



## Young adults in psychoanalytic psychotherapy: Patient characteristics and therapy outcome

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The aims of this naturalistic study are to present patient characteristics and analyse various outcome measures at termination for psychoanalytic psychotherapies with young adults. Patients ( $n = 134$ ) between 18 and 25 years were included, of whom 92 received individual and 42 group therapy. One third had a self-reported personality disorder. The patients were considerably more troubled than Swedish norm groups at intake and they showed improvement on all outcome measures during therapy. However, the post therapy means did not fully reach the norm group means. The largest positive changes (pre- versus post-therapy) were with respect to the patients' overall health and functioning. Changes were more moderate in self-reported symptoms, self-concept, and self-representation, while changes in interpersonal problems and object representations were small. The results of this study are discussed in the context of advantages and disadvantages of naturalistic versus randomized controlled study designs.

Young adulthood is a period of turmoil for some individuals. During this time there is a high incidence of internalized (e.g. depressions) as well as externalized psychiatric problems (e.g. alcohol abuse, conduct problems). Nevertheless, many individuals 'grow out' of these difficulties and are able to return to a more normal developmental pathway. However, for a subgroup of young individuals the problems tend to become more severe over time. This motivates the importance of supporting and treating young individuals with psychological problems in a way that is flexible and adapted to individual needs, even in subclinical cases where the difficulties are not yet severe enough to render a psychiatric diagnosis.

In Sweden, increasing prevalence of mental ill-health among adolescents and young adults has recently attracted attention (Berntsson, Köhler, & Gustafsson, 2001; Danielson & Marklund, 2000; Hagquist, 1997). The prevalence of mental ill-health among young people in Sweden varies between 5% and 30% in different studies contingent on definitions and cut-offs (Commission on Child Psychiatry, 1998). Further,

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among young adults the prescription of antidepressant medicine and the consumption of psychiatric in- and out-patient care increases (Dalman & Wicks, 2000; Apoteket, 2003). From puberty and onwards, girls experience more problems than boys, especially psychosomatic complaints and depression (Cederblad, 1996; Ivarsson, 1998; Olsson, 1998).

Young adulthood is a time of major external change and the life tasks involve moving away from home, defining one's vocational choice, achieving at college or at work, moving in with someone, perhaps marriage, pregnancy, and parenthood. It is also a time of great internal change. From a psychoanalytic perspective, the developmental task of the young adult is a consolidation of ego capacities that are required for life and career decisions. Considerable stress ensues, particularly when this consolidation has been only partially or unevenly achieved (Adatto, 1980; Emde, 1985; Escoll, 1987; Jacobs & Chused, 1987). As Jacobs (1988) suggests, young adults are often focused on the real-world and the current situation, and may therefore lack motivation for reflecting upon themselves and their past. Often they do not want to be caught up in transference feelings that pull them backwards in threatening ways. The psychoanalytic psychotherapist's task is thus to give the young patients more than they have expected. Working carefully and tactfully, using judicious interpretations, the therapist can help the young person to take further curative steps. This involves recognition of aspects of themselves and others that have been warded off and looking back at the threatening past. It also involves reliving feelings in the here-and-now of the consulting room, and being able to tolerate these feelings. It means trying new ways of acting, instead of the habitual ones.

While there is a shortage of randomized controlled trials, several naturalistic studies show promising effectiveness of long-term psychoanalytically oriented psychotherapy for a variety of psychological conditions in adults (Blomberg, Lazar, & Sandell, 2001; Fonagy, 2002; Leuzinger-Bohleber, Stuhr, Ruger, & Beutel, 2003; Leuzinger-Bohleber, & Target, 2002; Monsen, Odland, Faugli, Daae, & Eilertsen, 1995; Stevenson & Meares, 1992; Wallerstein, 1986; Weiner & Exner, 1991). A recent meta-analysis of randomized controlled trials involving short-term psychodynamic psychotherapy (STPP) for various specific psychiatric disorders shows that STPP has superior efficacy compared with waiting list controls and treatment-as-usual, while there are no significant differences in efficacy compared with cognitive behavioural therapy or other formal psychotherapies (Leichsenring, Rabung, & Leibing, 2004). The effects of STPP were stable and even tended to increase up to follow-up, according to this meta-analysis. Earlier meta-analyses of comparisons between psychodynamic psychotherapy (broadly defined) and cognitive behavioural therapy for depression and personality disorders show no difference in efficacy between these treatments (Leichsenring, 2001; Leichsenring & Leibing, 2003). Meta-analyses comparing a wide range of bona fide psychotherapies (including psychodynamic therapy) for a variety of psychological problems also show equal efficacy between modalities (Wampold, Minami, Baskin, & Callen Tierney, 2002; Wampold *et al.*, 1997). A meta-analysis of studies comparing individual psychotherapy and group therapy showed no overall differences in outcome between the two formats (McRoberts, Burlingame, & Hoag, 1998).

Although research focusing on psychotherapy with young adults is still sparse, the few naturalistic studies carried out suggest that psychodynamic psychotherapy is an effective treatment for this age group (Baruch, 1995; Baruch & Fearon, 2002; Blatt, Auerbach, & Aryan, 1998; Blatt, Stayner, Auerbach, & Behrends, 1996; Reiss, Grubin, & Meux, 1996). To our knowledge there are no randomized controlled trials for this age group specifically.

The Young Adult Psychotherapy Project (YAPP)<sup>1</sup> has a naturalistic design, which means that the treatments were examined as they were actually conducted in a clinical context. Interviews were conducted both with patients and therapists pre- and post-treatment, in order to study the patient's and the therapist's own understanding of the patient's problems, their thoughts about the background and ideas about what would be the best help. When actively applied by the therapist, this focus is also supposed to contribute to a treatment process that would be better suited to the particular strains experienced by the patient, as well as to reduce the age-specific difficulties in therapeutic collaboration. The quantitative outcome measures were comprehensive ranging from manifest symptoms to latent psychic structure, and included both self-rating scales and expert assessments. It was considered too difficult to use a design with randomization and a non-treatment control group when the treatment condition was of varying duration and often long-term. The naturalistic design, however, has the advantage of high external validity (Morrison, Bradley, & Westen, 2003; Seligman, 1995).

## **Aims**

The aims of the present study are to present patient characteristics at intake, and analyse various outcome measures at termination for completed psychoanalytic psychotherapies with young adults.

## **Method**

### **Setting**

The YAPP concerns different aspects of psychoanalytic individual and group psychotherapy. The psychotherapies included were conducted within the ordinary work of the Institute of Psychotherapy, Stockholm County Council, where subsidized psychotherapy is provided for people with various psychological problems. The young adults applied through the Institute's telephone service and were admitted as places became available. A minority of patients came via referral from psychiatric out-patient clinics. The therapists in the telephone service assigned the patients to further assessment for individual or group therapy. This assignment was performed with a combined regard to places available, an assessment of what treatment would suit the patient, and the patient's preferences. Psychotherapists accepted patients for psychotherapy mainly on the basis of motivation and suitability for the treatment at hand, without making a psychiatric diagnosis.

### **Sample**

The inclusion criteria for YAPP were: being 18–25 years, applying for psychotherapy, accepting participation in the research project, and accepting a first appointment. In all, 134 patients were included, whereof 92 patients enrolled in individual psychoanalytic psychotherapy and 42 patients in group therapy (in five different therapy groups). Patients with various problems were included in this study, even patients with multiple

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<sup>1</sup> *The Young Adult Psychotherapy Project is conducted at the Institute of Psychotherapy, Stockholm County Council, and the Psychotherapy Section, Department of Clinical Neuroscience, Karolinska Institutet. The project has been reviewed and approved by the Regional Research Ethics Committee at Karolinska Institutet. The project is supported by a grant from the Bank of Sweden, Tercentenary Foundation.*

or non-diagnosable problems. Common complaints were depressive mood, anxiety, problems in the relationship to parents, and low self-esteem (Wiman & Werbart, 2002).

### **Treatments**

The treatments were not manualized and treatment fidelity was not systematically examined. However, all treatments were psychoanalytic psychotherapy within the public mental health service with a mainly object relations theory orientation. Most of the therapists are long-term staff at the Institute of Psychotherapy and have a shared theoretical frame of reference. The treatments aimed at overcoming developmental arrests and improving the patients' ability to manage developmental strains (described in the introduction), and did not aim specifically at the relief of target symptoms. Most of the therapists had been involved in a clinical development project since the beginning of the 1990s, which aimed at developing psychotherapeutic methods especially adjusted for young adults. All therapists met every week in clinical teams, where treatment problems and clinical experiences were discussed. The duration and frequency of individual psychotherapy were adjusted to the individual patient's needs and jointly formulated in a written contract with the possibility of renegotiation. Of the five group therapies, four were closed and time-limited (1 or 1.5 years) and one was semi-open without a time limit; two included only female patients and three were mixed; four were conducted at the Institute and one at another out-patient centre (and in this group two 17-year-old patients were also included).

### **Therapists**

Thirty-six different therapists were involved in this study, all with a psychoanalytic orientation. Fifteen were psychoanalysts, 19 were psychotherapists, and two were psychologists with basic training in psychodynamic psychotherapy. They represented various professional backgrounds: physicians (5), psychologists (13), social workers (15), or other (3). The majority of therapists had decades of experience in psychotherapeutic work and worked as teachers and supervisors in a training programme for psychotherapy.

### **Design and procedure**

Inclusion of patients took place between 1998 and 2002. Every second patient who was assigned to individual therapy underwent a research interview ( $n = 47$ ). Remaining patients assigned to individual therapy were not interviewed pre-therapy ( $n = 45$ ). Patients applying for group therapy also participated in the research interview ( $n = 42$ ). All patients completed a background and personality questionnaire pre- and post-treatment as well as at follow-ups 1.5 and 3 years after termination. Note that the data presented in this study only concern the quantitative measures used pre-treatment for all patients and at termination for those patients who completed their therapies before 1 December 2004.

### **Drop-out**

During the inclusion period there was a drop-out of 36 patients who fulfilled the inclusion criteria concerning age and application for psychotherapy but did not enter the project, as they did not wish to participate, did not show up for the initial sessions, or due to administrative lapses. The presented pre-treatment data in this study were

collected from 134 patients. Of these 134 patients, 110 completed their therapy and 12 dropped out of therapy prematurely. The remaining 12 patients were still in treatment when this study was performed. There was also internal drop-out with missing data in either the patient questionnaires or interviews. A comparison of intake scores of the 12 patients with premature drop-out with the rest of the sample showed no significant differences with respect to age, sex, global functioning (GAF), interpersonal problems (IIP mean score), or self-reported symptoms (GSI).

### **Measures**

#### *Personality disorders*

The DSM-IV and ICD-10 Personality Questionnaire (DIP-Q; Ottosson *et al.*, 1998, 1995) was used to assess the prevalence of self-reported personality disorders. This instrument is recommended for screening of personality disorders on a group level, but not for diagnosing personality disorders in individuals without complementary interviews or observations. Internal consistency (Cronbach's  $\alpha$ ) has been reported to vary between .26 and .81 for the different personality disorders (Ottosson *et al.*, 1995).

#### *Symptoms*

Self-reported symptoms were measured with the Swedish version of the Symptom Checklist-90 (SCL-90-R; Derogatis, Lipman, & Covi, 1973; Derogatis, 1994), for which a reliability (Cronbach's  $\alpha$ ) of .97 has been shown (Fridell, Cesarec, Johansson, & Malling Thorsen, 2002). As the nine subscales are highly correlated the Global Symptom Index (GSI) was used as an aggregate measure.

#### *Self-rated health*

A number of studies have shown that Self-Rated Health (SRH; Bjorner *et al.*, 1996; Nilsson & Orth-Gomér, 2000) is a strong predictor of mortality and ill-health in a variety of populations (Heidrich, Liese, Lowel, & Keil, 2002; Larsson, Hemmingsson, Allebeck, & Lundberg, 2002; Mossey & Shapiro, 1982; Shadbolt, Barresi, & Craft, 2002). SRH was measured using the single question: 'How would you assess your health in general, both somatic and mental, at present?' with ratings on a scale from 1 (*very bad*) to 7 (*very good*). This single item of self-rated health has previously shown satisfactory test-retest reliability (Lorig *et al.*, 1996).

#### *Global functioning*

Global Assessment of Functioning (GAF; American Psychiatric Association, 1994) was assessed by a group of trained raters, who were not blind to the time of assessment (i.e. pre- versus post-therapy). Pre-treatment GAF ratings for two-thirds of the patients (those who had been interviewed, see Design and procedure) were based on interview data, as well as all post-treatment GAF ratings, except for occasional interview drop-outs. The remaining GAF ratings were based on the therapist's oral case presentation. The therapists did not participate as raters for their own patients. Studies on the reliability of GAF show varying results (.56-.91), depending on the procedure used (Endicott, Spitzer, Fliess, & Cohen, 1976; Jones, Thornicroft, Coffey, & Dunn, 1995; Michels *et al.*, 1996). To improve reliability in the present study, consensus ratings were used.

### *Interpersonal problems*

The total mean score from a shortened version (64 items) of the Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988) was used. The reliability (Cronbach's  $\alpha$ ) of the eight clusters in IIP is .78–.91 in the Swedish version used in this study (Rosander & Stiwne, 1997).

### *Self-concept*

Self-concept was measured using the Structural Analysis of Social Behaviour Intrex Questionnaire (SASB; Benjamin, 1974, 1983, 1996). The reliability (internal consistency) of the Swedish version is greater than .90 (Armeliuss, 2001). Instead of eight cluster scores, two mean values were computed: positive self concepts clusters (Clusters 2–4) and negative self concepts clusters (Clusters 6–8; Adamson & Lyxell, 1996).

### *Self and object representations*

Ratings of the Differentiation-Relatedness of Self and Object Representations (DRS; Blatt & Auerbach, 2001, 2003; Diamond, Blatt, Stayner, & Kaslow, 1995) were based on the patient's brief descriptions of his/her mother, father, and him/herself, obtained from the Object Relation Interview (ORI; Auerbach & Blatt, 1996). Ratings were made by a group of trained raters. The inter-rater reliability (intra-class correlation, consistent definition) was .71 (Hjälmdahl, Claesson, Werbart, & Levander, 2001) and a consensus procedure was used to further improve the quality of the ratings. Interviews were conducted both pre- and post-treatment with patients in group psychotherapy and half of the patients in individual psychotherapy (see Design and procedure), and thus outcome on DRS could only be analysed for these patients.

All instruments mentioned above have been used previously on young adults. There is a specific young adult (age 20–25) norm group for the Swedish version of the SCL-90 (Fridell *et al.*, 2002). The Swedish translation of the DRS was developed and tested for reliability and validity using a subgroup of the young adults in the present study (Hjälmdahl *et al.*, 2001).

### **Data analysis**

The total sample is described with respect to general demographics, living conditions, and pre-therapy status in terms of the instruments used. Cases with more than 10% missing data in an instrument were not included in the analysis. Next, the change from inclusion to termination of therapy is presented. The main measure of change used to compare the pre- and post-therapy status was the effect size (calculated as  $[\text{mean}_{\text{post}} - \text{mean}_{\text{pre}}] / \text{sd}_{\text{pre}}$ ). Furthermore, Pearson correlations (pre-post) were calculated as a measure of stability. Due to the risk of spurious significances,  $p$  values at the .05 and .01 levels should be considered with caution.

## **Results**

### **Pre-therapy characteristics**

The mean age of the sample was 22 years ( $SD$  2.2) and 73% were women. In all, 42 patients (31%) were enrolled in group therapy while the remaining 92 patients underwent individual therapy. The proportion of men was higher in group therapy



(36%) than in individual therapy (23%) due to a deliberate effort to keep three out of five therapy groups mixed with respect to gender.

About 31% of the patients lived alone, 25% lived with their parents, 25% lived with a partner and 19% lived with someone else (for instance in a student dormitory). One person was married and another one had a child. The most common occupation was student, either fulltime (47%) or in combination with work (19%). In total, 29% had a regular job as their main source of income. None defined him/herself as unemployed. About 89% of the patients were born in Sweden and 25% had at least one parent of foreign origin. In total, 69% had at least one parent with a university degree - 48% of the patients' mothers and 56% patients' fathers.

The prevalence and type of self-reported personality disorders were based on DIP-Q (Table 1). A total of 33.3% ( $n = 41$  of 123) of the sample fulfilled the criteria for a personality disorder (PD; including patients with personality disorder not otherwise specified; PD NOS). Excluding patients with PD NOS, the proportion of patients with at least one PD was 27.6% ( $n = 34$  of 123). Among the women this figure was 24.4% ( $n = 22$  of 90) and among the men 36.4% ( $n = 12$  of 33). In all, 21.1% ( $n = 26$  of 123) of the sample reported two or more personality disorders. The most common personality disorders were avoidant (19.5%; Cluster C), borderline (13.8%; Cluster B), and obsessive-compulsive (13.0%; Cluster C).

**Table 1.** Self-reported personality disorders according to the DSM-IV and ICD-10 Personality Questionnaire (DIP-Q) among females and males ( $n = 123$ )

Self-reported personality disorders (DIP-Q)	Women ( $n = 90$ )		Men ( $n = 33$ )		Total ( $n = 123$ )	
	$n$	%	$n$	%	$n$	%
Cluster A	11	12.2	8	24.2	19	15.4
Paranoid	6	6.7	2	6.1	8	6.5
Schizoid	0	0	1	3.0	1	0.8
Schizotypal	7	7.8	7	21.2	14	11.4
Cluster B	12	13.3	6	18.2	18	14.6
Antisocial	2	2.2	3	9.1	5	4.1
Borderline	11	12.2	6	18.2	17	13.8
Histrionic	2	2.2	0	0	2	1.6
Narcissistic	3	3.3	1	3.0	4	3.3
Cluster C	18	20.0	10	30.3	28	25.2
Avoidant	17	18.9	7	21.2	24	19.5
Dependent	8	8.9	4	12.1	12	9.8
Obsessive-compulsive	13	14.4	3	9.1	16	13.0

Note. Multiple diagnoses were possible and occurred frequently.

Several aspects of pre-therapy status for men and women as well as patients in individual and group therapy are summarized in Table 2. There were no significant differences between men and women with regard to self-reported symptoms, global functioning, and interpersonal problems. The mean pre-therapy levels of self-reported symptoms (GSI) of 1.3 clearly exceeded the mean of the Swedish norm group of 0.58 (Fridell *et al.*, 2002). For pre-therapy SRH the mean level in the whole sample (3.0) was

**Table 2.** Mean scores at intake separated for women and men as well as for individual and group therapy, and significance-tested (SD in parenthesis);  $n = 124-128$ , except for DRS where  $n = 88$

	Women	Men	t value (Women-men)	Level of significance (Women-men)	Individual therapy	Group therapy	t value (Ind.-group)	Level of significance (Ind.-group)	Total, mean
<b>Symptoms and functioning</b>									
GSI (SCL-90; mean)	1.4 (0.6)	1.2 (0.6)	1.7	ns	1.4 (0.6)	1.1 (0.5)	2.4	.05	1.3 (0.6)
Self-rated health (SRH)	2.9 (1.3)	3.3 (1.5)	1.4	ns	2.8 (1.3)	3.4 (1.4)	2.4	.05	3.0 (1.3)
Global functioning (GAF)	57.7 (6.1)	54.0 (10.8)	1.9	ns	56.4 (7.7)	57.6 (8.2)	0.9	ns	56.7 (7.8)
<b>Personality features</b>									
Interpersonal problems (IIP; mean)	1.4 (0.5)	1.3 (0.6)	0.5	ns	1.4 (0.5)	1.3 (0.4)	0.1	ns	1.3 (0.5)
Positive clusters SASB	38.4 (15.7)	43.8 (16.9)	1.7	ns	39.2 (16.2)	41.0 (15.8)	0.6	ns	39.8 (16.1)
Negative clusters SASB	34.7 (17.4)	33.2 (16.3)	0.7	ns	36.0 (17.1)	33.2 (16.7)	0.8	ns	35.1 (17.0)
DRS, mother	6.7 (1.4)	6.5 (1.5)	0.3	ns	6.6 (1.5)	6.7 (1.3)	0.5	ns	6.6 (1.4)
DRS, father	6.4 (1.5)	7.0 (1.4)	1.9	ns	6.5 (1.4)	6.7 (1.5)	0.7	ns	6.6 (1.5)
DRS, self	6.1 (1.5)	6.4 (1.6)	0.8	ns	6.2 (1.5)	6.2 (1.6)	0.1	ns	6.2 (1.5)

Note. GSI = Global Symptom Index, SCL-90 = Symptom Checklist-90, SRH = Self Rated Health, GAF = Global Assessment of Functioning, IIP = Inventory of Interpersonal Problems, SASB = Structural Analysis of Social Behaviour, DRS = Differentiation-Relatedness scale.



below the mean of the Swedish norm group of 5.2 (Lazar, personal communication, November 8 2004). The mean pre-therapy level of GAF (56.7) in the whole sample corresponded to moderate difficulties concerning functioning in social, occupational, or school settings or moderate symptoms such as flat affect, circumstantial speech, or panic attacks. Regarding interpersonal problems (IIP) pre-therapy, the mean level in the whole sample (1.3) also exceeded that of a Swedish norm group of young adults using another translation of the instrument (0.91; Horowitz, Alden, Wiggins, & Pincus, 2002). With regard to the SASB pre-therapy, the patients in this study had more troubled self-concepts (positive clusters mean of 39.8 and negative clusters mean of 35.1) than a Swedish norm-group (positive clusters mean of 62.6 and negative clusters mean of 14.3; Armelius, 1999). The mean pre-therapy developmental levels of self and object representations (DRS; 6.2–6.6) all corresponded to an emergent, ambivalent constancy of self and an emergent sense of relatedness. The comparison at intake between patients enrolled in individual therapy and group therapy revealed two significant differences. The patients enrolled in individual therapy had a higher mean on self-reported symptoms (GSI = 1.4) and a lower mean on self-rated health (SRH = 2.8) than the patients enrolled in group therapy (GSI = 1.1; SRH = 3.4).

#### **Outcome at termination**

The mean time in therapy was 15 months, in the whole range up to 38 months (the individual therapy mean was 15 months and the group therapy mean was 14 months).

The change scores from therapy inclusion to termination of therapy are presented in Table 3. The outcome measures include the effect size pre- versus post-therapy. Significance tests of change over time were conducted with paired *t* tests.

The largest improvement was with respect to the patients' overall psychological functioning (GAF) corresponding to an effect size of 1.50 standard deviation. The second largest improvement was in SRH with an effect size of 1.21 *SD*. The expert-rated GAF score and the self-rated health score were quite weakly correlated at inclusion ( $r_{xy} = .29; p < .001$ ) but correlated strongly after therapy ( $r_{xy} = .60; p < .001$ ). On GAF there was an increase from a pre-therapy mean of 57.3, which corresponds to moderate symptoms or moderate difficulty in social, occupational, or school functioning, to a post-therapy mean of 67.3, which corresponds to some difficulty in social, occupational, or school functioning or some mild symptoms. The mean level of self-rated health moved from 3.1 pre-therapy, crossing the mid-point of the scale (4 = *neither good nor bad*), to a post-therapy mean of 4.7, which was still slightly below the norm group mean (5.2). In addition, there was a large improvement on self-concept (SASB) positive clusters with an effect size of 0.82 *SD*. This improvement was from a pre-therapy mean of 39.5 to a post-therapy mean of 52.5, but both values were below the Swedish norm group mean (62.6; Armelius, 1999).

There were also positive changes with regard to self-reported symptoms (GSI), interpersonal problems (IIP), self-concept (SASB) negative clusters, and self and object representations (DRS). However, these changes were smaller than in the more global measures of health (GAF and SRH) and in self-concept (SASB) positive clusters. The improving mean levels of self-rated symptoms (GSI), from 1.2 pre-therapy to 0.8 post-therapy, and interpersonal problems (IIP), from 1.3 pre-therapy to 1.1 post-therapy, were still somewhat higher than that of the corresponding Swedish norm groups. Also the moderate change in self-concept (SASB) negative clusters from a pre-therapy mean of 33.9 to a post-therapy mean of 23.7, did not reach the Swedish norm group mean.

**Table 3.** Changes in psychological status from time at intake to time at termination for therapy completers (SD in parenthesis);  $n = 90-105$  except for DRS where  $n = 59$

	Pre-therapy mean, completers	Post-therapy mean, completers	Norm group, mean or cut-off	t value (pre-post)	Level of significance	Effect size, (pre-post)	Correlation (pre-post)
<b>Symptoms and functioning</b>							
GSI (SCL-90; mean)	1.2 (0.6)	0.8 (0.6)	.58 <sup>a</sup>	7.7	.001	0.77	0.60
Self-rated health	3.1 (1.3)	4.7 (1.5)	5.2 <sup>b</sup>	9.2	.001	1.21	0.33
Global functioning (GAF)	57.3 (6.7)	67.3 (11.4)	71 <sup>c</sup>	9.5	.001	1.50	0.39
<b>Personality features</b>							
Interpersonal problems (IIP; mean)	1.3 (0.5)	1.1 (0.6)	.91 <sup>d</sup>	5.6	.001	0.49	0.69
Positive clusters, SASB	39.5 (15.9)	52.5 (18.5)	62.6 <sup>e</sup>	6.7	.001	0.82	0.42
Negative clusters, SASB	33.9 (16.6)	23.7 (17.9)	14.3 <sup>e</sup>	5.7	.001	0.61	0.52
DRS, mother	6.6 (1.4)	7.0 (1.0)	7 <sup>f</sup>	2.0	.10	0.31	0.06
DRS, father	6.6 (1.5)	7.3 (1.0)	7 <sup>f</sup>	3.4	.001	0.46	0.29
DRS, self	6.1 (1.6)	7.1 (1.3)	7 <sup>f</sup>	4.3	.001	0.65	0.20

Note. A positive effect size refers to improvement and a negative effect size refers to worsening.

GSI = Global Symptom Index, SCL-90 = Symptom Checklist-90, SRH = Self Rated Health, GAF = Global Assessment of Functioning, IIP = Inventory of Interpersonal Problems, SASB = Structural Analysis of Social Behaviour, DRS = Differentiation-relatedness scale.

<sup>a</sup> Mean scores in the Swedish norm group age 20-25 (Fridell et al., 2002).

<sup>b</sup> Mean scores in the Swedish norm group age 20-64 (Lazar, Personal communication, November 8 2004).

<sup>c</sup> Theoretical cut-off: 71 = 'If symptoms are present, they are transient and expectable reactions to psychosocial stressors; no more than slight impairment in social, occupational, or school functioning.'

<sup>d</sup> Mean score in the Swedish norm group age 18-24 (Horowitz et al., 2002).

<sup>e</sup> Mean scores in the Swedish norm group age 21-34 (Armeliuss, 1999).

<sup>f</sup> Theoretical cut-off: 7 = 'Consolidated, constant (stable) self and other in unilateral relationships.'

Regarding self and object representations it is notable that there is a greater change regarding self-representation than representations of father and mother. The mean levels of DRS crossed the theoretical cut-off, with an increase from 6.1 to 6.6 pre-therapy (corresponding to the level of emergent, ambivalent constancy of self and an emergent sense of relatedness) to 7.0-7.3 post-therapy (corresponding to the level of consolidated, constant representations of self and others in unilateral relationships).

Finally, a comparison was made of the outcomes in individual therapy and group therapy. There were no significant differences between outcomes in the two forms of treatment (tested as the interaction effect [time pre/post]  $\times$  [type of therapy individual/group]) in any of the outcome measures ( $F_{GSI} = 0.65$ ;  $F_{SRH} = 1.59$ ;  $F_{GAF} = 1.28$ ;  $F_{IIP-total} = 1.89$ ;  $F_{SASB+} = 0.26$ ;  $F_{SASB-} = 0.02$ ;  $F_{DRS-mother} = 0.41$ ;  $F_{DRS-father} = 0.83$ ;  $F_{DRS-self} = 0.59$ ).

## Discussion

This study aimed at describing young adults in psychoanalytic psychotherapy with regard to their socio-demographic characteristics and outcome at termination of therapy. About three-quarters of the sample were women. It is a common finding that women are more inclined to apply for psychotherapeutic help than men (e.g. Zlotnik, Shea, Pilkonis, Elkin, & Ryan, 1996). Furthermore, there is a larger proportion of parents with university education and a smaller proportion of persons born abroad in this sample than in the corresponding age group in Stockholm at large (Statistics Sweden, 2001). At inclusion a third of the sample matched criteria for self-reported personality disorder. The results concerning the prevalence of personality disorders should be interpreted with caution. It has been pointed out that valid assessments of personality disorder should either be based on longitudinal data collected by skilled clinicians or thorough interviews investigating the person's interpersonal history and behaviour during the interview (Spitzer, 1983; Westen, 1997; Westen, Shedler, Durrett, Glass, & Martens, 2003). The validity of questionnaires and structured interviews for personality disorders could be questioned, as they show relatively weak convergence with each other and minimal convergence with diagnoses based on longitudinal data (Perry, 1992; Pilkonis, Heape, Ruddy, & Serrao, 1991).

The results showed that the patients had a better psychological status after psychotherapy than before. This included positive changes on all outcome measures. The largest effect sizes were on the two global measures - global functioning and self-rated health. The changes in positive self-concept and self-reported symptoms were on the borderline between medium and large. There were medium effect sizes for negative self-concept and self-representation. The changes were small regarding interpersonal problems and object representations of mother and father.

The finding that global functioning and self-rated health showed the largest effect sizes is in concordance with the observation of Hill and Lambert (2004) that global ratings of change usually produce larger effect sizes than ratings on specific dimensions or symptoms. These authors also point out that data based on therapists and expert judges usually produce larger effect sizes than self-report data. Also, in the present study, the expert-judged global functioning showed the largest effect of all outcome measures, but the effect on SRH was almost as large. The pre-post effect size concerning self-reported symptoms in this study (0.77) is comparable to the mean effect size for short-term psychodynamic psychotherapy on general psychiatric symptoms (0.90) in the meta-analysis by Leichsenring *et al.* (2004). In that meta-analysis the largest effect sizes

concerned target symptoms, for which there is no corresponding measure in the present study. The effect sizes in the present study clearly exceed the mean pre-post effect sizes of waiting list controls (0.12–0.27; Leichsenring *et al.*, 2004). Although there is a shorter time-span between measurements for waiting list controls in that meta-analysis than the mean length of therapy in the present study, this may indicate that the changes in this study were due to treatment and not to spontaneous remission.

Overall, the pre-post effect sizes in the present study are quite comparable to those in earlier studies using the same outcome measures, mostly other naturalistic studies of psychodynamic treatments. The mean effect sizes for GSI and IIP that are reported in two meta-analyses concerning patients with depression (Leichsenring, 2001) and personality disorders (Leichsenring & Leibing, 2003) are somewhat larger than those in the present study. The effect size for GAF in the present study is about the same as in other studies (Junkert-Tress, Schnierda, Hartkamp, Schmitz, & Tress, 2001; Lorentzen, Bogwald, & Hoglend, 2002; Patelis-Siotis *et al.*, 2001; Wilberg, Karterud, Urnes, Pedersen, & Fries, 1998). Other studies using self-reported symptoms (GSI) and interpersonal problems (IIP) show approximately the same effects as found here (Chiesa, Bateman, Wilberg, & Friis, 2002; Junkert-Tress *et al.*, 2001; Lorentzen *et al.*, 2002; Rosenthal, Muran, Pinsker, Hellerstein, & Winston, 1999; Strauss & Schmidt, 2003; Wilberg *et al.*, 1998). One previous study shows larger effect sizes than the present study on self and object representations (DRS; Blatt *et al.*, 1998). No published studies using SRH or positive and negative aspects of self-concept (SASB) were found. Instead, comparisons were made with unpublished data from Sandell (Personal communication, January 21 2004) concerning a large-scale study (STOPPP) of patients with various diagnoses in psycho-analysis and psychoanalytic psychotherapy, and from Armelius (Personal communication, January 19 2004) concerning a large-scale study of patients with severe disorders in Swedish residential treatment homes. Regarding these two instruments there were larger effect sizes in the present study than in the two studies mentioned.

If a randomized controlled trial had been carried out instead of the naturalistic design chosen, the main advantage would have been the strong internal validity, which enables causal inferences about the efficacy of treatment (Mulder, Frampton, Joyce, & Porter, 2003). However, a strict RCT design would have the disadvantage of a weak external validity. Strict criteria for inclusion of patients would have the consequence of excluding many 'ordinary clinical patients' from the study. Randomization of treatment conditions would mean the loss of the positive matching of patients seeking the kind of treatment they prefer and believe in. Therapy manuals and control of treatment fidelity could interfere with the therapists conducting the treatments in accordance with their clinical experience and competence (Seligman, 1995). Furthermore, RCT designs do not address the question of aptitude by treatment interaction (ATI); that is, that different patients within the same diagnostic group may be suitable for different forms of psychotherapy (Beutler *et al.*, 2004; Clarkin & Levy, 2004). A design with a no-treatment control condition would have caused serious practical and ethical difficulties in the present context, since the treatments under examination were long-term, up to 38 months. Clinical experience tells us that most young adults would have sought another treatment elsewhere during the project time, and not waited and suffered patiently without treatment. An alternative design would include randomization to another treatment – an already empirically supported treatment or treatment-as-usual (standard psychiatric care).

The major disadvantage of the naturalistic design chosen is the weak internal validity, which means that the study can only be informative about associations, not about

causality. It is unknown to what extent there would have been spontaneous remission among the patients if they had not received therapy. More specifically, there is no knowledge about such curative processes in young adulthood, a period of gross development. Further, the diversity of patient complaints and therapeutic goals in this sample was difficult to capture in a conventional outcome study. Moreover, there was no conventional control of treatment fidelity. However, the therapists were highly trained and experienced, ensuring that the study actually concerns psychoanalytic psychotherapy. The major advantage of the naturalistic design is the strong external validity, which permits high generalizability (Morrison *et al.*, 2003; Seligman, 1995). This study gives a good picture of changes in psychological status among young adults who have attended long-term psychoanalytic psychotherapies. Moreover, the interviews performed in the project at termination and at follow-ups explore the nature of the psychological changes and the curative processes, as experienced by the patients and the therapists. Qualitative studies performed within the project show that patients as well as therapists ascribe improvements in psychotherapy to both specific psychotherapeutic technique, such as the therapist's active interpretation, and 'common factors', such as having the opportunity to talk to someone and the therapist's warmth and acceptance (Lilliengren & Werbart, 2005; Philips, Werbart, & Schubert, 2005; Werbart, 2004).

The main strengths of this study are the longitudinal prospective design and the relatively large sample of patients. Further, the study deals with long-term psychoanalytic psychotherapy with young adults, which is a somewhat overlooked research area. There are several interesting areas for further investigation in this project; for example, regarding differences in outcomes between various groups of patients, different aspects of the therapeutic alliance, and further exploration of qualitative data. The majority of psychotherapy studies either examine the immediate outcome at termination or show decreasing outcome effects at follow-up (Westen & Morrison, 2001). It is an important question for future psychotherapy research to verify whether there is a treatment that produces lasting improvement of the patients' problems, or even an internalization of the therapeutic action leading to further improvement after the termination of treatment. There are research findings suggesting that psychoanalytic treatment has this effect (Blomberg *et al.*, 2001). Like most outcome studies, the study presented here stops at the termination of therapy, but future studies within the project will focus on the long-term outcome at 1.5 and 3 years after therapy termination.

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