Experimental Studies

The Boston Psychotherapy Study of Schizophrenia (BPSS)

Stanton, A. H., Gunderson, J. G., Knapp, P. H., Vancelli, M. L., Schnitzer, R., & Rosenthal, R. (1984). Effects of psychotherapy in schizophrenia: I. Design and implementation of a controlled study. *Schizophrenia Bulletin, 10,* 520-563.

This was a random allocation controlled study of schizophrenic patients who were offered either supportive psychodynamic psychotherapy or expressive psychodynamic psychotherapy.

Sample

The patient group was a recently hospitalised non-chronic group with diagnoses of schizophrenia.

Treatment

Therapists were all psychoanalytically oriented. Those patients in supportive therapy were offered help oriented towards coping with problems of daily living. Those receiving expressive therapy were oriented towards an integration and understanding of the meaning of their psychosis. Therapies were carried out over two years and patients were maintained on medication.

Results

Supportive therapy appeared to be significantly more helpful on measures such as relapse and the number of days in employment. The expressive group achieved better results in terms of ego functioning and cognitive improvement. Skill at dynamic exploration as assessed in independent ratings, was associated with greater reduction in global psychopathology, less denial of illness and less apathy. The 31% of patients who remained in their assigned therapy were observed to have the best outcomes at two years. It is, however, unclear if this result is not simply a reflection of the superior adaptive and interpersonal capacities required to maintain therapeutic contacts in the long term.

Evaluation

This is an important well-conducted study although it suffers from a lack of manualization of treatments and this type of therapy places exceptionally high demands on therapeutic skill. It is one of the studies to draw attention to the inadequacy of the supportive-expressive dimension in psychotherapy research.

The Anna Freud Centre Studies 1: The Work on Juvenile-onset Insulin Dependent Diabetes (AFC1)

Fonagy, P., Moran, G.S. (1990). Studies of the efficacy of child psychoanalysis. *Journal of Consulting and Clinical Psychology, 58*, 684-695

Moran, G.S., Fonagy, P. (1987). Psychoanalysis and diabetic control: A single-case study. *British Journal of Medical Psychology, 60*, 357-372

Moran, G., Fonagy, P., Kurtz, A., Bolton, A., & Brook, C. (1991). A controlled study of the psychoanalytic treatment of brittle diabetes. *Journal of the American Academy of Child and Adolescent Psychiatry, 30*, 926-935.

This series of studies aimed to establish the relevance of psychoanalytic psychotherapy for children and adolescents with insulin dependent diabetes mellitus who had chronic and pervasive difficulties in maintaining diabetic control.

Sample

Twenty two children and adolescents hospitalised for poorly controlled diabetes, mostly with episodes of hyperglycaemia, were allocated to one of two clinical units on the basis of their home address. The patients were offered comparable medical interventions and were well-matched on demographic and clinical variables.

Treatment

Patients assigned to one of the two units were offered psychoanalytic psychotherapy three to four times per week for relatively brief periods, initially on an inpatient basis. The therapy was carried out by experienced qualified clinicians working with an Anna Freudian orientation. The focus of the therapy was explicitly the patient's developmental emotional conflicts rather than specific conflicts over the diabetes and its management.

Measures

Therapeutic outcome was assessed in terms of hospitalisations, levels of diabetic control (HbA1c) and growth.

Results

There were clinically significant improvements in diabetic control in the psycho-analytically treated group. HbA1c levels were significantly lower at termination in the experimental group and these improvements were maintained on follow-up. By contrast, improvements observed in the group who benefited only from medical intervention, tended to dissipate by 3 months after discharge (see Fig 1).

Figure 1: HbA_{1c} Levels at admission and at 3 and 12 month follow-up for psychotherapy and comparison groups

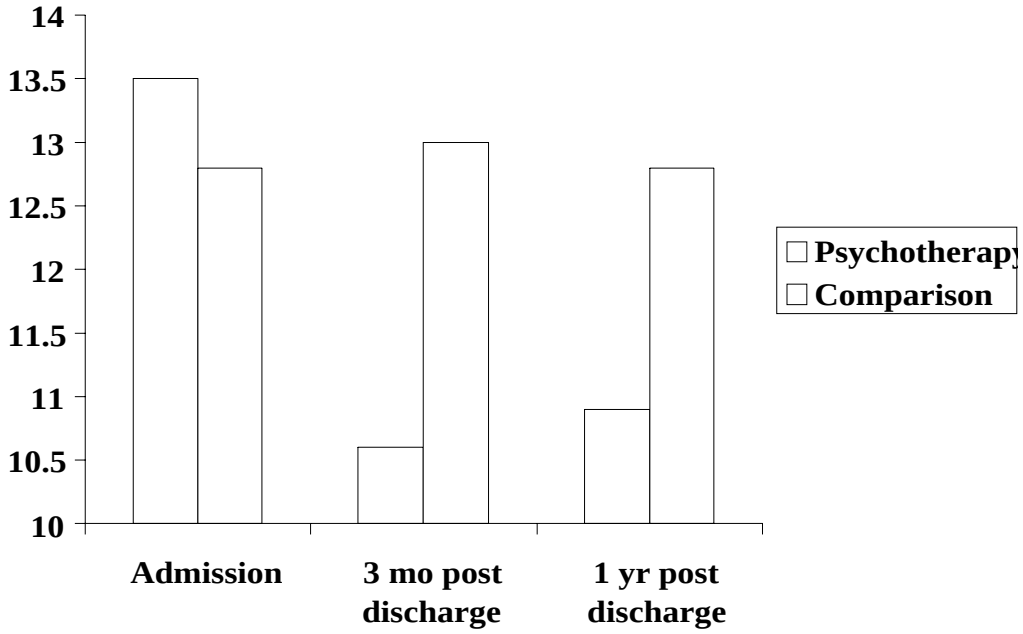


Figure 2: Changes in HbA_{1c} for psychotherapy and comparison groups

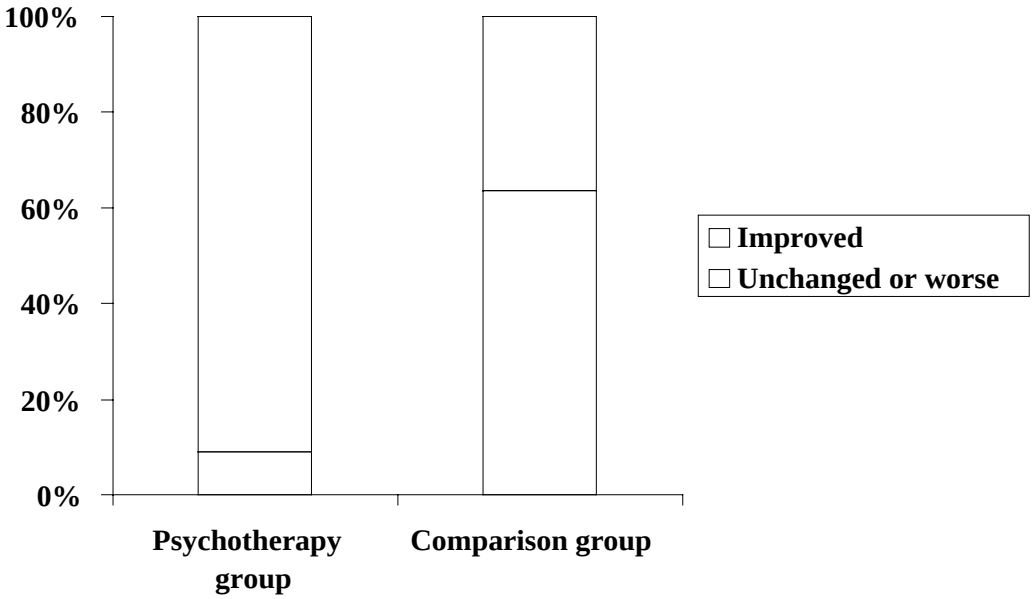
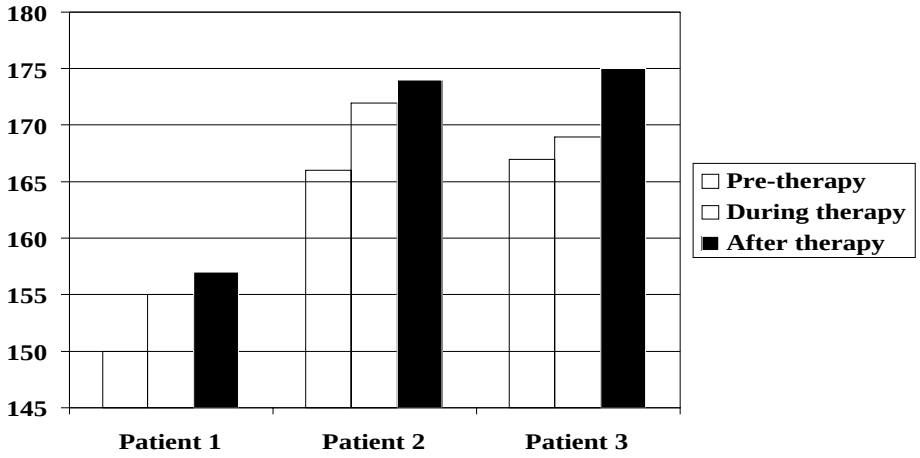


Figure 3: Predicted adult height of patients based on height and bone age



All but one of the psychotherapeutically treated patients showed clinically significant changes but only three of the 11 in the comparison group (see Fig 2). There was also a reduction in hospitalisation during the follow-up period in the psychoanalytically treated group.

Two spin-off studies were also reported. Moran and Fonagy (1987) reported that changes in metabolic control were closely associated in time with the analytic material as reported by the therapist. In general the emergence of manifest anxiety in the session associated with psychic conflict preceded improvements in diabetic control by about two weeks.

The second study reported (in Fonagy and Moran 1990) was a small series of three experimental single case studies. The original sample included three children (one girl and two boys) with significant growth retardation (height below the 5th percentile for age). Growth rate was carefully monitored for all these children. After a randomly determined time period the children entered psychoanalytic psychotherapy. Improvements in growth rate were observed in all three cases associated with the commencement of therapy, although these were more marked in children who were younger at the time of undertaking psychotherapeutic treatment (see Fig 3). In the case of one boy an increase of over 10cm was observed in the predicted adult height.

Evaluation

This promising series of studies suffers from an absence of replication, absence of placebo control, small sample size, unmatched length of hospitalisation and the absence of psychological measures of treatment outcome (although measures used were non-reactive). The importance of the studies is enhanced by the known long-term complications associated with this condition and the relatively poor outcome associated with other treatment methods.

The Los Angeles Study of Developmental Reading Disorders (LAS)

Heinicke, C. M. (1965). Frequency of psychotherapeutic session as a factor affecting the child's developmental status. *The Psychoanalytic Study of the Child, 20,* 2-98

Heinicke,. C. M., Ramsey-Klee,. D. M. (1986). Outcome of child psychotherapy as a function of frequency of sessions. *Journal of the American Academy of Child Psychiatry 25,* 247-253

This is an unusual study in focusing on children with a specific developmental disability in reading. Psychodynamic measures were used to establish a dose-response relationship between the intensity of the psychoanalytic treatment and outcome.

Sample

Children aged 7-10 with developmental reading disorders were randomly assigned to one of three groups. All the children had been threatened with being held back at school.

Treatment

Treatment was one session per week or four sessions per week for two years or once a week for the first year and four times per week for the second. The therapy was strongly influenced by the ideas of Anna Freud.

Measures

Outcome was measured in terms of the referral problem (the child's reading level) and general academic performance together with a standardised psychoanalytic diagnostic profile, based on the work of Anna Freud.

Results

Children receiving more frequent therapy had better results. Children seen once a week showed a greater rate of improvement than their counterparts in the first year of treatment although they were about even by the second year. Children seen more frequently, however, showed a greater rate of improvement in reading in the year after the end of treatment and were characterised by being more flexible in their adaptation and having a greater capacity for relationships at both the end of treatment and in the year after the end of treatment. The more intensive treatment in the second year had a clear beneficial effect.

Evaluation

Although this study focuses on reading disorder, it is relevant to other groups given the close intertwining of behavioural and learning disturbances (Rutter, 1989). It uses objective measures and random assignment and the measures are both objective and service relevant. Diagnostic characteristics of the sample, however, are not well described and the therapy offered is not well specified.

Anna Freud Centre Studies 5: Prospective Study of the Outcome of Child Psychoanalysis and Psychotherapy (AFC5)

Target, M., March, J., Ensink, K., Fabricius, J., & Fonagy, P.

This study has completed its pilot phase, is expected to be the first random assignment, clinical trial comparing the effectiveness of psychoanalysis and other, more widely-practised forms of therapy for children. The investigation is focussed on children who have severe and complex emotional disorders, between 6 and 12 years of age. All of these children, like most of the more difficult cases seen in any child mental health service, will have concurrent disorders in addition to their anxiety or depressive symptoms, which are causing impairment across the different contexts of the child's life.

Method

Sample

The study aims to recruit 160 children, over a 2-3 year period, to a clinical trial of three manualised forms of therapy; psychoanalysis in comparison with once weekly psychotherapy, cognitive-behaviour therapy and 'treatment as usual' (whatever intervention would normally be arranged by the participating clinics). Child psychiatric status and social and emotional functioning will be comprehensively evaluated before, during and after treatment, and for two years following termination, using a range of validated measures. Special attention will be paid to possible differences between the treatments in specific, clinically important domains of child and family functioning, and to evidence of cost effectiveness.

Design

The selection of the most appropriate treatment and control conditions was complex. There are serious problems with establishing an untreated control group of referred children: the children would need to remain untreated for years, to provide a comparison with the long-term outcome of psychoanalysis. This is neither practically likely to be achieved, nor ethically acceptable, for a very disturbed group of children who have actually been referred for treatment. The inclusion of a non-referred control group (for comparison with the untreated outcome of these disorders) was considered. However, these children would not in fact be comparable to those with similar disorders who had been referred (it is very likely that severely disturbed, anxious children who have not been brought for treatment come from different families from those with similar symptoms whose parents are seeking help). A second problem is similar to that for a referred, untreated group: they might very well seek or be offered treatment during the period of the study, or the researchers might well feel ethically bound to encourage the parents to initiate a referral. The use of a treatment-as-usual control group is becoming popular in both adult and child studies of psychotherapy outcome (Roth & Fonagy, 1996). The disadvantage is that comparison is provided by a set of treatments which may vary a great deal. However, the advantage to the study is that because of limited resources, this group is likely to receive considerably less treatment, on average, than do children in the first three groups, allowing the normal outcome of clinic treatment to be monitored, or - in the case of families who receive minimal treatment for whatever reason - the course of these disorders with assessment but no extensive treatment.

Outcome measures.

Some measures developed for the evaluation of each form of therapy, CBT and psychodynamic treatment, will be used to assess progress across all conditions. In addition, for some time the research team has been working to develop a set of appropriate outcome measures to get over a difficulty which faces all clinicians and researchers studying psychological treatments for children: the fact that many of the existing measures fail to capture key aspects of children's problems and of the changes clinicians hope to see. There are standardised ways of describing psychiatric symptoms, such as

checklists or structured interviews, but there are no detailed measures of social and developmental changes in normal and referred children of a kind which tap other aspects of child functioning, which may be a primary focus in psychoanalytic treatment. A vital part of the preparatory work for this child therapy outcome study has, therefore, been to put together a group of measures of child development and adjustment, and to validate them, first with non-referred children and currently with those presenting in clinical settings.

Having laid this groundwork, this outcome study will therefore use a group of assessments which look at global adjustment, aspects of attachment, social reasoning and understanding, and quality of relationships. These can be used alongside symptom measures, to give a broad and developmentally relevant picture of the child and of changes over the course of therapy. The measures are divided into five levels, all important in the assessment of child psychotherapy outcome: symptomatic or diagnostic; psychosocial adaptation; cognitive and emotional capacities which appear to underpin symptomatology and adaptation; relationships within the family and with peers; service use. The study will carefully monitor the costs of the treatment provided as well as any cost offset in the use of other services, concurrently or following therapy. A measure of child and parent satisfaction to assess the acceptability of each therapy to children and their carers will also be used.

Monitoring of treatment.

Different therapists will administer the psychodynamic and CBT conditions, in order to ensure that all participating therapists have extensive training in, experience of and commitment to the psychotherapeutic approach which they are to practise. All psychodynamic therapists will treat at least one child in intensive and one in non-intensive therapy. Each therapist will, in addition, be trained on following the manual relevant to their therapeutic orientation, and on the use of the measure used for monitoring treatment process (the same measure will assess adherence to each of the manuals). These procedures are essential to ensure that the intended therapies have in fact been delivered, to look at dose-response effects and more generally to relate aspects of process and outcome. All treatments are manualised and a measure of treatment fidelity is under development.

Evaluation

This is the first randomised study of psychoanalytic child psychotherapy and child psychoanalysis. While such a study is much needed, there are major obstacles still to be surmounted before full implementation is realistic. The challenges faced by the team include major funding problems (the study has been twice turned down by the British Medical Research Council and once by NIMH) as well as practical ones (such as recruiting a sample who gives informed consent to randomisation of such different treatment models) and financial issues. The pilot phase helped the researchers to identify key problems in the manualisation of treatment and the importance of recording is evident. It is unlikely that important results will be available in the next five years.

The Munich Psychotherapy of Depression Study (MPDS) - Comparing the effects of psychoanalysis and psychotherapy (MPDS)

Huber, D., Klug, G., & von Rad, M. (1997). Münchner Psychotherapie-Studie (MPS). In M. Leuzinger-Bohleber & U. Stuhr (Eds.), Psychoanalysen im Rückblick. Gießen: Psychosozial.

Huber, D., Klug, G., & von Rad, M. (2001). Die Münchner Prozess-Outcome Studie - Ein Vergleich zwischen Psychoanalysen und psychodynamischen Psychotherapien unter besonderer Berücksichtigung therapiespezifischer Ergebnisse. In U. Stuhr & M. Leuzinger-Bohleber & M. Beutel (Eds.), Psychoanalytische Langzeittherapien. Stuttgart: Kohlhammer.

The Munich Psychotherapy of Depression Study aims to answer two questions:

Are there any differences in the effectiveness between psychoanalysis and psychodynamic psychotherapy for depression? And if so: are those changes psychoanalysis brings about based on "structural changes" and, because of this, are they more profound and more stable than those psychodynamic psychotherapy brings about?

Are there any links between therapeutic process and outcome? And if so: what are they?

Design

To answer the first research question, a randomized control design was chosen to compare the two experimental groups: (1) a group of patients treated with psychoanalysis (PA) taking place three times a week in a recumbent position with an average duration of 240 hours and (2) a group of patients treated with psychodynamic psychotherapy (PT) taking place once a week sitting up with an average duration of 80 - 120 hours.

Because of the relatively small number of patients in each group (N= 30) a strictly random allocation could lead to an uneven distribution of important patient variables. Therefore the patients were stratified with regard to severity of symptoms and age. Therapies rather than therapists were assigned at random so as not to interfere with the important, individual patient-therapist match.

Randomisation

Each patient of the outpatient department of the Institute for Psychosomatic Medicine, Psychotherapy and Medical Psychology of the Technical University of Munich who met the inclusion criteria received an extensive audiorecorded clinical intake interview. Based on this recorded interview a board of three experienced psychoanalysts (the so called "indication board") decided whether the patient could be randomly assigned to the two experimental groups.

The inclusion criteria are as follows: between 25 and 45 years of age, ICD-10 diagnosis: depressive episode or recurrent depressive disorder/DSM IV diagnosis: MDD; BDI >16; previous psychotherapy finished at least 2 years before entering the study; not taking antidepressive medication; adequate German language skills.

The 10 participating therapists were experienced psychoanalysts and psychotherapists in private practice and have been working with patients for at least five years. They were trained at an approved institute and graduated there. They applied only those therapies they were used to, and nobody was forced to apply a therapeutic modality he did not consider as suitable for a specific patient who has been referred to him.

Treatments

Psychoanalysis is defined as a treatment modality that establishes a full transference neurosis, accompanied by regressive processes which are resolved by interpretation leading to insight and mastery. It is a re-constructive therapy with thorough and long-range goals (see Wallerstein, 1986). It has a frequency of at least three sessions a week, takes place using the couch with a minimum duration of 240 hours (a time limitation imposed by the German health insurance system).

Psychodynamic psychotherapy is defined as a treatment modality similar in mechanisms but without aiming at a full transference neurosis, limiting itself to agreed-upon sectors of psychic distress and personality malfunctioning leading to less extensive and stable results but similar in direction and kind (see Wallerstein, 1986). It takes place one session a week, face-to-face with an average duration of 80 to 120 sessions (according to the German health insurance system).

Measures

Data are gathered from patient, therapist and researcher ("external investigator"). The test battery of outcome measures is adapted from the core battery suggested by the Society of Psychotherapy Research (SPR; see Grawe, Donati & Bernauer, 1994), to be comparable with other ongoing studies. A main goal of the study is to measure not only symptoms and behaviour, but especially mode-specific effects; therefore special instruments to measure structural change and individual therapeutic goals were administered. Structural change was measured with the Scales of Psychological Capacities (SPC), developed by Wallerstein and the PRP II group because there is some evidence from the reliability-studies of the PRP II group and other validity studies as well, that it is a reliable and valid, and, on the whole, a very promising instrument (DeWitt et al., 1999; Huber et al., 2001a; Wallerstein, 1991). Individual goals are assessed by means of the Goal Attainment Scaling (Kiresuk & Sherman, 1968; Kiresuk, Smith, & Cardillo, 1994) which in the Heidelberg Study (von Rad, Senf, & Bräutigam, 1998) showed an interesting discrimination between PA and PT.

Measurement points for the outcome measures are at pretreatment, at post-treatment and at follow-up each year after end of treatment. Table 1 summarises the procedure for administering the battery of measures:

Table 1. Procedural Plan of the MPS study

Pre-treatment Measurement	• External investigator 1 and patient: intake-interview, ICD-10 and DSM-IV diagnosis, GAF, BADO, BDI, BSS, HAMD • Board of three experienced psychoanalysts/psychotherapists: decision on patient's inclusion in the study and on randomised allotment • External investigator 1 and patient: SPC- interview; informed consent • Patient: self-report questionnaires: BDI, SCL-90-R, IIP, FKBS, INTREX, SOZU, BADO, FLZ, FPI-R • External investigator 1 and patient: assessment of individual goals (goal attainment scaling GAS) • Referral to therapist • Therapist: documentation of diagnosis, psychodynamic hypothesis, level of personality organisation, treatment goals, prognosis, HAQ-T
Process Measurement	• Audio-recording of every session • Patient: self-report questionnaires: BDI, SCL-90-R, IIP, GAS and HAQ-P every 6 months • Therapist: therapy accompanying card to be filled out after every session; periodical process rating scale with HAQ-T every 6 months
Post-treatment Measurement	• External investigator 2 ("blind" for applied therapy) and patient: post-treatment interview, SPC-interview, life-events checklist, ICD-10 and DSM-IV diagnosis, GAF, BSS, HAMD, BADO • Patient: self-report questionnaires: BDI, SCL-90-R, IIP, FKBS, INTREX, SOZU, BADO, FLZ, FPI-R, GAS, HAQ-P, VEV • Therapist: periodical process rating scale and HAQ-T, assessment of termination of treatment
Follow-up Measurement (every year)	• External investigator 2 and patient: follow-up interview, SPC-interview, life-events checklist, ICD-10 and DSM-IV diagnosis, GAF, BSS, HAMD, BADO • Patient: self-report questionnaires: BDI, SCL-90-R, IIP, FKBS, INTREX, SOZU, BADO, FLZ, FPI-R, GAS, VEV

At the end of the intake-interview with ICD-10 and DSM-IV diagnosis the external investigator fills out the Global Assessment of Functioning Scale (GAF, DSM-IV axis 5; American Psychiatric Association, 1994), the Symptom Severity Score (BSS; Schepank, 1995), the Hamilton Rating Scale for Depression (HRSD, Hamilton, 1960) and the Basic Documentation of the German College of Psychosomatic Medicine (BADO, this version described by Huber, Henrich, & von Rad, 2000), including the rating of the psychic structure of the patient (axis 4: Structure of the Operationalized Psychodynamic Diagnostics, OPD; Arbeitkreis OPD, 1996). After a positive decision by the "indication board" and the "informed consent" of the patient the external investigator interviews the patient with a semi-structured SPC-interview to get the appropriate information to score the SPC-scales. In the third pre-treatment session the external investigator and the patient assess together the individual goals the patient wants to achieve during the therapy. The patient is assigned to one of the experimental groups after this intake procedure, so that the external investigator is "blind" for therapeutic modality during the pre-treatment measurement.

Before the treatment starts the patient fills out the following self-report questionnaires: Symptom Check-List (SCL-90-R, Derogatis, 1977; German version G. Franke, 1995). Beck Depression Inventory (BDI, Beck, 1961; German version Hautzinger, Bailer, Worall & Kenner, 1995). Inventory of Interpersonal Problems, short version (IIP, Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988; German version Horowitz, Strauß, & Kordy, 1994). Introject questionnaire (INTREX, Benjamin, 1974; German version Tress, 1993). Questionnaire for Coping Strategies (FKBS, Hentschel, 1998). Freiburg Personality Inventory, revised version (FPI-R, Fahrenberg, Hampel, & Selg, 1985). Questionnaire of Life Satisfaction (FLZ, Huber, Henrich, & Herschbach, 1988). Basic documentation of the German College of Psychosomatic Medicine (BADO, this version described by Huber et al., 2000). Questionnaire of Social Support, short version (F-SOZU-K-22, Sommer & Fydrich, 1991).

The therapist fills out the Helping Alliance Questionnaire (HAQ-T; Alexander & Luborsky, 1986; German version: Bassler, Potratz, & Krauthauser, 1995) and a documentation form with

psychodynamic diagnoses, main defences, level of personality organisation, motivation, main psychodynamic hypotheses, treatment goals and prognosis.

During the ongoing therapeutic process neither the patient nor the therapist is contacted personally, so as to minimise interference with the process, although research itself as an observation inevitably influences the process. The process measures are sent to patient and psychotherapist by mail.

The therapist records each session on an audiorecorder and fills out a therapy accompanying card immediately after each session. Every six months the therapist receives the following two measures: Periodical Process Rating Scales with questions about transference, resistance, analytic work, technique, setting, sessions relevant for patient´s change, counter-transference, dealing with current life events and with treatment parameters and main unconscious themes; HAQ-T.

Every 6 months the patient receives the SCL-90-R, BDI, IIP-C, GAS, and HAQ-P.

The external investigator 2 at post-treatment and follow-up will not be the same as at pre-treatment and will be "blind" about the therapeutic modality that was applied.

At post-treatment and follow-up the patient and external investigator 2 meet, and the pre-treatment instruments, including clinical and SPC interview, will be used again. In addition, a retrospective life-event checklist and a self-report questionnaire of Change in Experiencing and Behaviour (VEV, Zielke & Kopf-Mehnert, 1978b) are added.

The therapist gives an assessment of the termination of treatment.

Preliminary results

At this stage, the results from the first process measurement, half a year after beginning of treatment can be set out – with all the necessary qualifications regarding an ongoing study with an incomplete recruitment of patients.

The research question to be answered is the following: Are there any differences between psychoanalysis and psychodynamic psychotherapy during the first half year of treatment regarding: the attainment of the individual patient's goals; the therapists` assessment of the therapeutic process; and the patients` assessment of the therapeutic alliance?

42 patients passed the first six-month measurement; 21 of them in the psychoanalysis group, and 21 of them in the psychotherapy group. According to the inclusion criteria they have an ICD-10 diagnosis of depressive episode or recurrent depressive disorder; mean age is 34 years, mean BDI is 24; there are 13 men and 29 women in the sample. There is no significant difference in age, BDI-score or sex distribution between the groups.

Patient and external investigator together defined individual therapy goals in three different domains, and formulated five steps to reach this goal (any deterioration, no change, first step towards reaching the goal, reaching realistic goal and one more step than expected in reaching the realistic goal). The external investigator's task was to operationalize the goals together with the patient and to formulate a series of steps of similar difficulty to reach the goals; it was the patient's task to define the goals as precisely as possible.

There was no significant difference between the two experimental groups at that measurement point in any of the three domains of their individual goals (1st domain: $\chi 2=2{,}65$; df=3; n.s.; 2nd domain: $\chi 2=2.97$; df=4; n.s.; 3rd domain: $\chi 2=3.41$; df=2; n.s.). Out of 42 patients 29 have reached the first step, 10 patients had reached the realistic therapy goal and 3 patients were beyond the realistic therapy goal as conceived of at beginning of treatment.

The Periodical Process Rating Scales, filled out by the therapists every half year, were selected to evaluate the therapeutic process from the therapists` view. Eighteen out of 218 variables in the Periodical Process Rating Scales, which could be expected to give an idea of the therapist's technique, and of the intensity of the patient's reactions to it, were chosen and compared for the two experimental groups. The HAQ-P with its two factors: satisfaction with relationship and satisfaction

with success of treatment, (Bassler, Potratz, & Krauthauser, 1995) was chosen to give another window into the ongoing therapeutic process.

The variables of the two experimental groups were compared on an ordinal scale level by a non-parametric test, the Wilcoxon test. There were no significant differences between the 18 variables of the Periodical Process Rating Scale for a two-way test and a 5% significance level, except for the variable "affective tone of transference" (W=291.5, Z=-2.03, p=0.042). It is clearly more negative in the psychoanalysis group, showing more variance (mean=3.0; SD=1.48) than in the psychotherapy group (mean=2.11; SD=. 83). No significant differences could be found in the two factors of the HAQ-P between the two experimental groups.

The more negative tone of transference in the psychoanalysis group can be interpreted as an indication of the growing tension in the therapeutic dyad. It has to be attributed to the analytic attitude of the therapist, because the data do not indicate a generally increased disposition towards negative transference on the patients' side in the psychoanalysis group. Interesting enough the tension seems not to be recognized by the patients themselves who do not score a more negative experience in the helping alliance measured with the HAQ-P. There seems to be some evidence that in the opening phase of a psychoanalysis the positive affects of the therapeutic "honeymoon" prevail in the patient's consciousness whereas the negative affects in this group are still unconscious and only recognized by the therapist.

On the whole, these findings are to be regarded as a trend, and not as a definite result, because not all patients of the two experimental groups could be analysed statistically to this point. Therefore, more sophisticated research questions will be investigated only when data from all patients are available.

Evaluation

This is an extremely promising and potentially most important study. Particularly important and unusual is the focus on a single diagnostic group – depression. Most psychoanalytic studies take relatively heterogeneous groups of neurotic patients which even if successful, contain too few individuals with any specific diagnosis to conclude that psychoanalysis is an effective treatment for specific conditions. The researchers have selected a very wide array of instruments to test the hypothesis that greater intensity of treatment generates more powerful treatment effects. The process of randomisation, a major hurdle in these investigations, is progressing well and the recruitment phase is almost complete. Further information from this study is urgently anticipated by all those interested in the future of psychoanalysis and psychoanalytic therapy.

The Munich - New York Collaborative Study: The Psychodynamic Treatment of BPO (MNYS)

Buchheim, P., Dammann, G., Lohmer, M., Martius, Ph. (Munich) & Kernberg, O., Clarkin, J. (New York)

The Department of Psychosomatic Medicine and Psychotherapy at the Technical University of Munich and the Personality Disorders Institute of the Cornell Medical Center in New York have collaborated since 1997 in conducting an empirically supported training of psychoanalytic therapists (in Munich). They have also collaborated in designing a controlled, comparative psychodynamic treatment study of German outpatients with Borderline Personality Disorders.

Treatment

The first aim of the feasibility study is to empirically evaluate the training of a group of 30 experienced psychoanalytic therapists in the Munich centre in a particular type of object-relations treatment - “Transference focused Psychotherapy (TFP)". TFP was conceptualised and elaborated by Kernberg, Clarkin and co-workers as a manualised psychodynamic psychotherapy for patients with the diagnosis of Borderline Personality Disorder. The manual was written by the research team of the Cornell Psychotherapy Program based upon the treatment of 55 cases. Data available for this project included that from the treatment development study funded by NIMH, in which the sessions were recorded and carefully examined. This is a distillation of both the theoretical writings about the treatment and the actual experience in doing the treatment in a project explicitly designed to manualise it.

Training to adherence

The principles of the training program have been largely developed by the research team of the Cornell Psychotherapy Program over the last 17 years, with additional work over the past year in the German research group focusing on:

- the written manual describing the principles of the theory and the treatment with accompanying clinical illustrations.
- a video-tape library of actual sessions with BPD patients, illustrating various stages of the treatment process both in terms of good adherence and relative levels of competence.
- an intensive seminar that is taught by the senior therapists to instruct new therapists in the treatment.
- the supervision of an initial case of each of the therapists in training with ratings of adherence and competence.

In Munich to date, 30 psychoanalytic therapists have applied for and were selected for the training based on their experience and reputation as excellent clinicians. Since April 1997, the German psychotherapists have been taught by Otto Kernberg, John Clarkin and Michael Stone in three intensive seminars about the principles of the theoretical and clinical concepts of the TFP-Treatment with accompanying clinical illustrations. Additionally, two very experienced German supervisors were selected by the Munich research team to receive direct training from their colleagues in the Personality Disorders Institute.

The second important aim of the feasibility study, the description and evaluation of Therapy as Usual (TAU) of inpatients and outpatients with the Borderline Personality Disorders, will be conducted in collaboration with the Departments of Psychiatry of the two Medical Faculties at Munich Universities.

Evaluation

This is a major study with potentially important implications. The Munich clinic carries a particularly high caseload of patients with borderline diagnosis and therapists have considerable experience of this group of clinicians with the methodology of psychotherapy research. Additional strength is offered to the project by the international collaboration with the Cornell Group.

The London Partial Hospital Study (LPHS)

Bateman, A., & Fonagy, P. (1999). The effectiveness of partial hospitalization in the treatment of borderline personality disorder - a randomised controlled trial. *American Journal of Psychiatry*.

Bateman, A., & Fonagy, P. (2001). Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalization: an 18-month follow-up. *American Journal of Psychiatry, 158*, 36-42.

This study is an experimental trial of the psychoanalytic approach to the treatment of borderline patients. The treatment takes place in a day-hospital setting and the psychoanalytic psychotherapy is administered by supervised nurse therapists rather than psychoanalysts. The study is of interest however because it tests the importance and therapeutic value of a psychoanalytically informed environment in the management and treatment of these patients.

Sample

This is a unique randomised controlled study of the psychoanalytic psychotherapeutic treatment of borderline personality disorder patients in partial hospital setting although psychotherapy was not the only active component of the treatment, the psychoanalytic orientation was the critical organising principle of this day hospital. Forty-four patients were randomised to treatment as usual or the day hospital. All patients in the sample met both DSM-IIIR and Gunderson criteria for borderline personality disorder. The patient group showed severe psychiatric disorders including mood disorders, eating disorders, dysthymia and borderline, narcissistic or paranoid personality disorder. There was a high prevalence of physical abuse, sexual abuse, early loss, rape etc.

Treatment

The control treatment was variable. Almost three-quarters received day hospital care in non-psychotherapeutic settings. In addition they benefited from day centres, polypharmacy, community support, outpatients services and occasional inpatient services. The experimental group had individual psychotherapy under close supervision, group psychoanalytic psychotherapy, expressive therapy and the staff received consistent support. The theoretical framework included a focus on disorganised attachment manifesting as an intolerance of closeness, addressing gross limitations of mentalising capacity, assistance in developing a transitional state of mind, and a close focus on the counter-transference.

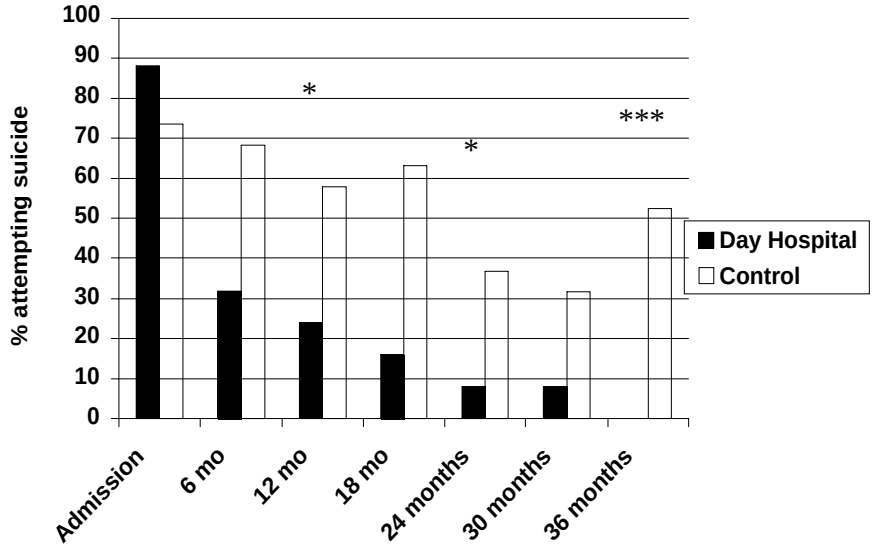
Measures

The most important measures were suicidal and self-mutilatory acts, hospitalisation, length of inpatient episodes and self-report measures of symptom distress (SCL-90) and mood (BDI and Spielberger State and Trait Anxiety Scale).

Results

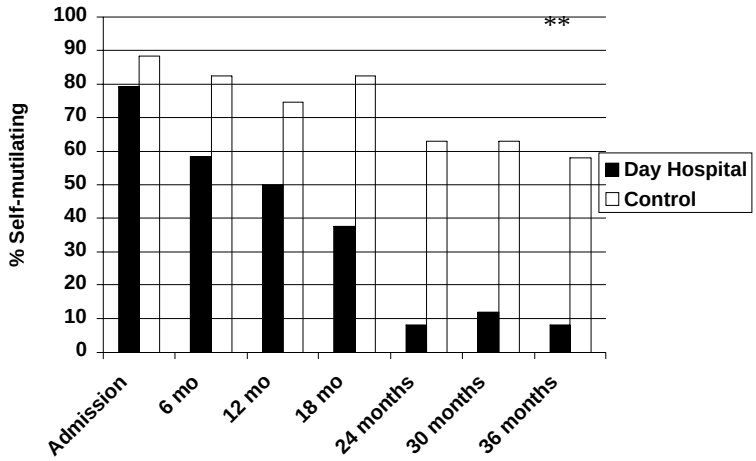
There was a dramatic drop in the number of suicide attempts after six months of treatment, maintained over the 18 months of day hospital treatment (see Figure 1). During the 18 months follow-up period the rate started to increase in th control group but continued to decrease in the experimental grouip.

Figure 1: Rates of attempted suicide in experimental (day hospital) and control samples over the 18 month study (significant differences: * .05; * .001).**



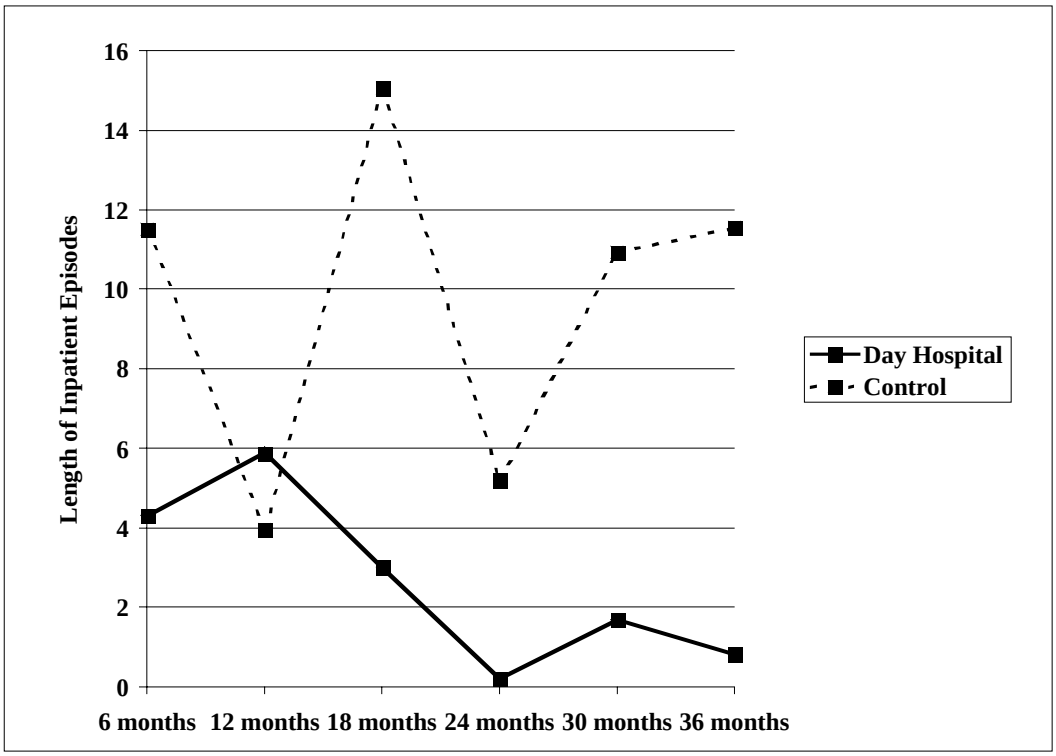
There was a significantly slower reduction in the rate of self-mutilating behaviour which decreased to under 40% in the final 6 months of the trial (see Figure 2). During the follow-up period the patients continuing to self mutilate were almost reduced to non in the treatment group but remained at about 60% in the control group.

Figure 2: Rates of self-mutilation in experimental (day hospital) and control groups over the 18 months of the study (significant difference ** .01).



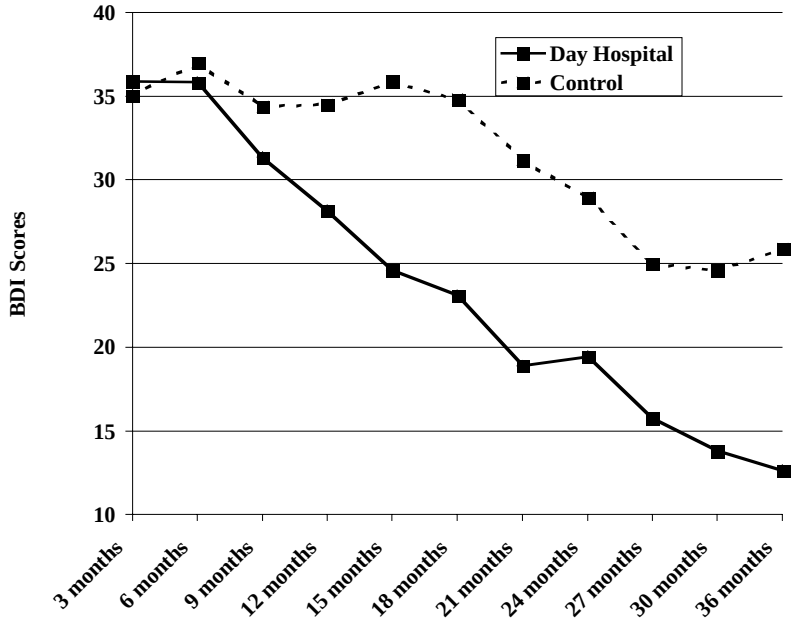
The number and length of hospital admissions during the 18 months of the trial remained low for the day hospital group but was on the increase again for the control group at 18 months (the time of discharge for the day hospital group) and remained around ten days for the average control patient (Figure 3).

Figure 3: Length (in days) of inpatient episodes per six month period for experimental (day hospital) and control groups.



Impressively, depression continued to decline for the day hospital group but was unchanged for the treatment as usual control group during the first 18 months of the treatment period for the experimental group and declined only slowly thereafter (Figure 4).

Figure 4: Depression ratings (on the BDI) for experimental (day hospital) and control groups at three monthly intervals up to 18 months.



Manifest anxiety was measured by the Spielberger manifest anxiety scale (State version). As with depression, meant level of anxiety decreased sharply during the 18 months of treatment in the experimental group and continued do do so over the follow-up period. While in the control group, anxiety decreased only marginally and remained at high levels until the end of the observation period (see Figure 5). Overall self report symptomatology across a number of symptom clusters was assessed by the SCL-90 GSI score also at 3 monthly intervals. Symptom distress as measured by this instrument also decreased consistently across measurement points during the follow-up period but did so at a far slower rate for the experimental group (see Figure 6).

Figure 5: Self ratings of state and trait anxiety (Spielberger) for experimental (day hospital) and control groups at three monthly intervals.

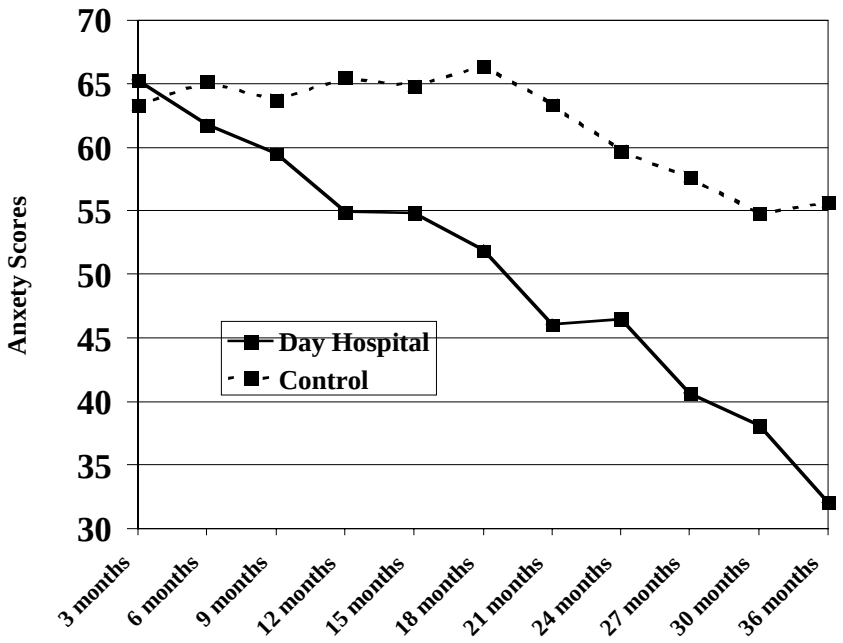
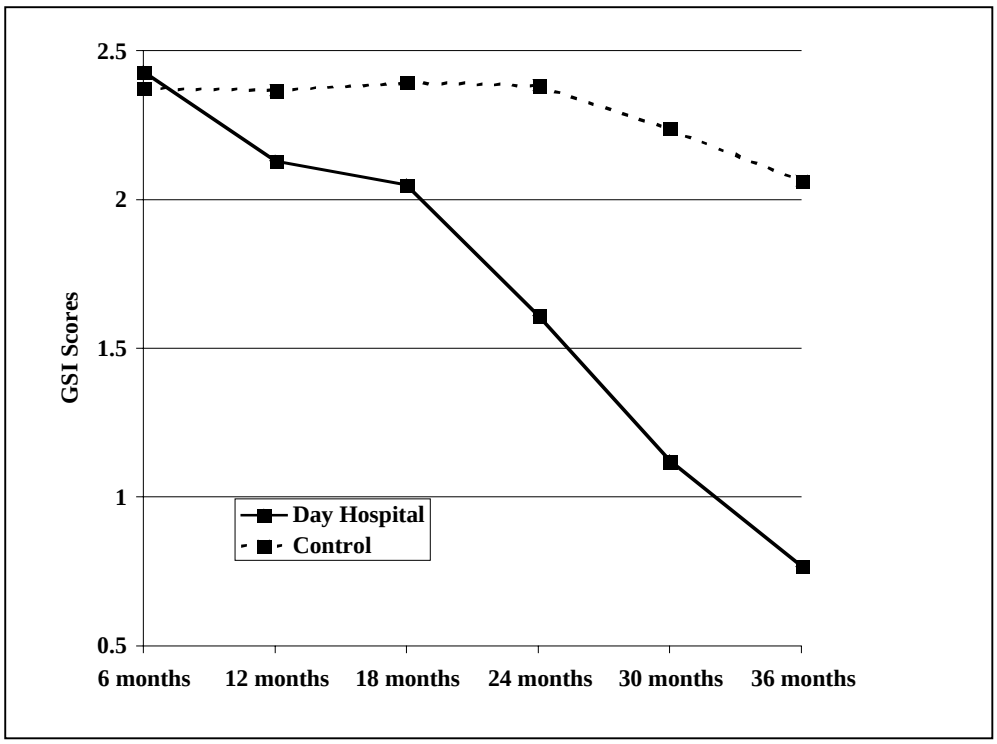


Figure 6: General symptom ratings on the SCL-90 at three monthly intervals for experimental (day hospital) and control groups.



Evaluation

This is the first randomised controlled trial of a psychodynamic treatment for borderline personality disorder. It should be added that a programme such as this has many features besides therapy that may have beneficial effects. The authors suggest that certain key psychoanalytic features of the programme account for its powerful effects, which appear to be well maintained over an 18 months follow-up period. The features of the program suggested by the authors as related to its effectiveness might include a consistent and reliable focus on the mental states (beliefs, wishes and desires) of the patients, its highly structured character, its intensity, its coherence coupled with a flexible treatment approach, its relationship focus and the individualisation of care plans. Other important areas may include a focus on acts of suicide and self-mutilation, and the selective use of medication. While the study was clearly not a test of the effectiveness of psychoanalysis, it was a test of some of the psychoanalytic principles of understanding borderline pathology advanced by these and other authors (Bateman, 1997; Fonagy & Target, 2000; Kernberg, 1975, 1987).

The Helsinki Psychotherapy Study (THPS)

Aalberg, V.,[1] Hannula, J.,[1] Julkunen, J.,[2] Järvikoski, A.,[3] Kaipainen, M.,[1] Knekt, P.,[4, 5] Lindfors, O.,[1] Marttunen, M.,[5] Mäkelä, P.,[1] .Renlund, C.,[1]

[1]Department of Psychiatry, Helsinki University Central Hospital, Helsinki, [2]Department of Psychology, University of Helsinki, Helsinki, [3]Rehabilitation Foundation, Helsinki, [4]Social Insurance Institution, Helsinki, [5]National Public Health Institute, Helsinki.

In Finland about 20% of the population suffers from different mental disorders and about 40% of all work disability pensions are due to them. Depressive and anxiety disorders form the most important and growing group of disorders causing work disability. One of the most widely used forms of psychotherapy rehabilitation in Finland is long-term psychodynamic psychotherapy, which commonly lasts at least 2-3 years, thus causing considerable costs. No study has so far been published comparing the effectiveness of this form of psychotherapy with that of other forms of psychotherapy. Accordingly the information on cost-utility of this form of long-term therapy is scarce.

Objectives

The primary objective of this randomized clinical trial is to evaluate the effects of four forms of psychotherapy in the treatment of depressive or anxiety disorders. More specifically, the objective is to compare the effects of the different forms of psychotherapy on psychiatric morbidity and symptoms, on social functioning and ability to work, and on psychological functioning as well as to compare the cost-utility of the different forms of psychotherapy. A secondary objective is to evaluate the effect of patient-related characteristics on the outcome of the different forms of psychotherapy.

Forms of psychotherapy

The following four forms of psychotherapy are included in this study:

problem solving therapy (the frequency of sessions is one every second or third week, up to a maximum 12 sessions and a duration of therapy of up to 8 months).

short-term psychodynamic therapy (the therapy consists of 20 sessions, one session a week, lasting 5-6 months)

long-term psychodynamic therapy (the frequency of sessions is 2-3 times a week and the duration of therapy is 2-3 years)

psychoanalysis (the frequency of sessions is 4 times a week, and the duration is about 5 years)

The therapists participating have practised at least for two years after their training in the special form of psychotherapy and most of them have over ten years of experience. The therapies are conducted as is usual in clinical practice. No therapy manuals are used. The therapy process is monitored by questionnaires and by interviewing the patients and the therapists after the end of the therapy. No video or audio taping are carried out during the sessions.

Study design

Altogether, 390 patients from the Helsinki region mainly referred by psychiatrists working in private practice, community mental health care system, student health care system and occupational health services are recruited to the study. 330 of the participants are randomly assigned to one of three treatment groups: problem solving therapy (120 patients), short-term psychodynamic therapy (120 patients), and long-term psychodynamic therapy (90 patients). The participants of the psychoanalysis group (60 patients) are self selected.

The status of the patients (symptoms, psychiatric diagnosis, psychological functioning, and social functioning) is assessed at the beginning of the study and repeated assessments are carried out

according to a fixed schedule; 3 months, 7 months, 9 months, 1 year, 1.5 years, 2 years, 3 years, 4 years and 5 years after the baseline examination.

Eligibility criteria, recruitment and exclusions

The patients come from psychiatric services representing individuals usually treated by psychotherapy in Finland. To be eligible, the trial participants have to be 20-45 years of age and to have a disorder causing social dysfunctioning (work functioning). The participants also have to simultaneously suffer from an anxiety or mood disorder (according to DSM-IV) and from neurosis or high-level borderline disorder (on a psychodynamic scale).

Potential participants are excluded from the study for the following reasons: psychotic disorder or severe personality disorder; adjustment disorder; substance abuse; organic brain disease or other severe organic disease; and mental retardation. Also individuals treated with psychotherapy within the previous two years, psychiatric health employees and persons known to the research team members are excluded.

Methods at baseline

Internationally approved methods are used for description of symptoms, psychiatric diagnosis, psychological functioning and social functioning at the baseline examination. The measurements directed to the participants are carried out as ratings based on interviews, self-reported questionnaires, and as psychological tests. The following main instruments are used:

Symptoms: Hamilton Depression Rating Scale (HDS) and Hamilton Anxiety Rating Scale (HARS-G) based on interview rating scales and Symptom Check list (SCL-90), Beck Depression Inventory (BDI) and Scale for Suicidal Ideation (SSI) based on questionnaires;

Psychiatric diagnosis: DSM-IV (based on structured interview);

Psychological functioning: Quality of Object Relations Rating Scale (QRS) based on interview assessment, Defence Style Questionnaire (DSQ), and Structural Aspects of Social Behaviour (SASB introject) based on questionnaires and Rorscach Inkblot Technique (Comprehensive System) and Wechsler Adult Intelligence Scale-Revised (WAIS-R) psychological tests;

Social functioning: Global Assessment Functioning Scale (GAF) based on interview rating scale and Social Adjustment Scale (SAS), Inventory of Interpersonal Problems (IIP), Life Situation Survey, Perceived Competence, Sense of Coherence Scale and assessment of working capacity based on questionnaires.

Laboratory determinations (serum cholesterol, serum thyroid hormones, serum glucose metabolism) are carried out based on serum samples taken from the participants, and a tissue sample bank at -70C has been founded. Individual information on use of psychiatric medication, hospitalization, mortality, disability pensions and sick-leave periods is obtained by linking the data to nationwide public registers. The therapists and therapy process are assessed by Common Core Questionnaire (CCQ) and Working Alliance Inventory (WAI). Health economic data is also collected from patients and from official registers.

Follow-up examinations

During the follow-up period, the questionnaires are carried out at every occasion of repeated measurements, i.e., after 3 months, 7 months, 9 months, 1 year, 1.5 years, 2 years, 3 years, 4 years and 5 years. Those questionnaires carried out after 3 months, 9 months, 1.5 years, 2 years and 4 years are brief. The interviews are repeated four times, i.e. after 7 months, 1 year, 3 years and 5 years. The psychological tests (WAIS-R and Rorschach) and the laboratory determinations are repeated after 3 years and 5 years.

Quality control

The reliability of the questionnaires is evaluated by estimating the agreement between answers on similar questions. The consistency of the interviewer's ratings is evaluated by repeated control ratings of 40 selected interviews. Based on these ratings both the agreement between raters and long time stability of the ratings are evaluated. Reliability is also estimated on the basis of 20 Rorschach protocols according to Comprehensive System guidelines.

Data monitoring

General adherence to the study protocol is continuously evaluated by monitoring recruitment success, rates of dropout, timeliness and completeness of form handling and accuracy of the data base. Treatment group balance for confounding factors, including disorder factors and information about the therapy process, is continuously evaluated. Other comparisons include dropout rates and missing data. Use of other treatments during the five-year follow-up period is evaluated by questionnaires and based on information from public registers.

Statistical analyses

The data is longitudinal with repeated measurements. The primary analysis, based on intention to treat, is designed to evaluate differences between the intervention groups over time in the different indicators using random regression models. Because of the complications caused by the fact that the therapies compared are of different duration and by confounding caused by medical treatment (psychotropic medication), a variety of other approaches will also be used.

Organization and present state of the study

Organization

The study is conducted jointly by the Department of Psychiatry, Helsinki University Central Hospital, the Social Insurance Institution and the Rehabilitation Foundation in collaboration with the National Public Health Institute and other Finnish organisations. The executive organisation consists of a steering committee, a scientific committee and several expert groups (data management, psychiatric, psychological, social and health economic). About fifteen researchers are working within the project. A safety committee follows the progression of the study scrutinizing possible side effects.

Pilot study

A pilot study to determine the feasibility of a large-scale trial was successfully conducted with 36 participants in 1993-1994.

Schedule

The baseline examination was started in 1995 and all patients will be recruited by the end of 1999. The follow-up will be completed at the end of 2004. Currently (August 1998) 397 patients have applied to the study, 254 have been accepted, 182 have started their therapy and 93 have ended it. Of the patients about 30% are men and about 70% of all patients suffer from mood disorders.

Reporting of results

The first main evaluation will compare the effects of problem solving therapy and short-term psychodynamic therapy in 2000 when both therapies have been completed. The second main evaluation comparing short-term and long term psychodynamic therapies will be carried out in 2002 when the long-term therapies have ended. Further evaluations will be performed based on data collected up to 2004 after a five year period from the baseline.

Evaluation

During the last five decades a large number of studies on the effectiveness of different types of short-term psychotherapy have been published. Although long-term psychotherapy is a widely used treatment which consumes a large amount of resources, no studies have been published comparing the benefits of long-term psychotherapy with those of short-term therapies. Therefore it is to be expected that the present study will give unique information on the relative efficacy of long-term psychotherapies. The study's state-of-the-art design and broad support should ensure that this is the case.