



Development of research designs for investigating concepts of Analytical Psychology and the efficacy/effectiveness of Jungian psychotherapy

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1. Introduction

Carl Gustav Jung (1875-1961) is one of the founding fathers of modern psychotherapy. After some years of collaboration with Freud at the beginning of the 20th century, Jung broke ties with Freud in 1912 and developed his own psychoanalytic approach, later called Analytical Psychology (AP). Jung had a major influence on the development of psychotherapy. His use of creative techniques made him the founder of art therapy methods; he was the first to use techniques of imagination to influence the inner world of patients, a method that has recently been adopted in a number of psychotherapy approaches (e.g., the treatment of posttraumatic stress disorder); and he was the first to postulate that in the training of psychoanalysts there should be an extensive training analysis. In spite of this influence and the fact that Jungian psychotherapy is well established all over the world in mental health care as well as in training structures, there are few publications on the empirical foundations of Jungian psychology and the effectiveness of Jungian psychotherapy.

Although Jungian psychotherapy has a long history and has been practiced for more than 100 years, the Jungian approach has long been criticized for a lack of proof of its effectiveness. At the beginning of the 1990s some psychotherapy researchers (e.g., Grawe et al., 1994) therefore claimed that Jungian psychotherapy should be banned. This initiated the first attempts by a number of Jungian training institutes to conduct empirical studies on the effectiveness of Jungian psychotherapy. The majority of these studies were conducted in the German speaking countries, since here the conditions for doing effective research were comparably good. In Switzerland, because of its long tradition, Jungian psychotherapy is one of the largest schools of psychotherapy with considerable resources that enabled systematic research. In Germany Jungian psychotherapy has been financed by public health insurance since 1967, along with Freudian and Adlerian therapies. It is thus well established in the healthcare system with a strong professional society (DGAP) and three major training institutes. In the German healthcare system patient data have to be stored by the public insurer (the *Krankenkasse* in German) for decades and several of the studies reported below made use of these records for investigating long-term effects of Jungian psychotherapy.

The results of these naturalistic studies can be summarized as giving proof of what in psychotherapy research is called effectiveness of Jungian psychotherapy, which means that it has provided evidence for improvement and positive effects on the clients investigated under real practice conditions. Nevertheless up to date there is no study which provides evidence in the sense of what is called efficacy, which can only be investigated in a so-called randomized controlled trial design (RCT), where the effect of a psychotherapy method is tested in a experimental group versus a control group with no treatment; only this design can provide certainty that the effects reached are caused by the psychotherapy method only. In a number of countries Jungian psychotherapy, even though it is well-established, has come under pressure recently because no RCTs providing evidence for the efficacy of Jungian psychotherapy are available.

Also in the past decades attempts to investigate the effectiveness of Jungian psychotherapy have met some resistance of Jungian analysts to participate in such studies (for details see Roesler 2018). Thus, even though there is quite some empirical evidence for a number of Jungian concepts, namely the complex, the notion of a dynamic unconscious, the meaning of dreams, personality typology etc., in the field of analytical psychology research designs are only rarely applied by practitioners. To investigate Jungian concepts with empirical methods, to apply questionnaires and other measures to control for the quality of applied psychotherapy etc. is still not part of the attitude of most of the Jungian practitioners. The few studies that have investigated Jungian psychotherapy have demonstrated that the Jungian approach can well be investigated with empirical methods, and that the fear of intruding the analytical

relationship is not justified. A very good example for this is the extensive research program, mainly conducted by Chinese and Korean researchers, which has demonstrated the efficacy and effectiveness of Sandplay Therapy in a number of naturalistic studies and RCTs as well as process studies (see Roesler 2019).

So from my point of view, there is a need to conduct more research in the field of analytical psychology, namely regarding the effectiveness and efficacy of Jungian psychotherapy, in the future. Why research? Apart from the pressure coming from outside of analytical psychology, from my point of view there is a number of reasons why it is important to investigate a psychotherapeutic approach such as Jungian psychotherapy.

Psychotherapy can do harm: studies covering all schools of psychotherapy have demonstrated that 33-65% of the clients do not improve and do not respond to the therapy or even deteriorate; 3-15% of all therapies lead to an increase of symptoms and severely negative effects on partners of clients; 22% of all psychotherapy patients break off early (Swift et al. 2017). This means that, even if there is the intention in the therapist to help the client, the treatment can have severely negative effects and the client would be better off if no psychotherapy had been applied.

Research on ineffective therapists: ineffective therapists systematically produce negative effect sizes -0.91 to -1.49, vs. systematically positive effects in good therapists 1.0 – 1.52 (Linden & Strauß 2018); it is estimated that over all schools of psychotherapy 10 to 15% of psychotherapists are ineffective with almost each of their clients (Barlow 2010). This means that the subjective judgment of the therapist that he or she is helpful may be wrong, and case reports or presentations are not enough to control for the quality of psychotherapy.

As examples for this kind of research findings, see the following publications:

Therapist effectiveness: Implications for accountability and patient care

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Abstract

Significant therapist variability has been demonstrated in both psychotherapy outcomes and process (e.g., the working alliance). In an attempt to provide prevalence estimates of “effective” and “harmful” therapists, the outcomes of 6960 patients seen by 696 therapists in the context of naturalistic treatment were analyzed across multiple symptom and functioning domains. Therapists were defined based on whether their average client reliably improved, worsened, or neither improved nor worsened. Results varied by domain with the widespread pervasiveness of unclassifiable/ineffective and harmful therapists ranging from 33 to 65%. Harmful therapists demonstrated large, negative treatment effect sizes ($d_{-0.91}$ to $_{-1.49}$) while effective therapists demonstrated large, positive treatment effect sizes ($d_{1.00}$ to 1.52).

Therapist

domain-specific effectiveness correlated poorly across domains, suggesting that therapist competencies may be domain or disorder specific, rather than reflecting a core attribute or underlying therapeutic skill construct. Public policy and clinical implications of these findings are discussed, including the importance of integrating benchmarked outcome measurement into both routine care and training.

Lingiardi, V. et al. 2017 (DOI: 10.1002/cpp.2131)

Do therapists subjective variables impact on psychodynamic psychotherapy outcomes? A systematic literature review

Background: Despite growing attention to the general therapist effects in a wide range of clinical settings, little is known about the individual, cross-situational, and therapy–nonspecific

variables that impact on the differential effectiveness of clinicians. The current study is a systematic review of the evidence relating to the influence of therapists subjective characteristics on outcomes of psychodynamic psychotherapies.

Method: A multistage and systematic search of articles published between 1987 and 2017 identified 30 relevant studies, which were organized into 6 areas according to the specific therapists variable considered.

Results: Therapists interpersonal functioning and skills showed the strongest evidence of a direct effect on treatment outcomes. Furthermore, there were preliminary evidence that therapists attachment styles, their interpersonal history with caregivers, and their self concept might affect outcomes through interaction effects with other constructs, such as technical interventions, patients pathology, and therapeutic alliance. The high variability between studies on therapists overall reflective or introspective abilities and personality characteristics suggested the need for more systematic research in these areas, whereas therapists values and attitudes showed small effects on therapeutic outcome.

Conclusions: The present review clarifies how a deep examination of the contribution of therapists subjective characteristics can help elucidate the complex association between relational and technical factors related to the outcome of psychodynamic treatments.

It has to be noted that what we psychotherapists do to our clients may be of highest importance for their lives and their well-being, and in some cases it may even be a question of life and death. So in a school as the Jungian, in which a lot of consideration and talk is spent on ethics, it should be noted that it is an ethical question to install processes of quality control and management.

Research reduces complexity. General rules and patterns cannot be found in single cases and subjective judgments may be wrong or misleading. This makes systematic research necessary. On the other hand there are some initiatives from Jungians involved in academia to conduct empirical research, and the IAAP has supported some of these studies. It is not my point to criticize any of these studies. I just would like to point to the fact that, at least from my point of view, I cannot see any coherent strategy in these attempts to promote empirical research in analytical psychology. Some of the studies which I have followed may be interesting, but to me seem more or less worthless in understanding more about the effects of Jungian psychotherapy and the factors that are behind therapeutic transformation, as well as in strengthening our position in the world of psychotherapy and clinical practice. I believe that it is very important for the future of analytical psychology to understand more about this, to test our hypotheses about the factors that are relevant for psychological change, and for conducting this research we need a coherent overall strategy.

The report presented here aims at giving an outline for how this research in Jungian psychotherapy could be done in the future. It includes the development of research designs for investigating Jungian concepts and Jungian psychotherapy. These research designs should include several options to investigate Jungian psychotherapy:

- a) a framework for a systematized documentation for single case studies
- b) a set of standardized measures for investigating the outcome of Jungian psychotherapy in the sense of a pre-post comparison
- c) systematized methods for investigating process aspects of Jungian psychotherapy, e.g. the connection between dreams and the course of therapy, the role of symbolic material etc.

These designs should be available as a set ready for application, and should be distributable by the IAAP to their member organizations, training institutes as well as individual members. The aim is to build up a database for future quality management in Jungian psychotherapy as well as forming an attitude in Jungian analysts which is more open to conduct research as well as to include research results into their practice.

First this report will give an overview of the evidence for Jungian psychotherapy on the background of contemporary psychotherapy research and the evidence found for psychoanalytic therapies in general. In the course of presenting this summary of research findings, recommendations will be given for tasks and projects necessary for building up a systematic research in Jungian psychotherapy.

References:

- Barlow, D.H. (2010): Negative effects from psychological treatments. *American Psychologist*, 65, 13-20.
- Desmet, M. (2018): *The pursuit of objectivity in psychology*. Gent: Borgerhoff & Lamberigts.
- Linden M. & Strauss, B. (2018): *Risiken und Nebenwirkungen in der Psychotherapie (risks and side effects of psychotherapy)*. Berlin: Wissenschaftlich Medizinischer Verlag.
- Roesler, C. (ed.)(2018): *Research in Analytical Psychology: Empirical Research*. London: Routledge.
- Roesler, C. (2019): *Sandplay Therapy: theory, applications and evidence base*. *The Arts in Psychotherapy*, 63. <https://doi.org/10.1016/j.aip.2019.04.001>
- Swift, J.K. et al. (2017). Treatment refusal and premature termination in psychotherapy, pharmacotherapy and their combination: a meta-analysis of head to head comparisons. *Psychotherapy*, 54, 47-57.

2. Contemporary Psychotherapy Research, Psychodynamic Psychotherapy and Jungian Analysis

Psychotherapy Research

Levels of evidence. In empirical research there is a differentiation between different levels of studies (Wampold & Imel, 2015). The highest level or Gold Standard is the Randomized Controlled Trial (RCT), with an experimental and a control group and participants who are randomly divided into these groups. Only RCTs can give proof of the efficacy of a psychotherapy method, which means that the effects in the patients are a result of the method alone, and not of other extratherapeutical factors (i.e. internal validity). In general only RCTs are accepted as a proof for the efficacy of the psychotherapy method. In recent years though there has been a discussion about the validity of RCTs, since their internal validity is high, but the external validity, its applicability to every day practice, is low (Westen & Morrison 2001). Several researchers have argued for naturalistic studies, which are conducted in every day practice and therefore are much better applicable to real practice conditions. In Germany the legal body responsible for accreditation of psychotherapy methods (Wissenschaftlicher Beirat Psychotherapie, WBP) meanwhile has defined new regulations asking for a combination of RCTs and naturalistic studies for psychotherapy methods to become accredited in the German healthcare system. Here empirical studies giving proof for the efficacy and effectiveness of psychotherapy methods need to be not only high in internal validity but also in external validity to be applicable for everyday practice (Nübling et.al. 2014). Generally speaking prospective data are more valid than retrospective, since retrospective studies are subject to biases, e.g. only those patients participate who benefited from the therapy.

Research designs

- Randomized controlled trial (RCT) – intervention and control group, randomization > efficacy
Problems: ethics, low external validity
- Quasi-experimental study – control group but no randomization > effectiveness
Problems: restrictions on internal validity
- Prospective outcome-study – no control group > effectiveness
Problems: restrictions on internal validity
- Retrospective Designs – catamnestic studies
Problems: restricted validity, biased samples

The problem of Manualization

Another problem that has been dealt with is the question of manualization of treatment. In RCTs, as they attempt to catch the effect caused by the treatment, usually therapists are asked to follow a manual which describes the methods that should be applied in detail, sometimes even describing a system of steps of therapy. In psychoanalysis and also in the Jungian

community it has often been argued that analysis cannot be manualized. This might be due to misunderstandings regarding what a manual in psychotherapy actually is. In psychoanalysis meanwhile a number of manuals for treating specific disorders has been developed and some of them have also been systematically tested in a number of empirical studies:

Mentalization-based treatment

- Bateman A, Fonagy P. Mentalization-based treatment for personality disorders. Oxford: Oxford University Press, 2016.

Transference focused therapy

- Clarkin JF, Yeomans FE, Kernberg OF. Psychotherapy for borderline personality: focusing on object relations. WashingtonDC: American Psychiatric Association, 2006.

It is not well known to many psychoanalysts, that the first manuals that were used in studies in the field of psychotherapy research were developed in psychoanalytic psychotherapy, e.g. in the so-called Vanderbilt study at the Menninger Clinic, Topeka, Kansas (Luborsky et al. 1975).

I have included the following recommendations for creating manuals, which were part of a presentation given by a senior analyst from the Anna Freud Ctr., London (the presentation is openly accessible in the Internet).

Nick Midgley,
Anna Freud Centre, London
Treatment manuals: a beginner's guide

What is a manual?

- **1960s/70s:**
 - Developed in context of psychotherapy outcome research
- **Primary aim:**
 - To describe therapy with sufficient detail and clarity to allow testing of 'treatment integrity'/'treatment fidelity'
- **Other functions:**
 - A role in treatment development and in clinical training
 - To give possibility of replication
 - To explore common and discriminating factors in different types of treatment

What is in a manual?

- Different **types of manuals:**
 - Stage I (pilot), II (RCTs) and III (transportable) manuals
- **Key components:**
 - Conceptualisation of disorder (formulation)
 - Theory and principles of treatment
 - Objectives of treatment and model of change process
 - Treatment frame – incl. contract setting?
 - Strategies, techniques, phases of treatment (incl. clinical examples)
 - Shared / non-shared features and techniques
 - Essential/unique; essential but not unique; acceptable but not necessary; not acceptable/ proscribed
 - Common problems and 'problem shooting'
 - Training procedure and scales of competence/adherence

Manuals in training:

- Manuals **do not make therapists:**
 - Previous training and experience
 - Seminars (how many?)
 - Clinical supervision
- Must focus on **competence**, not just adherence
- Needs to be **'real world' teaching:**
 - Patients often challenging, don't 'fit' manual
 - Importance of 'therapist friendly' manuals
 - Use of video/audio as examples?
- The idea of the **wiki-manual:**
 - E.g. <http://mbft-manual.tiddlyspot.com/>

Adherence:

- **Why assess adherence?**
 - Importance of reliability and discrimination
- **How is adherence measured?**
 - Therapist, supervisor or independent observer?
 - Whole session or part-session?
- What link does **adherence have with outcome?**
- **Adherence, competence or skilfulness?**
 - Slavish adherence and skilful adherence
- **Treatment-specific or generic measures?**
 - Manual as foundation for adherence ratings
 - The value of comparative studies

Even though it is not well known even to Jungian practitioners there are several handbooks for the application of Jungian psychotherapy (Stein, 1984; Kast, 1990; Eschenbach, 1979–1983, Dieckmann 1991). Besides these general handbooks there are specialized treatment manuals for therapeutic work with clients' paintings (Riedel 2005), the use of dreams and dream interpretation (Adam 2000), the handling of the transference-countertransference relationship (Jacoby 1998, Dieckmann 1980), and Active Imagination (Kast, 1988). There are also specialized handbooks for specific disorders: narcissistic personality disorder and depression (Asper 1987, Jacoby 1985); borderline personality disorder (Schwartz-Salant 1991), and other personality disorders (Doherty und West 2007).

In Sandplay Therapy there seems to be a more open attitude towards effectiveness research, as is documented on the website of Sandplaytherapists of America (STA) (www.sandplay.org/research.htm) and the *Journal of Sandplay Therapy*, both of which have defined standards for research. There is also a set of SPT treatment manuals in German and English (Homeyer & Sweeney 2011, Dale & Lyddon 2000, M. Kalff, 2007, Turner 2005a, Cunningham, 2013, Mitchell & Friedmann 1997, v. Gontard 2007).

Recommendation: *It would be necessary to develop a consensual practice manual for Jungian psychotherapy, which defines the methods and the steps to apply these methods (e.g. how dream interpretation is done in practice).*

A preliminary manual for Jungian psychotherapy was developed in the context of the PAP-study (Tschuschke et al. (2014). The role of therapists' treatment adherence, professional experience, therapeutic alliance, and clients' severity of psychological problems: Prediction of treatment outcome in eight different psychotherapy approaches. Preliminary results of a naturalistic study. Psychotherapy Research, <http://dx.doi.org/10.1080/10503307.2014.896055>.) (see Appendix: Rating Manual PAP-S). This could be used as a basis for developing a more detailed manual for Jungian psychotherapy.

Common factor models in psychotherapy research

For some years now there has been a trend towards looking at common factors in different schools and models of psychotherapy, instead of comparing the results of different schools in the sense of a competition. There is also a shift away from manualized treatments focusing on specific disorders towards transdiagnostic treatment methods: Moreover, a shift has occurred within psychotherapy research, pioneered by researchers in the field of CBT, and later those within psychodynamic psychotherapy, from developing manualised approaches focused on single disorders towards transdiagnostic and modular treatments, which focus on similarities among disorders, particularly those in similar classes of diagnoses that are associated with a high risk of comorbidity, such as anxiety disorders (Yakeley 2018).

This approach could be particularly suited to psychodynamic psychotherapy, because it is traditionally less tailored to the symptoms of single mental disorders, rather than problems, especially in the relational sphere, that are common to many mental conditions, and promotes a dimensional model of classification focusing on the core underlying processes of mental conditions. (Yakeley, 2018, p. 5).

Jerome Frank's Common Component Model:

- An institutionalized context, professional therapist, the personal qualities of the therapist create a positive expectation in the client
- Therapeutic relationship: intensive, trustful, emotionally supportive, creates belief in the competence of the therapist

- Plausible theory („myth“), which explains the problems and the way to their healing
- Theoretically founded methods („ritual“), which allow for new emotional experiences and insights > leads to changes in the inner world and in behavior

The most prominent of these models and also the latest, developed from the insights found in psychotherapy research across all kinds of schools and approaches, is the so-called Contextual Metamodel (Wampold & Imel 2015). The main elements of this model:

- Therapeutic alliance: capacity for empathy in the therapist is the best predictor for outcome
- Creation of hope in the patient is crucial, dependent on the acceptance of the theoretical model
- Allegiance: the belief of the therapist in the effectiveness of the method is a strong predictor for outcome
- Therapist factor: large differences were found between individual therapists, so the personality of the therapist seems to play a major role (see above)
- All of these elements create a holistic experience of healing
- The average effect size of this kind of psychotherapy is .75 - .85, which is equivalent to an 80% probability that the patient will be better off after therapy

Common-Factor-Models II: The Contextual Metamodel



Figure 2.2 Contextual Model.

Wampold, B.E., Imel, Z.E. (2015). *The great psychotherapy debate*. New York: Routledge.

Some insights which were found in Wampold's metastudy are highly interesting and have far-reaching implications for the future of psychotherapy research:

1. It is possible to apply a therapy method, e.g. CBT, but take out some elements, which are considered in theory to be highly important (e.g. exposure training) and the reduced method still reaches the same results as the original method.
2. Therapists are only effective if they are convinced that their method is effective (allegiance), but the method itself virtually plays no role.
3. The differences between therapists from different schools are much smaller in practice than would be expected from the debate of the schools.

4. Effective therapists adapt to the changing needs of the patient in a highly flexible way, and sometimes leave the methodology of their school completely.

In sum, the person of the therapist, his/her experience, competence and flexibility, as well as the trust of the patient in the therapeutic relationship and in the competence of the therapist seem to be much more important than schools or methods.

Evidence base of psychoanalytic and psychodynamic psychotherapies

Not well known even to many psychoanalytic practitioners, there is a long history of effectiveness research in psychoanalysis (Luborsky et al. 1975). There is solid evidence for psychodynamic psychotherapies, with some less solid results for long-term intensive psychoanalytic treatment (see Yakeley, 2018, for a recent overview).

“The terms psychoanalytic psychotherapy and psychodynamic psychotherapy are often used interchangeably, but psychodynamic therapy is usually considered to be a broader umbrella concept for psychotherapy modalities that have been adapted to different degrees from psychoanalytic principles, are less intensive than treatment with psychoanalysis, and operate on an interpretive–supportive continuum.” (Yakeley, 2018, p. 5).

Since the 1990s there has been an increasing number of empirical studies, randomized controlled trials, meta-analyses and systematic reviews, which give proof of the efficacy of short-term and long-term psychodynamic psychotherapy for a broad range of mental disorders; the effect sizes found for improvement are as large as for other evidence-based therapies, e.g. cognitive behavioral therapy (CBT), so that it is no longer possible to speak of a superiority of CBT over psychoanalysis (Leichsenring et al., 2014, 2015). The disorders treated effectively with psychodynamic psychotherapy include depressive and anxiety disorders, somatoform disorders, eating disorders, complicated grief, personality disorders, substance related disorders, and posttraumatic stress disorder.

“Most of these studies investigated short-term psychodynamic psychotherapies (eight to 40 sessions). However, some evidence suggests that long-term psychodynamic psychotherapy (12–36 months) in complex mental disorders is effective. In several meta-analyses, long-term psychodynamic psychotherapy was significantly more effective at improving target problems, general psychiatric symptoms, and personality and social functioning than were shorter or less intensive forms of treatment in patients with complex mental disorders, defined as chronic mental disorders, personality disorders, or multiple comorbid disorders. These findings are consistent with data on dose–effect relations, which suggest that for many patients with complex mental disorders, including chronic mental disorders and personality disorders, short-term psychotherapy is not sufficient. Moreover, some evidence indicates that long-term treatments have better longer-term outcomes following cessation of therapy than do short-term treatments,⁵⁵ and that effect sizes might not become evident until some time after treatment has ceased, suggesting the need for longer-term follow up” (Yakeley, 2018, p. 5).

An example for the findings regarding the differences between long-term and short-term psychotherapies is the Munich depression study (Huber et al., 2012), which compared long-term psychoanalytic psychotherapy with short-term psychodynamic psychotherapy and behavioral therapy in the treatment of chronically depressed patients in a randomized controlled trial. There were no differences between the treatment conditions at the end of therapy, but one year post therapy the psychoanalytic treatment resulted in significantly higher effect sizes for a number of measures. These differences between the treatment conditions increased in a three-year follow-up, so that in the CBT condition up to 60% of the patients, even those who had initially positive results, experienced a relapse to a clinically significant condition of depression, whereas the number of patients in the psychoanalytic

treatment who did not fulfill the criteria for a clinically significant depression even increased from end of therapy to the three-year follow-up.

Apart from these findings on outcome, process research has provided evidence for a connection between positive treatment results and specific psychoanalytic treatment methods, e.g. focus on emotions: “Therapist facilitation of patient affective experience/expression was positively associated with treatment improvements, and this relationship most likely exists independently of the influence of other factors. The results suggest a 30% difference in success rate between patients who received an affective therapeutic focus and those who do not. Results indicate that therapist facilitation of patient affective experience/expression increased patient success rates from 35% to 65%“ (Diener et al. 2007, p. 938). It was also found that if transference interpretations focus on the central unconscious need of the patient this is positively related with the development of the therapeutic relationship and the outcome. Even though there has been considerable research on psychodynamic therapies, there is still a number of problems connected with investigating psychoanalytic treatments:

“These challenges include the following: the poor methodology of many existing studies, such as unclearly defined patient samples or treatment methods, absence of adequate controls, and insufficient monitoring of adherence to the treatment model and inter-rater reliability; resistance within the psychoanalytic community to research methods such as the manualisation of treatments, randomisation of patients, recording of therapy sessions, studying of narrowly defined research samples that are not representative of clinical practice, and scepticism within the community as to whether unconscious conflicts, defences, and fantasies can be measured; and, finally, difficulties in investigating longer-term treatments and outcomes.“ (Yakeley, 2018, p. 4).

The following list includes the most important metaanalyses and studies on psychodynamic therapy efficacy:

de Maat S, de Jonghe F, de Kraker R, et al. The current state of the empirical evidence for psychoanalysis: a meta-analytic approach. *Harvard Rev Psych* 2013; **21**: 107–37.

Leichsenring F, Klein S. Evidence for psychodynamic psychotherapy in specific mental disorders: a systematic review. *Psychoanal Psychother* 2014; **28**: 4–32.

Shedler J. The efficacy of psychodynamic psychotherapy. *Am Psychol* 2010; **65**: 98–109.

Leichsenring F, Luyten P, Hilsenroth MJ, et al. Psychodynamic therapy meets evidence based medicine: a systematic review using updated criteria. *Lancet Psychiatry* 2015; **2**: 648–60.

Leichsenring F, Rabung S. Effectiveness of long-term psychodynamic psychotherapy: a meta-analysis. *JAMA* 2008; **300**: 1551–65.

Leichsenring F, Rabung S. Long-term psychodynamic psychotherapy in complex mental disorders: update of a meta-analysis. *Br J Psychiatry* 2011; **199**: 15–22.

Leichsenring F, Abbass A, Luyten P, Hilsenroth M, Rabung S. The emerging evidence for long-term psychodynamic therapy. *Psychodyn Psychiatry* 2013; **41**: 361–84.

Knekt P, Virtala E, Härkänen T, et al. The outcome of short- and long-term psychotherapy 10 years after start of treatment. *Psychol Med* 2016; **46**: 1175–88.

Fonagy P, Rost F, Carlyle J-A, et al. Pragmatic randomized controlled trial of long-term psychoanalytic psychotherapy for treatment-resistant depression: the Tavistock Adult Depression Study (TADS). *World Psychiatry* 2015; **14**: 312–21.

Yakeley, J. 2018. Psychoanalysis in modern mental health practice. *Lancet Psychiatry*. Published online March 21, 2018. [http://dx.doi.org/10.1016/S2215-0366\(18\)30052-X](http://dx.doi.org/10.1016/S2215-0366(18)30052-X)

See also the comprehensive list in “RCTs of PDT” in the Appendix

Differences between Jungian and Freudian psychoanalytic therapy

As the above summary demonstrates, psychodynamic psychotherapy (more or less in the Freudian tradition) is well investigated and has given proof of its efficacy in a number of RCTs studies so that today one can no longer speak of an inferiority of psychodynamic psychotherapy compared to e.g. cognitive behavioral therapy (CBT). Thus, one could argue that Jungian psychotherapy could consider itself to be just a part of the larger movement of psychodynamic psychotherapies, so that there would be no need to give additional proof of its efficacy and effectiveness. On the other hand Jungians have always pointed to the considerable differences between AP and classical Freudian psychoanalysis in theory as well as in the practice of psychotherapy. In Jung's view, the unconscious is not just a container for repressed drives and conflicts but it also contains constructive forces. At the center of the psyche a structure called the Self moves the personality towards its potential wholeness. This is seen as a spontaneous process called Individuation. From this perspective, the unconscious consists not only of a personal sphere but also of a collective part that contains the archetypes, universal psychological structures that influence the formation of the personality. Archetypal elements come into mind by way of symbols, which contain condensed information about the direction the ego has to take towards greater wholeness. Since the archetypal symbols contain universal information they can be interpreted by referring to cultural knowledge from mythology, religious and spiritual traditions, anthropology etc. Psychological disorders are explained as being an expression of a strong tension between the direction of ego consciousness and the unconscious with its tendency to strive towards greater wholeness of the personality. If the ego becomes one-sided and splits off other parts of the psyche so that they become incompatible with conscious functioning, the tension thus created can lead to neurotic suffering and symptoms. In Jungian psychology the unconscious is thus seen as a helpful force that tries to support ego consciousness in integrating split-off parts of the psyche. The unconscious in this process produces symbols and presents them to ego consciousness by way of dreams, fantasies, spontaneous creative acts, and also symptoms. This is the reason why Jungian psychotherapy makes use of dream interpretation as well as of different kinds of creative methods to give the unconscious the possibility to express itself. Jungian psychotherapy also focuses on the transference-countertransference relationship in very much the same way as the Freudian tradition does.

***Recommendation:** It would be helpful to create a paper which, on the one hand, lists the similarities between the Jungian approach and what is today called psychodynamic psychotherapy, as well as, on the other hand, the differences and specific characteristics of the Jungian approach. Maybe then it would be possible to decide that Jungian psychotherapy is, in its major therapeutic methods and factors, just one part of psychodynamic psychotherapy.*

Research on Jungian Psychotherapy

Even though Jung started his career as a researcher at the psychiatric hospital of the University of Zürich and received international reputation around 1905 because of his empirical research with the Association Experiment, after 1912 and his break with Freud Jung never took up empirical research again. This might be the reason why in the Jungian community a more skeptical attitude towards empirical research developed over the years. Only recently have there been systematic attempts to investigate Jungian concepts empirically. Reviews of the literature show that many of Jung's concepts are empirically supported today (Roesler, 2018). There is a certain controversy about Jung's central concept

of the archetype (Roesler, 2012), but other concepts have found their way into academic psychology, such as the personality dimension introversion-extraversion, which has become one of the so-called big five in personality psychology and is part of most well-established personality inventories.

In the field of psychotherapy research the skepticism about empirical methods in the community of Jungian practitioners has created some obstacles to the conduct of effectiveness studies. Practitioners worry that research might interfere with the therapeutic relationship and they have raised questions about how to catch the details of the psychotherapeutic process methodically. The studies reported below have found solutions to these questions: Different measures have been designed to tap into different aspects of the psychotherapeutic process characteristic of analytical psychotherapy. Operationalized Psychodynamic Diagnostics (OPD) have been developed to systemize diagnostic steps in psychoanalysis and this procedure has been adapted to Jungian psychotherapy (Junghan 2002). The “*Heidelberger Umstrukturierungsskala*” (Heidelberg scale for changes in personality structure) and measures for analytic foci, therapeutic alliance and transference are just a few examples of tools that were developed to systematically investigate different aspects of the psychotherapeutic process.

Table 1: *Overview of studies investigating Jungian psychotherapy*

Authors	Study	Design	N	Results
Mattanza et.al. 2006	Praxisstudie Analytische Langzeittherapie (PAL) Schweiz (Outpatient analytical long-term psychotherapy Switzerland)	Prospective naturalistic outcome study w/ follow-up, one group design	37	d = 0.71 – 1.48
Rubin & Powers 2005	San Francisco Psychotherapy Research Project	Prospective naturalistic outcome study w/ follow-up, one group design	39 (57)	Significant reductions in SCL-90-R, IIP
Tschuschke et.al. 2009, Tschuschke et.al. 2014	Praxisstudie ambulante Psychotherapie Schweiz (PAP-S) (Naturalistic psychotherapy study on outclient treatment in Switzerland)	Prospective naturalistic outcome study, multigroup design	81	Effectiveness given for all schools investigated
Keller et.al. 1998	Berlin Jungian Study	Catamnestic/retrospective study	111	Reduction of symptoms to “normal health state” for 88%
Breyer et.al. 1997	Konstanz Studie – A German consumer reports study	Catamnestic/retrospective study	646	Significant benefits in health and well-being

Praxisstudie Analytische Langzeittherapie (PAL) Schweiz (Outpatient analytical long-term psychotherapy Switzerland) (Mattanza et.al. 2006)

A group of researchers at the Jung Institute in Zürich participated in a larger German study of long-term analytical psychotherapy (Rudolf 2004) conducted at the University of Heidelberg. This was a naturalistic prospective outcome study; patients were monitored from the beginning of therapy in the usual everyday practice context (no control group). 26 therapists with 37 cases participated. 57% of these patients suffered from depressive disorders and 47% of them had personality disorders. The burden of disease in the sample was therefore considerably high. The mean duration of treatment was 35 months (ranging from 8.5 to 60

months) with a mean of 90 sessions (minimum: 21, maximum: 190), which is equivalent to a low-frequency treatment. The sample was compared with a representative sample from a study conducted in Zürich investigating outpatients of psychiatric practices (Bischof et al., 1994) and was considered representative for Jungian psychotherapy in Switzerland. Measures were applied before the beginning of therapy, after three and six months and then every half-year during the course of therapy, after completion of therapy and in a one- and three-year follow-up.

Measures (for more details see Mattanza et.al., 2006):

Researchers: external experts conducted interviews with patients at all points of measurement and these were videotaped and rated using Operationalized Psychodynamic Diagnostics (OPD), Jungian adaptation (Junghan 2002); based on these ratings for every patient individual Psychodynamic Foci were defined and the development of these foci was tracked over the course of psychotherapy. Changes in personality structure were measured over the course of therapy using the *Heidelberger Umstrukturierungsskala* (Rudolf et.al. 2004). Videotaped interviews with experts were also used to investigate changes in life conduct. Patient functioning was assessed using the Social and Occupational Functioning Assessment Scale (SOFAS) and the Global Assessment of Functioning Scale (GAF). Experts also rated therapeutic alliance and transference on specialized rating manuals (SGRT, TAB). Interrater reliability for all the above-mentioned measures was above $r = 0,75$ over all points of measurement.

Therapists: the participating therapists rated the severity of physical and psychological symptoms by applying ICD-diagnosis and *Beeinträchtigungsschwerescore* (BSS, severity of symptoms score) and applied status and process ratings.

Patients: SCL-90-R, PSKB-Se-R, Inventory of Interpersonal Problems (IIP), a personality inventory (*Trierer Persönlichkeitsfragebogen* TPF), and gave admission to use their health insurance data.

General functioning of patients was moderately reduced at the beginning of therapy (mean of 74), interpersonal problems were comparably severe (mean: 1.8), psychological symptoms were severe in 80% of patients, as were social and communicative deficits in 90% of patients. Mean duration of symptoms was 6.7 years.

Results: Positive restructuring of patients' personality towards more consciousness, better coping, and solution of major problems (effect size: $d = 0.94$). This resulted in positive changes in everyday life conduct with a very high effect size ($d = 1.48$). Physical symptoms were reduced with an effect size of $d = 1.08$ and psychosocial symptoms with $d = 1.43$. Global Severity Index of the SCL-90-R was reduced from 0.71 to 0.28 which is equivalent to a normal level at the end of therapy, whereas reduction had a very high effect size $d = 1,31$. The symptom scales of PSKB for anxiety, physical symptoms, depression, and suicidality were combined and their mean values reduced from 57.21 to 48.69 with an effect size of $d = 1.01$. Interpersonal problems (IIP) were reduced with a medium effect size of $d = 0,71$. All the reductions mentioned were highly significant. All results remained stable after 1 year and 3 years. There are findings for further positive changes between the end of therapy and follow-up so some effects show only after completion of therapy.

San Francisco Psychotherapy Research Project (Rubin & Powers 2005)

Originally this naturalistic study conducted by the San Francisco Jung Institute was designed as a prospective outcome study with four points of measurement (pre and post therapy, one-year, and five-year follow-up). Measures: SCL-90-R; IIP, Global Assessment of Functioning Scale. The participants were patients of the outpatient clinic of the San Francisco Jung Institute; of 100 patients 57 participated in the study. Because of low participation of analysts from the Institute the project had to be terminated earlier and the original design had to be

collapsed into a one-group pretest-posttest-design. This included 39 of the original 57 patients and only part of these completed follow-up. So the internal validity of the study could not be secured. There were significant reductions in SCL-90-R and IIP.

Berlin catamnestic study (Keller et.al., 2002)

In the early 1990s the Empirical Psychotherapy Research Group in Analytical Psychology of Berlin conducted a nationwide catamnestic, retrospective study. Former patients of Jungian psychotherapies were asked to participate and were tested via questionnaires and interview. All members of the German Society for AP (DGAP) were asked to participate, 78% responded, and 24.6% participated. The reasons for refusal to participate were documented and no bias was found. The participating therapists documented all cases terminated in 1987/88 and gave a global evaluation about the success of therapy. In Germany psychotherapy is financed quite generously by the health care system (up to 300 hours of analysis); at the beginning of therapy the therapist has to apply for financing. These applications contain data about the health state and symptoms of the patient, personality, social context, psychodynamics, and diagnosis. This information is stored by the ministry of health for decades; the Berlin study made use of these and other health care utilization data. Diagnoses: 46% affective disorders, 24% other neurotic and psychosomatic disorders, 17% personality disorders.

Catamnestic studies are affected strongly by bias through selection effects, but these were tested in the study. Of 353 documented cases, 111 participated in the study; a bias was found concerning the number of therapy drop-outs which was higher in the sample than in the population. Apart from that the sample was representative of the population. The mean duration of treatment was 162 sessions with a frequency of 1 to 2 sessions per week.

Measures: patients received a follow-up questionnaire that included measures of life satisfaction, well-being, social functioning, personality traits, interpersonal problems, health care utilization, and standardized measures (SCL-90-R, VEV, Gießen-Test). The severity of symptoms before treatment was assessed using the Schepank method of impairment severity index (Schepank, 1994).

Results: Of 60.4% of patients reporting their well-being as very poor (severe set of diagnoses) prior to therapy, 86.6% rated their global well-being at follow-up as very good, good or moderate (well-adjusted close to normal reference group on all scales of psychopathology). Six years after the termination of treatment 70-94% reported good to very good improvements in psychological distress, general well-being, life satisfaction, job performance, partner and family relations, and social functioning. The global health state of 88% could be described as "normal health" compared to a calibration sample (Gerdes & Jackel, 1992). Patients were better off than any of the clinical groups with which they shared diagnoses prior to therapy. The findings in SCL 90-R and Gießen-Test showed no difference to the standardization samples, the subjects fell within the normal range on all scales.

There were also significant reductions in health care utilization. The mean number of 16 days lost due to sickness in the 5 years before psychotherapy was reduced to a mean of 8 days in the 5 years after the end of therapy. The mean number of 8 days of hospitalization in the year before psychotherapy was reduced to a mean of 1 day after the end of therapy. There was also a reduction of visits to primary care services below the level of two representative studies of private practice patients (Hoffmeister, 1988; Schacht, 1989) and a reduction in intake of psychotropic drugs. All of these reductions were statistically significant. In sum, Jungian psychotherapy appeared to reduce the health insurance claims of the patients even below the level of the average German member of the health insurance system. The results of the Jungian sample in the Questionnaire of Change in Experience and Behavior (VEV) showed

significant improvements in various areas of life ($p < 0.01$) compared to the calibrated random sample. They were also compared to an equivalent one-year follow-up sample of inpatient cognitive-behavioral treatment ($N=142$, Zielke, 1993) and there were practically no differences.

In sum, there was not only a high level of satisfaction on the part of the patients with the Jungian treatment but there was also a reduction in symptoms which moved the patients into the area of normal health. The effects of psychotherapy were long-lasting and touched all areas of the life of the patients so that even the use of healthcare services was so drastically reduced that Jungian therapy was also cost-effective in the long run. These results have to be interpreted on the background of limitations of the design even though the study made great efforts to control for biases.

Konstanz-Studie (Breyer et.al. 1997)

The study conducted in Konstanz/Germany is a replication of the famous Consumer Reports Study by Seligman applied to therapies from several psychodynamic schools and in its design comparable to the above-mentioned Berlin study. Ninety psychotherapists distributed 979 questionnaires to former patients of whom 66% participated in the study. There were no systematic biases found in the sample. About a fifth of the participating therapists had a Jungian background and there are no systematic differences between this subgroup and the overall sample so that the study is representative for psychoanalytic practice in Germany in general and for Jungian psychotherapy. The results are very much comparable to those of the above-mentioned Berlin study, in all dimensions the study found significant benefits in health and well-being. There were again significant changes between end of therapy and follow-up. As in the Berlin study health insurance data were used and it was found a highly significant reduction in health utilisation parameters.

Table 2 (from Breyer et.al. 1997): *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)

All of these results remained stable in a six-year follow-up. A special aspect of this study is a cost-benefit computation: there were significant savings accrued as a result of individual and group psychotherapy in the first two years after therapy. These were significantly higher in relation to the severity of the health status of the patient at the beginning of therapy. As this study is retrospective the results have to be interpreted on the background of risk of biases but these were controlled for as far as possible.

Table 3 (from Breyer et.al. 1997): *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)

Praxisstudie ambulante Psychotherapie Schweiz (PAP-S) (Tschuschke et.al. 2010)

The Naturalistic Psychotherapy Study on Outpatient Treatment in Switzerland, conducted by the Swiss Charta for Psychotherapy, had the main goal of comparing different types of psychotherapy with regard to specific and nonspecific common therapeutic factors. The design is comparable to that of the Zürich Jungian study but investigated eight different schools of psychotherapy, mainly from the psychodynamic and the experiential field. In Switzerland these different psychotherapeutic schools are organized in the Charta for Psychotherapy and one aim of this study was to generate proof of the effectiveness of these methods so they could become accredited officially in the new legal system regulating psychotherapy in Switzerland. The choice of measures applied followed the recommendations given by the Society for Psychotherapy Research and includes outcome as well as process variables. The study ran for 7 years (2006-2012), including therapies and follow-up.

Measures

Patients: self rating of therapy outcome (OQ 45), symptoms (BSI), depression (BDI), Sense of Coherence (SOC-9), congruence (K-INK), therapy motivation (FMP).

Researchers: Standardized Clinical Interview for DSM (SKID), Global Assessment of Functioning Individual (GAF) and Relationships (GARF), Operationalized Psychodynamic Diagnostics (OPD).

The Psychoanalysis group contained Jungian AP as well as Freudian Psychoanalysis, so there was no differentiation, but since the Jungian approach is the largest school in Switzerland regarding professional membership and training institutions it can be assumed that the results of this group are representative for Jungian psychotherapy also. The overall sample includes 379 clients. In Tschuschke et al.'s paper (2014) there is a detailed analysis of a subgroup of 81 clients (46 female, 35 male) with a mean age of 39.6 years. Regarding their life situation and education the sample was representative for the client population in psychotherapy in Switzerland. Diagnosis: substance related disorders 4.8%; mood disorders 23.8%; anxiety, posttraumatic stress disorders, and somatoform disorders 34.0%; eating and sexual disorders 5.4%; personality disorders 10.2%; other diagnosis: 2.7%

In the general results of the study all the participating schools of psychotherapy were found to be effective. Outcomes were operationalized using the strategy of multiple outcome criteria on the basis of the Global Severity Index of the BSI, the Outcome Questionnaire, and the Global Assessment of Functioning Scale. These three tests were employed within the first probationary sessions before the start of treatment, immediately after the last therapy session, and at follow-up one year after the end of therapy. Scores were tested only on the pre-/post basis since follow-up data were not available for all the cases. Changes in all three tests pre to post were highly significant. Effect sizes: BSI 0.69, GAF 1.12, OQ 0.61. On average all clients benefited from the therapies. The authors of the study emphasized the point that generalizations from these results are hampered by several limitations. The most important

point here is that the cooperating Jungians provided too few cases and too few therapists to allow generalization.

Nevertheless the study produced some interesting findings. One part of the study consisted of describing the interventions applied by the different schools in detail. In the study, therapies were videotaped and external raters evaluated which of the described interventions were practically applied. In each school the majority of interventions applied was not school-specific but either general or stemming from a different school. Only about 15% of the interventions came from the specific background of the therapist. This of course automatically raises the question of whether there even is a specificity in the practical therapeutic work of Jungian therapists and what that would be.

See Appendix for the full texts of the Jungian studies

Conclusion on Jungian studies

Regarding the studies on Jungian psychotherapy, as there are no randomized controlled trials and the internal validity of the above-mentioned studies can be questioned, at the moment there is no conclusion possible regarding the efficacy of Jungian psychotherapy. On the other hand the reported studies due to their naturalistic designs have to be considered high in external validity. Also, the researchers in all the above-mentioned studies took great efforts to control for biases and to reach for representativeness. All of the studies found improvements on all of dimensions investigated, in some studies even drastic ones. All of the studies report positive effects on a wide variety of disorders with good or very good effect sizes on: symptom reduction, well being, interpersonal problems, change of personality structure, reduction of health care utilisation, changes in everyday life conduct. All of these effects are stable in follow-up up to seven years after therapy.

There are even further positive changes between termination and follow-up. The majority of patients seem to have benefited from Jungian psychotherapy, health care utilization parameters were significantly reduced so that there are also indicators for cost effectiveness. With an average of only 90 sessions Jungian psychotherapy is a very time- and cost-effective form of long-term psychodynamic psychotherapy. Where effect sizes were computed they range from moderate to very large. All of these results point clearly in the direction of effectiveness of Jungian psychotherapy.

A severe problem that comes to light in the overview of the studies is the fact that Jungian analysts tend to be very reluctant in participating in empirical studies. As a consequence the German Association of AP and its training institutes have decided that future training candidates will have to apply a set of empirical measures to their training cases in order to form a database and to make ongoing quality management possible.

Currently ongoing studies in Germany

Researchers from the societies of Analytical Psychology in the German-speaking countries (Austria, Germany, Switzerland) have formed a research platform (www.infap3.eu) which is currently planning to conduct several studies in the field of Jungian psychotherapy. The training institutes in Germany agreed that future training candidates will have to apply a couple of empirical measures (symptoms, life satisfaction, Operationalized Psychodynamic Diagnostics) to their training cases in order to form a database and to make ongoing quality management possible. In the long run this aims at creating a more open attitude to empirical research in the coming generations of Jungian analysts. On the other hand this process aims at stabilizing the currently comfortable position Jungian therapy has in the German healthcare system for the future by delivering empirical results about the effectiveness of the methods and applying standard quality management processes.

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3. Conclusions: What these findings mean for a future psychotherapy research in analytical psychology

As a result from the findings and insights mentioned above, a number of conclusions can be drawn:

1. Especially the insights summarized in Wampold's Contextual Metamodel, which integrates all of the research conducted in psychotherapy over all the different schools, implies that it is not the method which is crucial for outcome in psychotherapy, but the person of the therapist and how he/she succeeds in creating positive expectations in the client as well as in handling the therapeutic relationship. Especially the capacity of the therapist to adapt in a flexible way to the special needs of the client as well as to their changes over the course of therapy seems to be a crucial factor. This implies that teaching manualized approaches, as for example in CBT, does not really make sense; in contrast, it seems to be the training of future psychotherapists and how it succeeds to form personal competencies which produces effective therapists.

On the one hand, this is something that in the Jungian approach always has been emphasized; it was Jung who asked for making a training analysis compulsory for candidates in training. On the other hand this would diminish the importance of teaching specific methods and emphasizing a certain theoretical model of how the psyche functions and how psychotherapy has to be conducted.

It would also point to the fact that it is very important to strengthen the selection process of future candidates in analytic training, since it seems that certain crucial competencies, e.g. the capacity for empathy, cannot be influenced very much by training.

For future research, from my point of view it would imply that only experienced and well-trained therapists should be investigated in outcome studies, since it is their personality and deep personal competencies which are responsible for effective therapies. This could mean that, when installing a research design, the selection of participating therapists should be based on a survey in institutes and societies who is considered to be a very experienced and effective therapists ("the masters"). When participating in a study, these experienced therapists should not be asked to follow a manual, but instead follow their personal experience and intuition. Nevertheless it might be interesting to investigate these experienced therapists regarding what they actually do when they apply analysis, but this is a task of a special approach to process research.

This implies, the best way for future studies involving such experienced therapists could be to conduct them in training institutes, and would include the outstanding members of the faculty/training analysts as participating therapists. Training institutes with ambulatories will have the possibility to create a patient sample and do a randomization (in the case of a RCT) and refer the patients in the control group to an alternative treatment, e.g. "treatment as usual" = psychiatric basic care, medication.

2. The randomized controlled trial design (RCT) has dominated psychotherapy research and what could be called evidence-based psychotherapy for more than two decades now, and even though there are strong limitations to the design, e.g. low external validity, it will presumably continue to dominate psychotherapy research for the next 10 years or even longer. It took a while for government authorities in a number of countries to introduce the RCT design into their procedures for accrediting psychotherapeutic schools and methods, and it will take even more time until its dominance will end or until it will at least be combined with other research approaches. This means that the problems some training institutes or societies in some countries (e.g. Switzerland) have with accreditation with government authorities, which have

to do with the fact that there is up to date no RCT for providing evidence for the efficacy of Jungian psychotherapy, will continue or may even grow over the next years. From my point of view, this makes clear that there is a high need for conducting a RCT in Jungian psychotherapy so that these results can be presented when it comes to accreditation procedures. Otherwise there is the danger that Jungian psychotherapy will lose its accreditation in some countries in the long run. Therefore below there will be a sketch for a RCT design to be conducted in the context of Jungian psychotherapy.

3. The most important thing for empirical studies to be accepted in the community of psychotherapy researchers as well as by government authorities responsible for accreditation, is that they are based on well established procedures and measures. Therefore when studies are conducted in Jungian psychotherapy they should make use of a set of well established measures, for which there are norm data available, which makes study samples comparable to other samples and studies. Below, a set of such measures will be described together with a design for a naturalistic pre-post outcome study, which is already applied in the training institutes in Germany; the instruments, forms and computation procedures will be made available in the appendix.

4. On the other hand, such measures as usually applied in quantitative empirical research, have been criticized for describing only surface phenomena e.g. symptoms, behaviors etc. Psychoanalytic psychotherapy, in contrast, aims at changing the inner world, personality structure, self worth regulation, emotional regulation, attachment representations etc. There is also research which points to the fact that psychodynamic therapies are not only capable of changing the personality/structure of the client, but it can be demonstrated that these structural changes are connected with slow, but longlasting improvement in symptoms; on the other hand when preliminary improvement, e.g. in CBT, is lost and there is a relapse in the follow-up, this can be connected with a lack of such structural changes (see for example the LAC-study in the appendix; Grande, T. et al. (2009): Structural change as a predictor of long-term follow-up outcome. *Psychotherapy Research*, 19(3): 344-357).

So for future research to be conducted in Jungian psychotherapy there is a need to find measures for constructs which are of importance for an analytical approach. Fortunately, today there is a number of standardized measures available which have been designed by psychoanalysts and which are capable of catching inner world phenomena, e.g. Operationalized Psychodynamic Diagnostics OPD, which are described below. Also in the Jungian tradition the Word Association Test/Association experiment has been applied as a part of the diagnostic process, and below there is a description of how this test can be used in a pre-post outcome design. Future research in Jungian psychotherapy should include such instruments to be able to investigate changes in the inner world of the client over the course of analytical psychotherapy. This would also make studies in AP very interesting for the community of psychotherapy researchers, as it combines outcome measures with measures for psychodynamic concepts like personality/complex structure.

5. The reluctance of Jungian analysts to participate in studies, which almost resulted in the breakdown of a number of earlier studies, seems to be a great barrier for establishing ongoing quality management and empirical investigations in Jungian psychotherapy. The societies and training institutes should care for integrating research into their training programs for future analysts. This could mean that libraries include some of the most important journals in psychotherapy research (e.g. *Psychotherapy*, *Psychotherapy Research* etc.), that part of the training is how to read studies and include the findings into practice, and that it becomes part of the training to participate in research and quality management. When empirical studies are

conducted in the Jungian context, the training analysts and the persons responsible in societies and institutes should act as a good model and participate in the studies or take over the responsibilities in the field of research.

6. There is a long tradition in psychoanalysis to create case reports and single case studies, which are capable of describing processes in psychotherapy in depth. Nevertheless single case studies have the problem that often they are difficult to compare, they are influenced by the need to present oneself as a capable and effective analyst, they are subject to blind spots in the author etc.

“Narrative case reports... are invariably compromise formations. We hope they include a heavy dose of relatively accurate perception and memory. But as compromise formations, they are likely to reflect a variety of wishes and fears. Convincingly, to appear intelligent and clinically talented to one’s colleagues, to establish one’s identity as a member of the analytic community (or a subset of it), to express identification with admired others and with those whose admiration one desires, to express competitive or hostile impulses toward those with whom one disagrees or dislikes, and so forth. Among the most important limitations are lack of replicability, lack of reliability of inference, lack of control over variables that would allow causal inference, and unknown generalizability.” (Westen, 2002, p. 883)

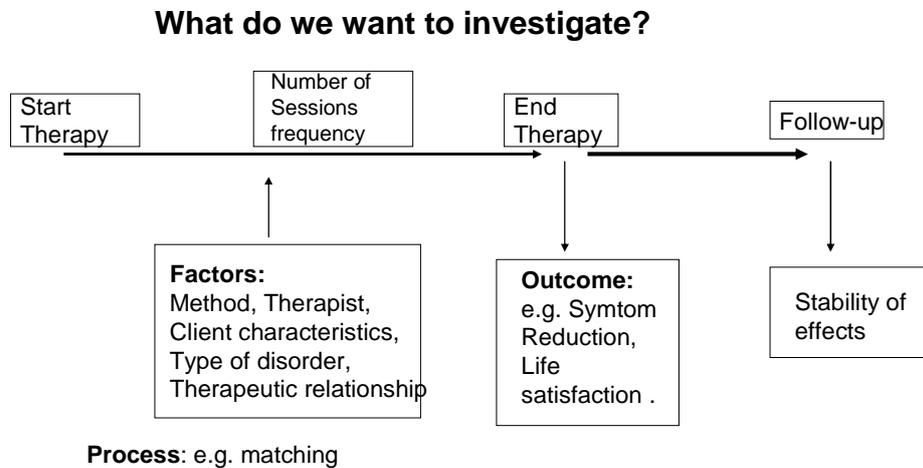
This is a controversy which has dominated psychology for more than a century: on the one side there is what is called the Idiographic tradition, i.e. single case studies, which is the strength of Psychoanalysis, and which allows for a deep understanding of complexity and interpretation of meaning, but is often unsystematic and not generalizable; on the other side is what is called the Nomothetic tradition (“in search of general laws”), which makes use of quantitative studies with large samples, it is capable of reducing complexity, insights can be generalized, and there is a systematic comparability of cases, but information and depth of the single case gets lost.

On the other hand, a lot of energy and time is spent on formulating detailed case reports, e.g. in training, and they take a large part in the journals, e.g. *Journal of Analytical Psychology*. From my point of view, it would be important to direct this energy into a form which can also be used for research on process and outcome of Jungian psychotherapy. A number of approaches in psychotherapy research have developed to combine the strengths of both traditions, which make use of systematized forms for case reports, so that larger numbers of these cases can be combined in a study and the results can be generalized, e.g. Change Interview (Elliott 1999), Pre-Post-Narrative Assessment Interview (Hardtke & Angus 2004), Hermeneutic Single Case Efficacy Design (Elliott 2002).

My recommendation here is to use the design of Pragmatic Case Studies in Psychotherapy (PCSP) developed by Rutgers University and combine it with dimensions important for psychoanalytic/Jungian psychotherapy (see below for details). This is a documentation frame for reporting cases in psychotherapy in a systematized way, and it is also an open access online journal where these cases can be published; the design, the contents of the report and other resources can be accessed on: <http://pcsp.libraries.rutgers.edu/index.php/pcsp>. (see appendix)

1. Case Context and Method
2. The Client
3. Guiding Conception with Research and Clinical Experience Support
4. Assessment of the Client's Problems, Goals, Strengths, and History
5. Formulation and Treatment Plan
6. Course of Therapy
7. Therapy Monitoring and Use of Feedback Information
8. Concluding Evaluation of the Therapy's Process and Outcome

4. Study designs



A first point which has to be clarified is what a study is aiming at, what kind of data and insights it is meant to produce. As I pointed out above, there is a certain need to conduct a RCT so as to provide evidence for the efficacy of Jungian psychotherapy, so below a RCT design will be described. A second aim of future research in Jungian psychotherapy could be to establish a more open attitude for research in analysts and candidates; therefore a design for systematic single case studies is described below. Also there is a need for establishing ongoing quality management, which can easily be applied in training as well as practice settings, which applies well-established standardized measures in a simple naturalistic pre-post-test outcome design. This would allow for continually collecting outcome data for the effectiveness of Jungian psychotherapy, which could be presented to accreditation authorities. This naturalistic outcome design could also be combined with a systematic in depth single case study design, which could include typical analytical and Jungian measures, e.g. the Word Association test, which would allow for a description not only of outcome, but also of process dimensions, e.g. the changes in complex structure over the course of therapy, or the role of dreams and dream patterns and its connection to therapeutic change (Tillmann, J.G.; Clemence, A.J.; Stevens, J.L. (2012): Mixed methods research. Design for pragmatic psychoanalytic studies. *Journal of the American Psychoanalytic Association*, 59, 1023-1040).

Design 1: Randomized Controlled Trial

RCTs focus on the effects of a psychotherapeutic method on a specific disorder. My suggestion is to focus on unipolar depression, because this is the disorder most often treated in outpatient practice, at least in analytical psychotherapy. In a number of RCTs and meta-analyses the efficacy of psychodynamic psychotherapy for treating unipolar depression has been tested. For the selection of the sample it is important to take care that the patients included do not have other comorbid symptoms or disorders, especially not personality disorders, because these are more difficult to treat and will impact on the effect size of the study.

Sample: I suggest to include 30 patients in the experimental group. It is very important to take care that no participant drops out of the sample, which would negatively impact the relevance of the study and distort the results. Therefore patients should be paid for their participation in the study, e.g. €60 for each point of measurement.

Control group: for a RCT a control group has to be formed, the same size of the experimental group, which receives no treatment or an alternative treatment. No-treatment control groups usually are put on a waiting list, but this has ethical implications, especially if the study takes longer time, which is usually the case in analytical psychotherapy. So I suggest to cooperate with another school of psychotherapy, e.g. CBT, so that the control group receives an alternative therapeutic treatment, and in the end the effects of both groups can be compared; or to refer the patients to psychiatric care and medication, which could be considered as “treatment as usual”. Alternatively, the control group could be formed by stratification, which means that for each patient in the experimental group another patient has to be found for the control group, and both patients have to match regarding a set of variables, in this case severity of depression, age, sex, education, income etc. This could be performed via the ambulatory of a training institute.

Participating therapists: as I pointed out above, it would be important to include experienced, well-trained and effective, maybe even outstanding therapists, as for example training analysts. Each therapist should contribute not more than two or three cases to the study, first because this would limit the workload for the participating therapists, and second because this would provide a larger sample of therapists for the study, which would heighten the relevance of the study. To enhance the participation of experienced therapists they should be paid for their participation in the study, e.g. 100 to 200€ per case.

Points of measurement: pre therapy, post therapy and follow-up six months after termination of therapy.

Measures: for a study on unipolar depression the most well established measure is Beck’s Depression Inventory (BDI). Additionally one of the most often applied measures in psychotherapy research and clinical psychology should be applied, e.g. the symptom checklist (SCL-90) or its short form, brief symptom checklist (BSCL). For additional measures see the above mentioned Jungian studies, PAL and PAP-S. For most of these measures a payment to publishers is needed to be allowed to apply them in empirical studies (usually around 1-2€ per measurement).

This design can also be combined with the application of the Word Association Test (see Design 4.1.), which would make this study highly interesting for the community of psychotherapy researchers, since then it would combine classical quantitative measures with a measure for an analytical concept.

Duration of treatment and study: even though the efficacy of short-term psychodynamic psychotherapies (25-40 sessions) is well proven, I suggest to investigate a higher number of sessions for treatment, e.g. 80 sessions, because then analytic psychotherapy can demonstrate

its full effect. Also because of this reason and to investigate so called sleeper effects, a follow-up half year after termination of therapy should be conducted.

Statistical analysis: t-tests for significance of changes and computation of effect sizes (Cohen's d)

Costs: appr. 65 000.- €

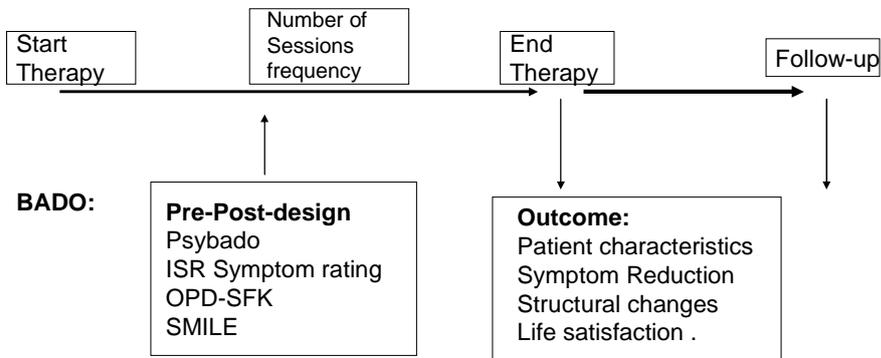
Patients and controls (60 x 180 = 10 800 €)

Therapists (60 x 200 = 12 000 €)

Instruments (1800 €)

Researchers and assistants (development of the design, monitoring, training of participating therapists, statistical analyses, report etc. = appr. 40 000 €)

Design 2: Naturalistic pre-post outcome study with quantitative measures



This study design is already conducted in Germany (BADO = Base Documentation): training candidates at the three German training institutes (Berlin, Munich, Stuttgart) have to apply a set of measures to their training cases. The measures are easily accessible, free of charge open access, and cover the main areas of patient problems/resources: sociodemographic variables, symptoms, personality structure and sense of meaning in life. Additionally, the psychological state of the patient could be rated by the therapist using the well established Global Assessment of Functioning Scale (GAF) from the DSM. The measures are applied at least at initiation of therapy (T1) and termination of therapy (T2), and, if possible, at follow-up (T3). The quantitative data provide statistical results regarding significance of changes, effect sizes and relation of the patient sample to normal groups.

Short descriptions of the measures:

Sociodemographic variables: age, sex, education, profession, income, earlier therapies etc.

ISR (ICD-10-Symptomrating): 29 item patient questionnaire, based on the ICD-10 diagnostic and classification system, covering different kinds of symptomatology and validated with large samples of patients and healthy persons. Results are integrated into five specific syndromes (depression, anxiety, somatoform syndrome, eating disorder, obsessive-compulsive disorder, additional scale).

Operationalized Psychodynamic Diagnosis (OPD) is a form of multiaxial diagnostic and classification system based on psychodynamic/ depth psychology principles, analogous to those based on other principles such as DSM-IV and ICD-10. The OPD is based on five axes: I = experience of illness and prerequisites for treatment, II = interpersonal relations, III = conflict, IV = structure, and V = mental and psychosomatic disorders (inline with ICD-10 Chapter V (F)). After an initial interview lasting 1-2 hours, the clinician (or researcher) can evaluate the patient's psychodynamics according to these axes and enter them in the checklists

and evaluation forms provided. The new version, OPD-2, has developed from a purely diagnostic system into one including a set of tools and procedures for treatment planning and for measuring change, as well as for determining the appropriate main focuses of treatment and developing appropriate treatment strategies. For psychodynamically and depth psychology-oriented therapists and psychiatrists, physicians interested in psychosomatics, and clinical psychologists.

von der Tann, M. (Ed.), & OPD Task Force. (2008). Operationalized psychodynamic diagnosis OPD-2: Manual of diagnosis and treatment planning (E. Ristl, Trans.). Ashland, OH, US: Hogrefe & Huber Publishers.

Smile (Schedule for Meaning in Life Evaluation): patient questionnaire which allows patients to point out 7 subjectively meaningful topics which give meaning to their lives. In a second step patients rate the extent of satisfaction and the importance for each of the seven topics.

The **Global Assessment of Functioning (GAF)** is a numeric scale used by mental health clinicians and physicians to rate subjectively the social, occupational, and psychological functioning of an individual, e.g., how well one is meeting various problems-in-living. Scores range from 100 (extremely high functioning) to 1 (severely impaired).

The measures (patient forms, short descriptions, statistical procedures) are provided in the appendix. Analysts, members of IAAP or local or national societies can use these measures to document either individual cases or larger samples, e.g. at institutes or in societies. Participating therapists should ask their patients for signing an informed consent before filling out the forms and questionnaires. Data of completed cases (at least for T1 and T2) can be sent (letter or PDF via e-mail) to

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for statistical analysis.

Design 3: Systematic single case report design

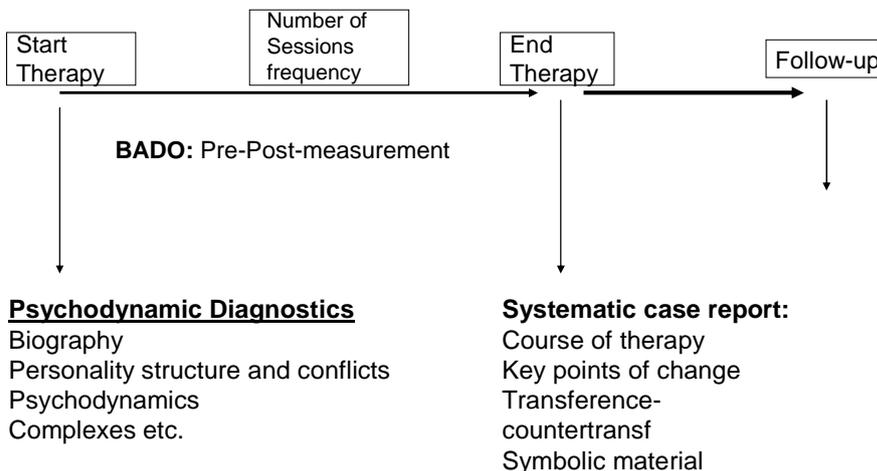
This design is based on Pragmatic Case Studies in Psychotherapy (PCSP) developed by Rutgers University. This is a documentation frame for reporting cases in psychotherapy in a systematized way, which makes individual case reports comparable with each other and allows for quantification and statistical analysis over larger samples of cases. It consists of a detailed description of how to structure the case report and which data have to be included:

1. Case Context and Method
2. The Client
3. Guiding Conception with Research and Clinical Experience Support
4. Assessment of the Client's Problems, Goals, Strengths, and History
5. Formulation and Treatment Plan
6. Course of Therapy
7. Therapy Monitoring and Use of Feedback Information
8. Concluding Evaluation of the Therapy's Process and Outcome

The design, the contents of the report and other resources can be accessed on: <http://pcsp.libraries.rutgers.edu/index.php/pcsp>. The detailed PCSP reporting frame is also available in the appendix.

The original reporting frame is free of any theoretical elements so that it can be applied over all schools of psychotherapy. For the application in a Jungian context it would be necessary to include information in the sense of a psychodynamic diagnosis, which means biographical data, information on personality structure, conflicts and complexes, and psychodynamic hypotheses. The report on the course of therapy should include key points of change, the transference-countertransference relationship, dreams and symbolic material.

A Jungian framework for systematic single case studies 1



Design 4: Combination of quantitative outcome study (design 2) with qualitative in-depth single case reports (Design 3)

The naturalistic outcome study can be combined with single case reports by applying the quantitative measures (see Design 2) at initiation as well as at termination of therapy, and creating a systematized case report (see design three). This would allow for investigation of process dimensions in the sense that different trajectories and outcome patterns can be connected with in-depth information of the case in the sense of personality structure, psychodynamics, patterns in the therapeutic relationship etc.

With the aim to connect these data with dimensions that are interesting for Jungian psychology, this design can be enriched by applying additional research methods, which have been developed in analytical psychology, namely the Word Association test and Structural Dream Analysis.

4.1. Word Association Test/Association experiment

Foray: The Association Experiment

From 1904-11 when working together with Eugen Bleuler at the psychiatric hospital “Burghölzli” of Zürich University, Jung conducted research with the Association Experiment (Jung, 1992, CW II). Jung took over this experiment from the so-called father of experimental psychology, Wilhelm Wundt, who developed it to test associative processes in his psychological laboratory at Leipzig University. The origins of the AE can be traced back to the founding fathers of psychology as a science, Francis Galton and Stuart Mill. In this experiment a list of 100 words is presented to subjects who have the task to react as quickly as possible with the first association coming to their mind for each word; additionally a psychogalvanometer was used to record physiologic responses to the word. It was found that some of the words stimulated emotional reactions in the subject but this remains unconscious to the person. The emotional reaction leads to “failures”, i.e. prolonged reaction time, inability to reproduce the association in the second round, laughing, commentaries or other forms of emotional expression. The words from the list connected with such failures were investigated more deeply by asking the subjects for more associations to these words, the so-called context. Up to this point the AE was a pure experiment under controlled conditions without the introduction of any kind of subjective interpretation. Taken together these words form a network of meaning for which Jung coined the term complex.

Even though research with the AE marked the beginning of the formation of Jung's concepts, it has almost disappeared from contemporary analytical psychology. With his leaving the University in 1911 Jung also left empirical research behind and never took it up again. Later Carl A. Meier, the first president of the Zürich Jung Institute, systematically collected Jung's unfinished research studies and results and published them in a coherent volume called “Die Empirie des Unbewußten” - Empiry of the Unconscious (Meier, 1968/1994). In his summary of Jung's research with the AE he concluded that the results give proof that the associative process is an unconscious process which allows for forming a psychological typology of the person, especially whether he or she is an extroverted or introverted type; that failures point to unconscious (pathological) complexes which have emotion as a dynamic component; and that the results support Freud's assumption that free association leads to the uncovering of suppressed content.

In 1979 a systematic investigation was conducted to develop norm data for the AE word list (Schlegel, 1979) and a detailed manual for the application and interpretation of the AE in the context of psychotherapy (Kast 1988).

We (Roesler & van Uffelen 2018) conducted our own study which followed an earlier pilot single case study conducted by Vezzoli et al. (2007). In this study the AE in its original version (Jung's 100 word list) was applied to a single case, first at the beginning of a psychotherapy and again after completion of the therapy. In the pre-post comparison it could be demonstrated that the complex structure of the person had changed in the course of the therapy in a positive direction, that is the ego complex

became more differentiated from the father and mother complexes. The most interesting part of this pilot for our study was the combining of the AE with standardized clinical measures: structured clinical interview for DSM (SCID), the symptom checklist SCL-90-R, Minnesota Multiphasic Personality Inventory (MMPI).

In our own study we replicated the design in the sense that we investigated the results of the AE in comparison to a set of standard measures: Symptom Checklist SCL-90-R, Freiburg Personality Inventory, revised version (FPI-R), Association experiment with the 50 word list from Schlegel (1979), depth psychological clinical and biographical interview ("Anamnese") focusing on the biographical development of the person, problems and resources.

The aim of the study was to compare the results of the Association experiment with the findings from the other measures regarding parallels and differences. All of the measures were applied to a sample of 18 clients (17 to 69 years; $M = 43$ years) who requested therapy in a community counseling center. Since the study combines qualitative and quantitative data for the interpretation of the results we used a mixed method design (Teddlie & Tashakkori, 2003) for computing a defined set of categories:

1. Self-esteem
2. Norm orientation
3. Aggression inhibition
4. Aggression
5. Depression/inferiority complex
6. Anxiety
7. Psychosomatic problems
8. Obsessive-compulsive tendencies
9. Unresolved grief
10. Trauma
11. Performance orientation
12. Shame and blame complex

These 12 categories were formed as a synthesis of the dimensions that are covered by the standardized measures as well as by the AE and the clinical interview.

Our findings support the insight that the AE, even though it is more than 100 years old and has rarely been applied in clinical psychology, is capable of identifying symptoms and problem areas for diagnostic purposes to the same extent as standardized clinical measures. Additionally the AE is capable of identifying unconscious tendencies and problem areas which subjects in clinical interviews have difficulties communicating, as for example low self-esteem and feelings of guilt and shame. The AE is also capable of putting these problems into context in the sense of collecting biographical information which can be formed into a psychodynamic understanding of how symptoms, defense mechanisms and coping strategies form a coherent whole in the person. Our findings support the viewpoint that the AE in the form in which it was applied by Jung is one of the jewels of analytical psychology and should be promoted much more strongly in the Jungian community. Our findings demonstrate that, even though the application of the AE takes a considerable time and effort, this is worthwhile since it supports the therapist in systematically collecting information for a coherent psychodynamic hypothesis for the case as well as for the therapy plan.

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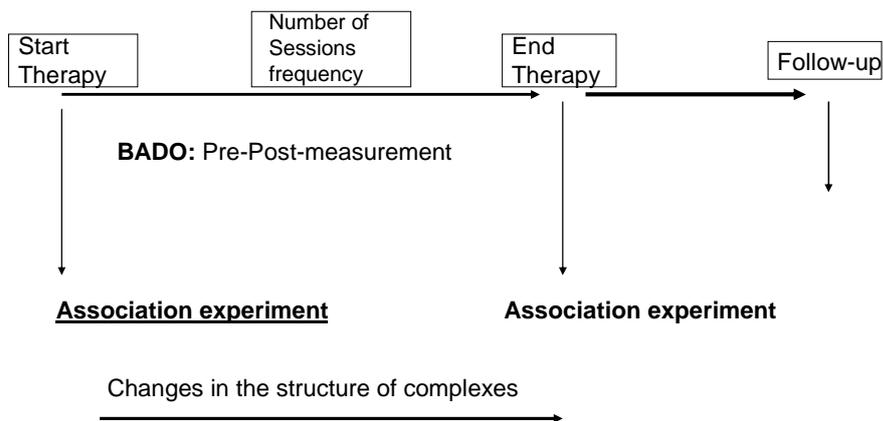
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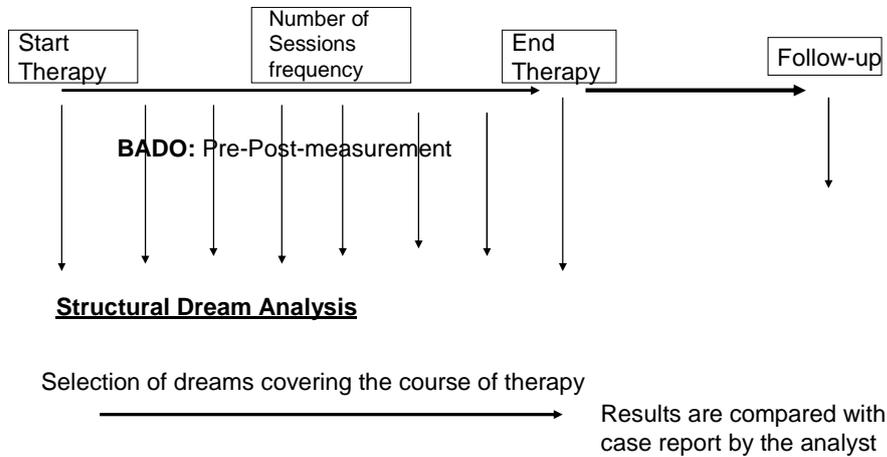
In the context of the design presented here, the Association experiment should be conducted parallel to the application of the quantitative measures at T1 and T2, which allows for the investigation of changes in the structure of complexes over the course of therapy. The 100 word list in English is provided in the appendix.

A Jungian framework for systematic single case studies 2



4.2. Investigating the role of dreams and their connections to the therapy process with Structural Dream Analysis (SDA)

A Jungian framework for systematic single case studies 3



Method: Structural Dream Analysis (SDA)

The usual research approaches investigating the meaning of dream content make use of coding systems, e.g. the well-known coding system of Hall and Van de Castle (1966). Also in psychoanalytic dream research, elaborated coding systems for dream content have been developed and used in studies investigating the process of psychotherapy (e.g. Moser & von Zeppelin, 1991). In psychoanalytic research on dreams (see Fonagy et al., 2012, for a current overview), there is often the problem that basic assumptions about the function of dreams are taken for granted. For example, the Moser & von Zeppelin coding system is based on the assumption that the function of dreaming is to protect sleep and so investigates the changing positions of elements in the dream which 'evidences' this function. But as it is, this coding system is not able to falsify any Freudian assumptions. In our study, we attempted to prevent the research method from implicitly including any theoretical psychodynamic assumptions about the dream. Consequently, Structural Dream Analysis (hereafter, SDA) was developed as a method to investigate dreams from a structuralist point of view. The assumption is that the meaning of a dream consists not so much in it containing certain symbols or elements but more in the relationship between the elements and in the course of action which the dream takes, i.e. its structure. The aforementioned coding systems, which count the appearance of certain elements and symbols in dreams, from our point of view, are not able to identify the meaning of dreams, since meaning is the result of interpretation. An example is the famous system built on content analysis of over 50,000 dreams by Hall & Nordby (1972). Typical dreams reported in this classification involved aggression, predatory animals, flying, falling, being persecuted by hostile strangers, landscapes, dreams of misfortune, sex, getting married and having children, taking examinations or undergoing some similar ordeals, traveling, swimming or being in the water, watching fires, and being confined in an underground place. The problem with this kind of classification, from our point of view, is that these typical dream motifs describe very different entities, from objects and beings to action patterns and story structures. There is no theoretical model behind such a classification which could connect the dream motifs with a meaning for the dreamer. This was already criticized by

Stevens (1995), who gives the following example: "Simple content analyses reveal that agonistic dreams are more common among males of all ages and hedonic dreams more common among females, but both types of dreams occur in both sexes. A more significant variable than gender in determining the relative incidence of such dreams is the kind of family the individual grew up in" (p. 249).

SDA is a qualitative, interpretive research method that attempts to formalize the process of interpretation of the dream in a way that the conclusions are independent from the interpreter. In our study, a reliability test found an interpreter agreement for the results coming from the same case of $k = .70 - .82$. SDA sees the dream as a narrative. In narratology, a narrative is defined as a development from a starting point, which often is a problem that needs repair or solution. The narrative goes through ups and downs leading to the solution of the problem or a valued endpoint to the story (Gülich & Quasthoff, 1985). Similarly, the dream is a short story about how the protagonist, in most cases the dream ego, processes a problem. SDA thus makes use of analytic tools developed in narratology. Two earlier methods of narrative analysis were incorporated: a) Vladimir Propp's (1974) structuralist method of Functional Analysis used to investigate the structure of fairy tales. Each fairytale is divided into its functional parts (e.g. "The King is ill and needs healing"; "The hero fights the Dragon") and each functional part receives an abstract symbol, e.g. a letter or number. As a result each fairytale can be written as an abstract formula of symbols and then different fairytales can be compared regarding their structure. b) Boothe's (2002) narratological method JAKOB used in analytical psychotherapies for the analysis of patient narratives and their development over the course of the psychotherapy. This method focuses on the role the narrator takes in the narrative in terms of activity vs. passivity and his/her relation to other protagonists in the narrative, as well as on different episodic models which describe the course the narrative takes. The meaning of symbols in the dreams we investigated was analysed by a systematized form of amplification. In psychotherapy, the analyst assumes that the series of dreams presented by the analysand follows an inner structure of meaning. SDA aims at identifying this inner structure of meaning from the series of dreams alone without referring to additional information about the dreamer, their psychodynamics or the course of psychotherapy. The meaning conveyed by the dream is analysed in a systematic series of interpretive steps for which a formalized manual is available (for more details see Roesler, in print). The interpreters, who have no information about the dreamer, are given a series of 10 to 20 dreams covering the whole course of the psychotherapy and which ideally mark the core points and topics of it. The dreams are provided by practising analysts who also write a case report about the psychopathology and psychodynamics of the patient involved as well as about the development of core conflicts and themes in the course of the therapy. Only when the dream series are completely analyzed using SDA are the results compared to the reports by the therapists.

A major finding is that a high percentage of all dreams from all cases can be categorized by a very limited number of structural patterns. The most **general pattern** can be described as: **the ego is confronted with a requirement, has to cope with a challenge, has to fulfil a plan or task**. This general pattern can be differentiated into five more specific patterns regarding the extent of agency of the dream ego:

Whereas in Pattern 1 there is no ego present at all, in Patterns 2 and 3 the dream ego is present but under pressure from other forces in the dream and the initiative is not with the ego but with others. The ego is subjected to their activity, power and control. In Patterns 4 and 5 the ego has taken over the initiative and attempts to follow a personal plan but may be confronted with difficulties. In Pattern 5 this activity focuses on a social relationship.

Pattern 1: No dream ego present

In the dream there is no dream ego present, the dreamer just observes a scene as if watching a movie and does not actively take part in the dream. In some cases the dream ego flies above and looks down on a scene or happenings in the dream.

Pattern 2: The dream ego is threatened

In dreams of this kind the dream ego is threatened, e.g. attacked or injured and usually tries to escape or protect itself against the threatening figures. In b) to d) below, the dream ego very often reacts with panic and either feels powerless or tries to escape from the threat. Often this results in the dream ego being chased by the threatening figures. The dreams in this pattern can be differentiated depending on the severity of the threat.

- a) the dream ego is damaged, e.g. severely wounded, or even killed. In some cases the killing has already happened and the dream ego is found as a dead body.
- b) the threat to the dream ego comes from a force in nature, e.g. a natural disaster, earthquake, fire, flooding, storm etc.
- c) the dream ego is threatened by (dangerous) animals.
- d) the dream ego is threatened by human beings, e.g. criminals, murderers or “evil people”, or human-like figures, e.g. ghosts, shadows etc.

Pattern 3: The dream ego is confronted with a performance requirement

The dream ego is confronted with a performance requirement, which is set by another figure or agency in the dream. The dream ego is confronted with a task which it has to fulfil, or is required to find something or to give something to another person in the dream so that they can fulfil a task etc. The most common form of this pattern is the examination dream. An important part of this pattern is that the initiative is not with the dream ego but with other figures confronting the dream ego with a requirement. The dream ego is subjected to their control and power.

- a) Examination in a school or university setting.
- b) The dream ego is subject to an inspection by an official person, e.g. a ticket inspection on the train where the right of the dream ego is questioned.
- c) the dream ego has the task to find something (which was lost before), get something, produce something etc.

A very typical pattern in these kind of dreams is that the dream ego does not feel capable of performing the task, does not possess the right tools or capabilities, or has failed to bring these devices, has lost them on the way etc. For example, the dream ego is not prepared for the examination, or arrives too late for it.

Pattern 4: Mobility dream

The dream ego is moving towards a specified or unclear destination, e.g. traveling and making use of different forms of transportation like bicycle, car, bus, train, airplane, ship etc. An interesting differentiation is the question whether these transportation devices are public or individual. Again this form of dream can be differentiated depending on the extent of the dream ego's agency which shows in the extent to which the dream ego determines its own movement.

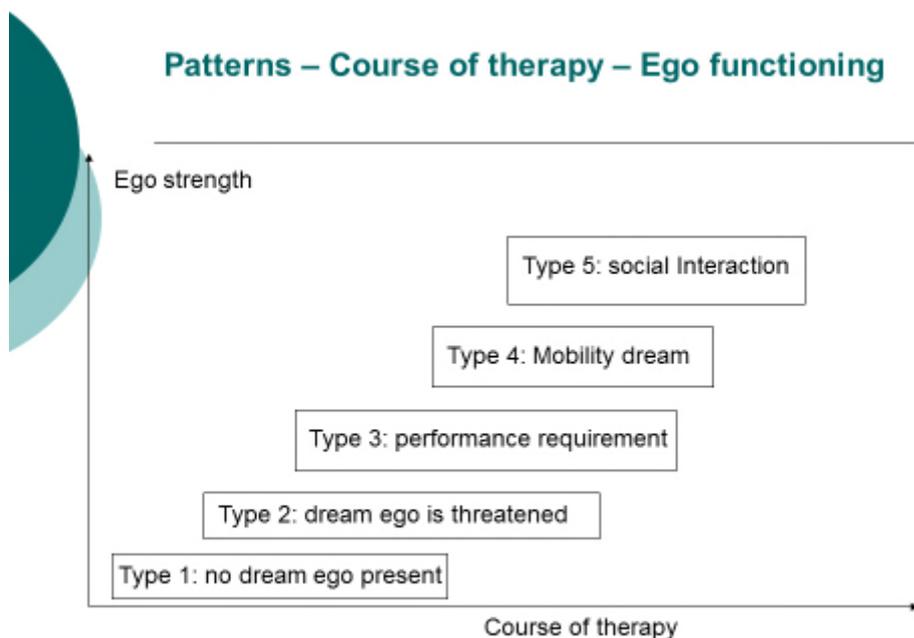
- a) disorientation: the dream ego has no idea where to go, even where it is and there are no signs of direction etc.
- b) the dream ego is locked up in a closed space, imprisoned etc., and is looking for a way to get out.
- c) the dream ego wants to move, travel etc. but has no means to do so, e.g. it misses the train

- d) the dream ego attempts to move and has some means of transportation but cannot control the movement, e.g. it cannot steer a car
- e) the dream ego is moving but the way is blocked or the means of transport breaks down or crashes and movement cannot be continued
- f) the dream ego is moving, making use of some means of transportation but it is going the wrong way, is in the wrong train or bus, or is not authorized to use it (e.g. has no ticket) and therefore cannot continue the journey
- g) in the positive form, the dream ego succeeds in moving towards and reaching the desired destination.

Pattern 5: Social interaction dream

The dream ego is occupied with making contact or communicating with another person or figure in the dream. The dream ego wants to get in contact with another person, or is in communication and attempts to communicate something to the other person, or is more generally occupied with creating a desired contact with the other person which can include sexual contact. This dream pattern can be differentiated depending on the dream ego's activity and how successful it is in reaching its desired contact.

- a) the dream ego wants to get into contact but is ignored by others
- b) the dream ego is criticized, devalued or made ridiculous by others and feels shame
- c) the dream ego is successful in creating the desired contact
- d) a special case: the dream ego is aggressive towards others (even kills others) which expresses the will of the dream ego to be separated and autonomous.



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Application in the context of the study design

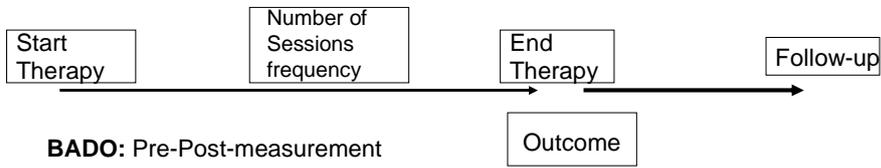
Criteria for choosing dreams from analytical psychotherapies

The proposed method is capable of analyzing series of 10 to 20 dreams from analytical psychotherapies in an economical timeframe. For this reason there has to be made a choice from the dreams documented in the course of an analysis. In the ideal case this choice should be made by the analyst having done the treatment. Here are some considerations informed by earlier publications from analytical psychology on how to do this choice.

Diekmann proposes to choose dreams from different phases of the analysis. Here those dreams are to be chosen that represent core points of the analytic process. A core point is defined as a point in the analysis when there is a clear change in the inner world and/or behavior of the analysand. Already Jung points out that a series of dreams is not a linear development but has to be imagined as a more radial one. Dreams are centered around core topics and illustrate these from different perspectives more or less again and again in the course of psychotherapy. For the application of the method it therefore makes sense to choose the dreams from core points where central topics are manifested and in some cases transformed. The dreams should cover the whole course of the therapy. Ideally the choice of dreams for application of this method includes the first dream or initial dream of an analysis as well as the last dream or completing dream of the process.

Combination of all the above mentioned methods (qualitative – quantitative)

A Jungian framework for systematic single case studies: Overview



Psychodynamic Diagnostics

Association experiment

Dreams

Symbolic material: Pictures,
Sandplay etc.

Systematic case report

Association experiment

Structural Dream Analysis

**Standardized systematic form of case documentation and report
>> cases are comparable**



Measure	T1 Start Therapy	T2 Termination Therapy	T3 Follow-up	Results
Quantitative Part				
Sociodemographic Data	X			
ICD-Symptom Rating	X	X	X	
Satisfaction with Life Scale	X	X	X	
OPD Structure Questionnaire	X	X	X	
GAF Scale	X	X	X	
Qualitative Part				
Word Association Test	X	X		Structure of complexes and changes over course of therapy
Structural Dream Analysis	10-20 dreams			Changes in dream patterns over course of therapy
Case report (Pragmatic Case Study)	Symptoms, Conflicts, Complexes, Psychodynamics, Personality, Course of Therapy, Key and Turning Points, Major Symbols, Results and Evaluation			