risk of systematic errors resulting from historical changes, for instance in health care policy, is eliminated, because such changes during the three panel years affect the groups in all treatment stages equally.

One could, however, argue that we do not know the extent to which any of the variables reflect ill health at all. Cultural and economic factors may contribute to different results when comparing studies in different countries. For example, in Sweden, the economic aspect in terms of cost considerations on the part of the patient can be dismissed, when consultations with medical doctors, psychiatrists, and some types of paramedics are concerned. Consultations are practically free thanks to a limitation of charge paid by the patient. Currently, in Stockholm County, it is set at the fairly moderate level of 100 USD per year. In countries where health care policies are not equally generous, economic aspects may well influence the inclination to seek the advice of a doctor or paramedic.

Of course, cross-national differences may also exist in treatment efficiency or treatment goals. For example, in Sweden, psychotherapists in private practice work quite independently from the primary care, where the responsibility for sickness certification (sick-listing) and rehabilitation lies. One may speculate that this would make Swedish psychotherapists less concerned about reducing the patients' health care utilization. In fact, although one of the main goals of the subsidization program was to reduce the incapacity rate, it is probable that not many of the treatments in our material were primarily focused on the patients' sick leave rate simply because the majority of the treatments were initiated before the program offered an alternative means of financing. Furthermore, when medication is concerned, cultural differences complicate comparisons between studies from different countries. In Sweden concurrent medication during psychoanalytic treatment is not customary or recommended, even considered inappropriate by some, whereas in the United States, where the analyst typically is a psychiatrist, it is not unusual that the analyst prescribes medication parallel to analysis and continues to do so after termination (Donovan & Roose, 1995).

Another complication with sociocultural and socioeconomic connections can be formulated, somewhat provocatively, in the question, "When is it at all reasonable to call in sick?" One possible answer is, "When there is a national insurance that makes it economically viable," which is the case in Sweden. In other countries, on the contrary, sick leave is reimbursed by private health insurance companies with typical demands for profitability put upon them. For Stockholm County as a whole from 1992 to 1994, the national health insurance statistics reported an increase of the incapacity rate from 31.6 to 33.7 days, followed by a minor decrease in 1995 and 1996. The health insurance authorities' estimate of the national "total incapacity rate" 1992 (where an estimate of short-term, ≤ 2 weeks, sick leaves is added) amounted to 43.7 days. In fact, this estimate offers the most correct match to our self-report data. If we use it as the reference line and plot growth curves for the two treatment groups (not controlling for sex or age), they seem to approach the level of the estimated total incapacity rate from different directions (Figure 5), the psychotherapy group from a higher level and the psychoanalysis group from a lower level. Thus, although no significant change was found (Table VI), the curves suggest a trend toward "normalization", in terms of Swedish condi-

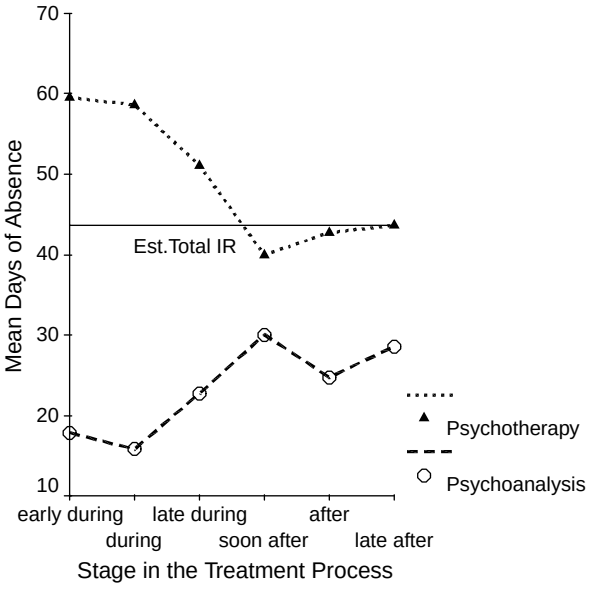

Figure 5. Changes in mean number of days of absence from work across stages in the treatment process for patients in psychotherapy and psychoanalysis in comparison with the estimated national total incapacity rate (IR) for 1992.

tions, in both groups and also lend support to the results of the logistic regression (Table VII).

Furthermore, a combination of cultural and personality factors must not be forgotten. Not all patients act on their subjective experience of being ill. Englund (2000) found that the most important factor affecting the general practitioners' sickness certification practice was patients' attitude toward sick leave. Among patients with the same symptoms, those wishing sick leave were sick-listed by the doctor to a greater extent than those who were negative to sick leave. Furthermore, the few studies Englund found through a Medline search reported only a weak relation (or none at all) between the severity of illness and work impairment, including sick leave. Patients with severe medical conditions, such as cancer, managed to keep working, although they undoubtedly qualified for disability pension. Englund suggests that the crucial moderating factor is the patient's confidence in his or her own capacity, his or her self-esteem, and sense of being in control of his or her life, creating associations to the concept of self-efficacy (Bandura, 1977).

Regarding the subnormal pretreatment level of absence from work in the psychoanalysis group, a personality-related explanation, perhaps also with sociocultural connections, may be found in the concept of performance-based self-esteem (Johnson, 1997), which Aronsson and Gustafsson (2002) found to be a risk factor for sickness presenteeism (i.e., going to work despite judging one's current state of health such that sick leave should be taken). The highest rates of sickness presenteeism were found among personnel in the health care, educational, and social sectors (Aronsson & Gustafsson, 2002; Aronsson, Gustafsson, & Dallner, 2000). It was exactly these groups that dominated the STOPPP patient sample.

These examples may reflect common phenomena as well as societal factors that are rather unique for Swedish conditions. Sickness absence in Sweden has increased at an alarming rate since 1996 and has only recently become a topic of national worry and much debate. Back and neck diagnoses, followed by psychiatric disorders, comprise the two largest diagnostic groups responsible for sick leave and disability pension in Sweden. Currently, these two groups account for 70% of the sickness absence (K. Alexanderson, personal communication, October 15, 2004; see also SBU, 2004). In fall 2004 the national health insurance authorities launched a campaign with the goal to halve the number of sick leave days. One argument in the Swedish debate has been that ill health and illness must be differentiated (Aronsson, 2004). A conclusion that can be drawn from the current study is that at least three dimensions must be differentiated: being ill, feeling ill, and acting upon any of the two, and that the relations are much more complicated than one would like. One would reasonably expect some agreement between one's subjective experience and how one acts on that experience. We have found strong treatment effects on the subjective experience of ill health but no effects on ill health-related behavior. Are we, in fact, looking at essentially different phenomena when we compare subjective health and ill health-related behavior? We will pursue our attempts to answer this question.

Notes

[1] It should be noted that in the curve plots the means of the observations on each step on the time scale are weighted equally, whereas in the regression analyses the means are weighted according to the number of observations on each step. Because of the small number of observations, the "before" and "late before" stages were excluded from the curve plots.

[2] The unexpected increase of consultations with paramedics awoke our suspicion that patients might have misinterpreted this question as including the psychotherapeutic treatment (although the wording in the questionnaire underscored that this should be excluded). Therefore, all cases involving 20 or more consultations were thoroughly reexamined using all available data (including outpatient register data), and our suspicion could be dismissed in all but four cases. These were excluded from this analysis (and were excluded in Table III). Thus, the increase concerned other, mainly supportive, psychiatric contacts.

[3] In analogy with the curve plots, proportions before treatment are not reported because of the small number of observations in the pretreatment stages.

[4] Number of observations at each stage of the treatment process varied between the different Sex × Age groups: female patients 30–49 years, $M = 59$, range = 51–68; female patients 50–59 years, $M = 16$, range = 10–23); male patients 30–49 years, $M = 24$, range = 17–29).

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Zusammenfassung

Haben psychoanalytische Behandlungen positive Effekte hinsichtlich der Gesundheit und der Benutzung von Behandlungseinrichtungen. Weitere Ergebnisse des Stockholm Psychotherapie und Psychoanalyse Ergebnisprojekts (STOPP)

Die Effekte psychoanalytischer Therapie auf die subjektive Gesundheit und die Benutzung von verschiedenen Behandlungseinrichtungen wurden bei einer Stichprobe von 420 Patienten in verschiedenen Stadien der Therapie untersucht. Ergebnismasse, auf Selbstberichten in Fragebögen basierend, und über drei aufeinanderfolgende Jahre erhoben, beinhalteten die Selbsteinschätzungs-Gesundheits-Skala (Self-Rated Health Scale, SRH), den allgemeinen Symptomindex (General Symptom Index, GSI), aus der Symptom-Check-Liste-90 (SCL-90), und die Skala des Gefühls von Kohärenz (Sense of Coherence Scale, SOCS) sowie Selbstberichte zur Benutzung von psychiatrischen und algemeinmedizinischen Behandlungseinrichtungen während der letzten zwölf Monate. Die Studie ist quasi-experimentell mit einem beschleunigten Longitudinal-Design. Mit den individuellen Rohwerten der abhängigen Variablen und einer 8-Stufenskala des Behandlungsstadiums wurden Regressionsanalysen durchgeführt. Um den Einfluss von Alter, Geschlecht und Bildungsniveau auszupartialisieren, wurden diese drei Variablen zusammen als erste eingegeben. Im Gegensatz zu signifikanten Ergebnissen bei den subjektiven Gesundheitseinschätzungen gab es keine signifikanten Veränderungen bei der Benutzung von Behandlungseinrichtungen. Die Komplikationen bei der Integration von Psychotherapieeffekten auf die Gesundheit und die Benutzung von Behandlungseinrichtungen werden diskutiert.

Résumé

Des traitements psychanalytiques ont-ils des effets positifs sur la santé et l'utilisation des services de santé ? Suite des résultats du Stockholm Projet des Résultats de la Psychothérapie et de la Psychanalyse (STOPPP)

Les effets du traitement psychanalytique sur la santé subjective et l'utilisation des services de santé étaient étudiés dans un échantillon de 420 patients dans des phases différentes du traitement psychothérapeutique. Les mesures basées sur un questionnaire d'auto-évaluation appliqué pendant 3 années consécutives comprenaient l'Echelle de Santé Auto-évaluée (SRH), le General Symptom Index (GSI) de la Symptom Checklist-90 (SCL-90), la Sense of Coherence Scale (SOCS) ainsi que l'indication par les patients de leur l'utilisation des services de santé pendant les 12 mois découlés. L'étude avait un design quasi-expérimental, longitudinal accéléré. Les scores bruts individuels des variables dépendantes étaient régressés, une par une, sur une échelle de phase de traitement en huit étapes. Le sexe, l'âge et le niveau d'éducation étaient entrés dans un premier bloc pour faire sortir leurs effets respectifs possibles. Contrairement aux développements positifs trouvés, de manière significative, pour les mesures subjectives de santé (SRH, GSI et SOCS), aucun changement significatif a été trouvé pour les variable d'utilisation des services de santé. Les complications de l'interprétation des effets de la psychothérapie sur la santé et l'utilisation des services de santé sont discutées.

Resumen

Los tratamientos psicoanalÍticos, ¿tienen efectos positivos sobre la salud y la utilización del sistema de cuidado de la salud? (*Health Care utilization*). Nuevos hallazgos del Proyecto de resultados de la psicoterapia y el psicoanálisis (STOPPP)

En una muestra de cuatrocientos veinte pacientes en diversas etapas de su tratamiento psicoterapéutico se estudiaron los efectos del tratamientos psicoanalítico sobre la salud subjetiva y la utilización del sistema de cuidado de la salud. Las medidas de resultados, basadas en un cuestionario autoadministrado tomado por tres años consecutivos, incluyeron la Escala de Salud Auto-evaluada (Self-Rated Health Scale, SRH), el Indice General de Síntomas (GSI) de la Symptom Checklist-90 (SCL-90) y la Escala del Sentido de Coherencia (SOCS) así también como informes personales sobre la utilización del sistema de cuidado de la salud durante los últimos doce meses. El studio tuvo un diseño casi-experimental longitudinal acelerado (*quasi-experimental, accelerated longitudinal design*). Se regresaron los puntajes individuales en bruto de las variables dependientes una por una, en una escala de tratamiento de ocho pasos (*eight-step treatment stage scale*). En un primer bloque se incluyeron el sexo, la edad y el nivel educativo para determinar sus efectos posibles. En contraposición con los desarrollos significativamente positivos encontrados en las mediciones subjetivas de salud (SRH, GSI y SOCS), no se encontraron cambios significativos en las variables de utilización del servicio de cuidado de la salud. Se debaten las complicaciones de interpretar los efectos psicoterapéuticos sobre la salud y la utilización del sistema de cuidado de la salud.

Resumo

SerÁ que os tratamentos psicanalíticos têm efeitos sobre a saúde e a utilização dos serviços de saúde? outros resultados do projecto de psicanálise e resultados psicoterapêuticos de stockholm (pprps)

Foram estudados os efeitos do tratamento psicanalítico sobre a saúde subjectiva e a utilização dos serviços de saúde numa amostra de 420 pacientes em vários estádios de tratamento psicoterapêutico. Foram recolhidos durante 3 anos consecutivos medidas de resultados terapêuticos, baseadas em questionários de auto-relato, nomeadamente

a Escala de Auto-relato de Saúde (EAS), o Indíce de Gravidade Geral (GSI) derivado da Lista de Sintomas (SCL-90) e a Escala do Sentido de Coerência (ESC), e ainda os auto-relatos da utilização dos serviços de saúde durante os últimos 12 meses. O estudo foi de natureza quasi-experiemental, de desenho longitudinal. Os resultados brutos das variáveis dependentes, foram submetidos uma a uma, a regressões, numa escala de estádios de tratamento de oito passos. O sexo, a idade e o nível educacional foram introduzidos no primeiro bloco para controlar o seu potencial efeito. Em contraste com os significativos desenvolvimentos positivos encontrados para as medidas de saúde subjectivas (EAS, GSI e ESC), não foram encontradas mudanças significativas em relação às variáveis de utilização dos serviços de saúde. Serão discutidas as dificuldades na interpretação dos efeitos psicoterapêuticos sobre a saúde e sobre a utilização dos serviços de saúde.

Sommario

Effetti positivi dei trattamenti psicoanalitici. I trattamenti psicoanalitici hanno effetti positivi sulla salute e sull'assistenza medica? Ulteriori esiti del risultato del progetto di Stoccolma di psicoanalisi e di psicoterapia (STOPPP).

Gli effetti del trattamento psicoanalitico sulla salute soggettiva e sull'utilizzazione dell'assistenza medica sono stati studiati in un campione di 420 pazienti in varie fasi del trattamento psicoterapeutico. Le misure di risultato, basate su un questionario self-reported preso per 3 anni successivi, hanno incluso le scale Self-Rated Health Scale (SRH), General Symptom Index (GSI) dalla Symptom Checklist-90 (SCL-90), e Sense of Coherence Scale (SOCS), così come i rapporti sull' utilizzazione dell'assistenza sanitaria durante i 12 mesi precedenti. Lo studio era un disegno longitudinale accelerato e quasi-sperimentale. I diversi punteggi grezzi delle variabili dipendenti sono stati regrediti, uno per uno, su una scala della fase di trattamento di otto-punti. Il sesso, l'età ed il livello di formazione sono stati inseriti in un primo blocco parziale verso i loro effetti possibili.
Contrariamente agli sviluppi positivi significativi trovati sulle misure sanitarie soggettive (SRH, GSI e SOCS), nessun cambiamento significativo è stato trovato sulle variabili di utilizzazione della sanità. Sono discusse le complicazioni nell'interpretazione degli effetti della psicoterapia sulla salute e sull'assistenza medica.

摘要

本研究以 420 位不同心理治療階段的患者為樣本，探討精神分析式治療對主觀健康感和醫療資源使用的影響。連續三年以自陳問卷作為測量結果的工具，包括自評健康量表 (SRH)、從症狀核對表-90 (SCL-90) 取得的一般症狀指數 (GSI)、統合感量表 (SOCS) 以及自陳在過去 12 個月中使用醫療資源的狀況。本研究設計屬類實驗加速縱貫研究。個人依變項的原始分數用逐一迴歸的方式在八步驟的治療階段量表中取得。性別、年齡和學歷在第一批就排除其可能影響。相對於測量主觀健康感 (SRH, GSI 與 SOCS) 分數的正向發展，在使用醫療資源之變項上則未發現顯著的改變。本研究並進一步討論心理治療對健康和使用醫療資源的影響及解讀上的複雜度。