

The Konstanz Study - A German Consumer Reports Study (TKS)

Breyer, F., Heinzl, R. & Klein, Th. (1997). Kosten und Nutzen ambulanter Psychoanalyse in Deutschland (Cost and benefit of outpatient analytical psychotherapy in Germany): *Gesundheitsökonomie und Qualitätsmanagement*, 2, 59-73

This retrospective questionnaire study included former patients of a randomly drawn 20% sample of members of two German analytical psychotherapy associations (DGPT & DGIP) with a total membership of 394 who had terminated their analytical therapy between 1990 and 1994. The return rate of the anonymous questionnaire from therapists was 66%. Overall 183 responses (46.4%) were received; 91 declared their readiness to participate (23.1%) and 92 explained why they could or would not take part (23.4%). Reasons for therapist non-participation is shown in Table 1. One subject filled out two questionnaires for his patients, reducing the sample of participating therapists to 90. The theoretical orientation of the participants is shown in Table 2.

Table 1: Reasons for non-participation

	N	%
No terminated treatments during 1990-1994	48	52.2%
Disease, age	8	8.7%
Shortage of time	12	13%
Participation in other study	5	5.4%
Unable to contact patients	5	5.4%
Unwilling to contact former patients	1	1.1%
Rejection of study design	11	12%
No reasons given	2	2.2%
Total	92	100%

Table 2: Theoretical orientation of therapists participating in the German Consumer Report Study

Freudian	61
Jungian	10
Freudian & Jungian	4
Adlerian	15

Sample

The 90 therapists were asked to send out 979 questionnaires - 789 to former patients in individual therapy and 190 to former patients in group psychotherapy. The return rate was 66%. Forty two questionnaires were excluded, as the actual termination time turned out to be more than 6 years earlier. Thus, the final analysis was based on N = 604 patients.

Due to the naturalistic design, the large sample and the relatively high return rate, the results of the study may be taken to be representative for insurance based psychoanalytic therapy as it is currently practised in Germany; it is much more representative than the similar Consumer Reports study is for the United States. A further interest of the study is the relatively long treatments included in the study as well as some three or more times weekly treatments.

Treatments

Table 2 contains the mean length of treatment and treatment duration of the sample from which treatment density (frequency of sessions per week) may be derived. Treatment density was, not surprisingly, higher for Freudians and Jungians than Adlerians and eclectics and somewhat higher for psychologists than for psychoanalysts. Group therapy rarely took place more than once per week.

The length of the treatments with the relatively small standard deviation points to a certain selectivity of the sample. Patients mostly terminated their therapy when their insurance funding was exhausted rather than for other reasons. This is in contrast to the sample from the Ulm out-patient centre when duration of treatment is widely varying (Kächele et al., in preparation). Subjects were asked retrospectively to report their self-assessed physical, mental, social and overall health status at three points of time: at the beginning and end of their therapy and at the time of follow-up questioning.

Table 2: Mean number of sessions, length of treatment and estimated treatment intensity for 604 patients in psychoanalytic therapy followed up for up to 6 years after termination

	Mean number of sessions (SD)	Duration in months (SD)	Estimated no of sessions per week
All	238.65 (7.55)	41.04 (1.02)	1.58
Psychologists	276.66 (13.70)	42.60 (1.38)	1.77
Physician	213.77 (9.66)	39.28 (1.72)	1.48
Others	191.15 (23.37)	31.10 (2.65)	1.67
Freudians	255.92 (10.05)	40.85 (1.29)	1.71
Jungians	232.79 (15.19)	39.11 (2.28)	1.64
Adlerian	171.90 (11.35)	39.80 (2.72)	1.18

Eclectic	197.03 (14.86)	44.97 (3.45)	1.19
Individual therapy	261.28 (8.41)	42.42 (1.05)	1.68
Group therapy	119.79 (9.07)	32.67 (2.98)	1.00

Results

Table 3 displays the mean well-being scores as rated retrospectively by study subjects. There seems to be a substantial shift in well-being from bad to good associated with therapy. The change is interestingly most clearly marked for physical health. It is also interesting to note that the full impact of change on the relationships variable mainly emerges at the follow-up stage whilst the other two dimensions improve only to a limited extent between termination and follow-up.

Subjects also reported on their health care utilisation (physician's visits, hospital days, drug consumption) and on their days lost from work. Table 4 displays these data.

Table 3: Retrospective reports of subjective well-being from start of treatment to follow-up

	Start of treatment	Change by termination	Change by follow-up	Change from termination to follow-up
Total well-being	4.33	- 2.06**	- 2.17**	- 0.11**
Somatic well-being	3.21	- 1.01**	- 1.08**	- 0.07*
Psychological well-being	4.44	- 2.16**	- 2.26**	- 0.10*
Quality of relationships	3.66	- 1.19**	- 1.52**	- 0.33**

scale: 1 = very good 5 = very bad

** p < 0.001 on related t-test (one tailed)

* p < 0.05 on related t-test (one tailed)

Table 4 displays mean values for medical visits at the start of therapy, changes by termination and changes during the follow-up period. There were reductions in both primary care and specialist care visits over both time periods with both types of consultation being almost halved by follow-up assessment. Consistent with these observations, sickness absence was reduced by 60% at follow-up and hospitalisation by 66%.

Table 4: Changes in health utilisation parameters (mean values and percents relative to the year previous to therapy, at therapy termination and follow-up)

Indicator	Start of therapy	At termination (% reduction)	At follow-up (% reduction)	% change from termination to follow-up
Number of visits to family doctor	6.28	3.76** (40%)	3.03* (52%)	19%**
Number of visits to medical specialist	3.97	2.65** (33%)	- 1.59**	10%*
Days of sickness absence	14.48	8.46** (42%)	- 8.62**	31%**
Days of hospitalisation	3.39	1.17** (66%)	- 2.22**	0%

** p< 0.001 on related t-test (one tailed)

* p< 0.05 on related t-test (one tailed)

Generalisation of these findings might be problematic because several selection biases may be operating. There may have been an oversampling of successful therapists in the recruitment procedure and an over-sampling of "good" former patients by these therapists. Further there may have been bias in patients' self-selection with those who feel improved being more likely to agree to participate. To check for selection bias due to selection of "good" patients by therapists, the correlation between mean success rate and number of questionnaires sent out by a therapist was computed. This provided no evidence to suggest that fewer questionnaires sent out was associated with better outcome. Nevertheless, the results should be interpreted with some caution.

Bearing in mind these concerns, the study offers substantial evidence that the self-assessed health status of patients improved significantly associated with psychoanalytic therapy, and this effect did not weaken and in some respects even increased over the follow-up period (up to six years). The self-reported utilisation of other health care services also decreased significantly, notably the number of physician visits and hospital days. Although the validity of such retrospective reports is open to doubt, events such as sickness absence are normally accurately reported, but no attempt could be made by the study to validate these figures given the anonymous nature of the survey.

An econometric analysis yielded the expected results. The size of savings was bigger, the worse the patient's self-assessed health status at the beginning of the therapy. Importantly, savings increased with greater number of sessions and was greater for younger patients. There were no significant differences of the effects between the different professions of the therapists (psychologists vs physicians) or the analytical schools (Freud vs Jung vs Adler) or

even between patients of individual and group therapy. Hence, the results are in important respects similar to the ones found in the Consumer Reports study. Savings in health care utilisation were costed and the reduced work loss and its consequent contribution to GNP was allowed for, and it was shown that in the two years (on average) between the end of the individual therapy and the time of follow-up questionnaire the monetary benefits of therapy alone added up to one-quarter of its costs (see Table 5).

Table 5: Savings accrued as a result of individual and group psychotherapy in the first two years after therapy

Savings	Expected reduction in health care events (individual therapy)	Cost of events (individual therapy) (DM)	Expected reduction in number of health care events (group therapy)	Cost of events (group therapy) (DM)
Family doctor visits	7.3	130.90	7.5	134.70
Speciality doctor visits	3.0	101.30	7.1	235.40
Days sickness	19.5	6,906.10	26.0	9,198.00
Days in hospital	3.0	1,339.50	10.74	759.90
Total savings		8,477.80		14,330.00
Costs of treatment		3,235.00		4,305.00
Savings/costs ratio		0.255: 1		3.32:1

These figures suggest that analytic group psychotherapy is more cost-effective than individual analytic psychotherapy by a ratio of almost 13:1. The main source of this difference is the higher costs of individual analytic psychotherapy as opposed to group therapy: 7.5:1. This was a result of both the higher unit cost and greater number of individual sessions (2.5 times) relative to group therapy. Medical cost reduction is less dramatic in this study: group patients turned out to have 1.7 lower costs than the patients in individual therapy. The sample of group therapy patients was, however, too small (N=59) to justify generalisations about the relative cost-effectiveness of these treatments.

Evaluation

This study is an interesting replication of the well-known “consumer survey study” carried out in the USA several years ago. Seligman’s (1995) report did not include long term or intensive treatment. The current report demonstrated that long term therapy works and may be shown to pay for itself in terms of reduced health care costs given follow-up studies of sufficient length. The weaknesses of the consumer survey methodology have been extensively discussed in the literature. The absence of a comparison control group makes attribution of

improvement and savings to the psychotherapeutic experience problematic. Controlled studies of psychotherapy have their own methodological problems, however, and consumer surveys undoubtedly add an important perspective to evaluations of the efficacy of psychoanalytic therapy.

Taking a psychoanalytic perspective, the problems of the consumer oriented approach may soon be seen in a different light. Long term treatments, particularly those interrupted as a consequence of funding restrictions, are likely to leave significant unresolved transferences which would bias subjective evaluation in unknown ways. Untangling the relationship of objective measures and subjective reports in the context of long term therapy may be an important field of investigation as the methodology of consumerism is adopted in the field of outcome evaluation.

