Psychoanalysis, Psychodynamic Psychotherapy, and Evidence-Based Practice: A Selective Bibliography of Articles Written Since 2007

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The concept of "evidence-based practice" is not one which is easily applied to psychodynamic therapy and psychoanalysis. However, it is becoming clear that without research on the effectiveness of psychoanalytic work, this important work will be increasingly attacked by academia, clinicians using other shorter-term therapy approaches, and legislators, desperate answers to funding crises.

Fortunately, there has been a flurry of articles which address the value of analytic therapy and psychoanalysis that I wanted to bring to your attention. I am using these articles in discussions with legislators who are not convinced that mental health treatment which requires more than 20 sessions could be valuable, and even cost-effective, when decreased medical problems and lost time at work are taken into account. Further, the underlying concept of working with the unconscious is being explained in ways which disengages it from the biases of the past. The following articles and downloads are those that have been most useful in bringing psychoanalytic/psychodynamic therapy and psychoanalysis into the 21st century for the layperson and for those who advocate for access to psychoanalytic treatment.

These 18 articles are arranged in order of publication, latest first. There are some complete articles, some excerpts, some links, and some abstracts.

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1. ***"Collaborating With the Fortress Around Early Childhood Trauma: A Depth Psychotherapy Process"***

Katherine May, *Perspectives in Psychiatric Care,* 11/8/16, DOI: 10.1111/ppc.12198

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Abstract: A depth psychotherapy process is a deepening of experience facilitating access into a fortress of body and mind defenses that aims to protect although may imprison the adult survivor of early childhood trauma.

Conclusions: When psychotherapy moves beyond managing manifest symptoms and behavior, individuals have an opportunity to connect with their authentic self and experience wholeness in their personality and relationships.

Practice Implications: A theoretical and practical approach including the therapeutic frame, therapeutic alliance, and body psychotherapy attempts to collaborate with a fortress to encourage its cooperation in the release of its captive.

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2. ***"Psychotherapy Research: Implications for Practice"*** (complete text)

Geoffrey D. Carr, *Psychiatric Times*, 8/12/11, Vol. 28, No. 8.

A couple of days after I agreed to write this article, I picked up a copy of *The New York Times* and was greeted with a front page story, "Talk Doesn't Pay, So Psychiatry Turns Instead to Drug Therapy" by Gardiner Harris.[1] Mr Harris laid bare the current state of psychiatry under managed care and insurance company reimbursement, along with the general conclusion that psychotherapy is as good as or more effective than drugs for many mental disorders. In an era of evidence-based medicine, it is unfortunate that these disorders, the most common reason for physician visits, are often treated without the benefit of the most effective treatments.

The evidence for psychotherapy

First, the empirical evidence for the efficacy of psychotherapy for a wide range of mental health problems is extremely strong. Meta-analyses of the effectiveness of psychotherapy over the past few decades have generally found effect sizes of approximately .80, classified as "strong."[2,3] The Center for Evidence-Based Medicine at the University of Toronto provides comparisons of mental health interventions for a wide range of diagnostic categories, and their data also show that the efficacy of psychotherapeutic interventions is high.[4]

Research that examined the relative effectiveness of psychotherapy versus medication has generally found similar benefits.[5] Findings from several studies have shown that even with severe depression, for which SSRIs have their clearest benefit, behavioral activation therapy is comparable in effectiveness in a head-to-head comparison, and as effective as maintenance medication in preventing relapse.[6-8]

Given that most patients with mental disorders are likely to receive medication, it is valuable to note that adding psychotherapy to the medication treatment regimen can improve patient outcomes. Most of the research in this area has been conducted with depression, and a systematic review by Pampallona and colleagues[9] concluded that adding psychotherapy provides significant benefits to patient outcomes.

No differences in effectiveness

If a patient is to be referred for psychotherapy, the first questions are to whom, and for what kind of therapy? Given the principles of evidence-based medicine, it seems most obvious to look to outcome studies of particular types of psychotherapy to particular patient diagnoses. There are many thousands of these studies to choose from. The rather uncomfortable but consistent finding, however, is that the particular type of psychotherapy makes little difference to patient outcome. It likely does not matter if the patient is referred to that rumpled psychoanalytic therapist down the street or to that bright cognitive-behavioral therapist over at the university. A recent study compared the benefits of 7 major psychotherapies for depression and concluded that none were more or less effective than the others.[10]

When we compare effect sizes of different psychotherapies on particular patient diagnoses, we find that there are no significant differences among psychotherapy approaches. This applies whether we are looking at different treatments for adults with particular diagnoses, for youths, for couples and families, or for those with alcohol(Drug information on alcohol) and drug abuse.[11-15] While a considerable amount of effort has gone, and continues to go, into investigating what particular therapies work for what particular problems, the research data have compellingly and overwhelmingly demonstrated that this is a fruitless pursuit. "Bluntly put, the existence of specific psychological treatments for specific disorders is a myth."[16(p28)] It is very compelling for us to believe that particular treatments will work best for specific diagnoses and patient characteristics. The research, however, does not support this.

What is already known about the effectiveness of psychotherapy?

■ Psychotherapy is an effective treatment for many mental disorders, and it is a valuable adjunct treatment for most others. While most research has demonstrated robust benefits for the neuroses-type disorders involving anxiety or depression, recent research has demonstrated significant benefit for patients with psychotic disorders and even to those with some neurological disorders such as Alzheimer disease.

What new information does this article provide?

■ This article provides both a strong endorsement of referring patients for psychotherapy and a dilemma. It indicates that the research discriminating between the benefits of different types or schools of psychotherapy is weak. It also indicates that the particular therapist is a potent factor for outcome and that ongoing measurement of therapeutic progress and therapeutic alliance offers substantial benefit. The dilemma is that at this time there is no systematic way to find out which therapists are most effective or to measure progress and alliance.

What are the implications for psychiatric practice?

■ The research strongly supports referring patients for psychotherapy. The dilemma of finding effective psychotherapists may be best solved by developing referring relationships with a small number of therapists who report measuring progress and alliance and by obtaining feedback from your patients to verify their effectiveness.

In their meta-analysis, Ahn and Wampold[17] examined the effects of removing components of psychotherapeutic treatments and found no evidence that removing or adding a specific ingredient altered outcomes. "Research designs that are able to isolate and establish the relationship between specific ingredients and outcomes should reveal how specific ingredients lead to change… Decades of psychotherapy research have failed to find a scintilla of evidence that any specific ingredi-ent is necessary for therapeutic change."[18(p204)] Although we may yet find certain strategies that work best with certain patient symptoms, at this point the research suggests that such differences are minimal.

These conclusions are not, predictably, without their detractors. Schools of psychotherapy can be fiercely tribal in defending the superiority of their approaches. In a recent article, the research data were interpreted as indicating that psychodynamic psychotherapy is as effective as or more effective than other forms of therapy and was met with inevitable critiques from advocates of other approaches.[19,20]

A greater challenge to the equivalence conclusion comes from studies that have randomly assigned patients with a given diagnosis to receive different forms of psychotherapy. While there are many such studies, and some do find apparent superiority of one treatment over another, how these apparent differences should be interpreted is a source of dispute. As we have found with pharmaceutical companies' research on their own products, we find that when psychotherapy research is conducted by advocates of an approach, the results tend to favor that approach.

The preferred therapy may be compared with other treatments that are not intended to be therapeutic for the specific disorder or are obviously set up to be inferior (eg, less patient contact time, poorly trained therapists, therapists who do not believe in the "treatment" they are supposed to be delivering).[21] When these biases and research design flaws are factored out of the data, any differences between recognized psychotherapies disappear. "A rational weighing of the status of current evidence behooves scientists to take another, more careful look at why ESTs [evidence-supported treatments] have failed to distinguish themselves from other treatments and to use this information in framing a broader approach to psychotherapy research."[11(p301)]

Characteristics for good outcomes

The research data that show equal effectiveness of different approaches to treatment are sometimes interpreted as "anything goes in psychotherapy." In reality, the data provide clear evidence that what goes on in psychotherapy matters very much to the outcome. Treatments that are intended to be therapeutic, that the therapist believes in, and for which there is a compelling rationale work. There are characteristics of psychotherapy that lead to poor or damaging outcomes; others predict good outcomes.

The data indicate that some therapists are consistently better than other therapists, that therapeutic relationship factors account for much of the variability in outcome attributable to psychotherapy, and that a major way that better therapists achieve their better outcomes is through enhancing the therapeutic relationship. "Available evidence documents that the therapist is the most robust predictor of outcome of any factor ever studied."[16(p38)]

Wampold[22] concluded that the portion of outcomes attributable to differences between therapists is 8% to 9%, far outstripping the amount attributable to an empirically supported treatment (0% to 4%), to the differences between treatments (0% to 1%), or even the therapeutic alliance itself (5%). Consistent with this, patients do not emphasize particular psychotherapies or methods when accounting for their improvement but instead emphasize the relationship with their therapists.[23]

Each psychotherapy includes different active ingredients that promote patient improvement. Given the complexity of human beings and their brains, it is foolhardy to suggest that there is only one way to help someone with emotional distress. What we find, however, is that these ingredients do not work very well unless the person delivering them is genuinely caring and empathic, and able to form a solid therapeutic alliance with the patient.

Similar results are found when we examine the effectiveness of antidepressant medication. Patients' improvement with medication or placebo was found to be more related to the impact of the particular psychiatrist providing the medication (or the placebo) than to the treatment itself. The most effective psychiatrists helped their patients more using placebo than did the less effective psychiatrists who treated their patients with an antidepressant.[24] This finding that the person delivering the treatment is a potent factor in outcome mirrors similar recent findings in medicine in general, with teachers in education, and even the accuracy of political experts.[25-28]

The therapeutic alliance

While the field of psychotherapy absorbs the evidence, which suggests that different approaches are equivalent, the biggest shift in psychotherapy practice in recent years has been toward the systematic measurement of patient progress and therapeutic alliance. A pervasive human foible that physicians and psychotherapists do not escape is the belief that we are all better than average.

Psychotherapists tend to believe that we have good rapport and alliances with our patients and that our effectiveness with our patients is better than that of most other therapists. For the most part, we draw these conclusions without much evidence. It turns out that collecting these data in a consistent way actually is a potent way of increasing therapeutic effectiveness.[29]

A variety of measures are now in common use that allow psychotherapists to track the patient's experience with the therapist and the therapy and to monitor the patient's session-to-session progress.[30] While we have known for many years that some therapists are consistently better than others, we have been finding that these tools can be a great equalizer. When patients are not experiencing a good alliance with the therapist, these tools allow the therapist to find out immediately and to take steps to improve it or refer the patient to another therapist.

The American Psychological Association convened a Presidential Task Force on Evidence-Based Practice that endorsed the importance of ongoing tracking. "The application of research evidence to a given patient always involves probabilistic inferences. Therefore, ongoing monitoring of patient progress and adjustment of treatment as needed are essential to [evidence-based practice in psychology] EBPP."[31(p280)]

Psychiatrist David Burns,[32] who popularized cognitive-behavioral therapy through his best-selling books (eg, *Feeling Good*), serves as a good example for the transformation that is taking place in psychotherapy. He now advocates a "tools, not schools" approach and has developed his own tools for tracking patient progress and the therapeutic alliance.

Continuing controversy

Almost 30 years ago, the American Psychiatric Association convened a Commission on Psychotherapies to review and integrate the research data that were available at that time.[31] More than 20 esteemed researchers produced a consensus report, and many of the issues they highlighted continue to challenge us today.

Controversy still reigns over the question of whether certain types of therapy are more effective than other types for certain kinds of problems. What has also not been adequately studied is what aspects or elements of the complex therapeutic interaction are relatively the most effective… Psychotherapy is a highly complex set of interactions that take place between individuals over an often indeterminate period of time. It is an open-ended, interactive feedback process in contrast to the closed, one-way causation that is typical of most laboratory research. Research has not as yet been able to fully document these complex sets of interactions.

Although there has been a veritable explosion of psychotherapy research over the past few decades, it has not provided the simple answers we were seeking.

Conclusion

For prescribing psychiatrists who want to offer treatment alternatives to patients who prefer to avoid medication, the evidence is clear that psychotherapy is an effective choice. Even in cases in which medication is accepted, the evidence suggests that psychotherapy may significantly improve patient outcomes. Unfortunately, at this point there is little available guidance on which psychotherapy is most effective and which psychotherapists will best serve your patients.

As unscientific as it may seem, in the absence of other information, the best evidence of therapist effectiveness may be the response of patients. If patients report that they really like their therapist and that he or she is definitely helping them, that therapist would likely be a good bet for other patients. Most valuable, however, will be referring to psychotherapists who systematically measure their patients' progress and how the patients respond to therapy.

While the evidence on the benefits of tracking the alliance and outcome is clear and robust, it is still in its infancy. Therefore, there is still no easy way to find out about therapists who routinely use these types of measures beyond inquiring. It appears to be, however, the most important question to ask.

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3. **"Interaction Between Alliance and Technique in Predicting Patient Outcome During Psychodynamic Psychotherapy"** (abstract)

Jesse Owen and Mark Hilsenroth, *Journal of Nervous and Mental Disease,* June, 2011, Vol. 199, No. 5, pp. 384-389.

ABSTRACT: The current study examined whether alliance interacted with psychodynamic interventions to predict patients' psychotherapy outcomes. A prospective study of psychodynamic psychotherapy with 68 outpatients who were treated by 23 therapists was used. The patients rated the alliance with their therapist early in treatment. Therapist use of psychodynamic techniques was reliably rated by independent clinicians for the same sessions. The therapy outcomes were measured at the end of treatment based on the patients' global symptomatology as well as estimate of improvement across a broad range of functioning. In all models, we controlled for the patients' pretherapy psychiatric severity. Analyses were conducted using multilevel modeling to account for therapist effects. Results revealed that patient rated alliance was significantly related to improvement on a measure of broad band functioning. In addition, alliance and psychodynamic interventions interacted to predict this scale of multidimensional therapy outcome. Further, results showed that several individual psychodynamic techniques interacted with alliance that were meaningfully related to this measure of broad band outcome including (1) linking current feelings or perceptions to the past; (2) focusing attention on similarities among patient's relationships repeated over time, settings, or people; and (3) identifying recurrent patterns in patient's actions, feelings, and experiences. In this sample of outpatient psychodynamic treatments, the dynamic techniques were most effective when provided in the context of strong alliances.

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4. **"Psychodynamic Psychotherapy"** (complete text)

Arline Kaplan, *Psychiatric Times,* January 4, 2011, Vol. 27, No. 12.

Short- and long-term psychodynamic psychotherapies are effective for several psychiatric disorders, as described in 2 recent mental health publications and by Glen Gabbard, MD, an international expert on the therapies.

"A kind of prejudice exists against dynamic therapy, as if there haven't been randomized control trials that show its effectiveness," said Gabbard, author of Psychodynamic Psychiatry in Clinical Practice, Fourth Edition, Brown Foundation Chair of Psychoanalysis and professor of psychiatry at Baylor College of Medicine.

Many psychiatrists, residents, and other mental health professionals believe that psychodynamic therapy lacks empirical support or that other psychotherapies are more effective, according to Gabbard. Nevertheless, part of the responsibility for those misconceptions rests with psychoanalysts and psychodynamic therapists themselves.

Gabbard explained that they were "far too complacent for years and years" and did not "get their act together to do rigorous research on dynamic therapy and analysis." Consequently, research on psychodynamic therapy has "lagged behind that of cognitive-behavioral therapy and is still catching up."

Now there is increasing investigation among proponents of psychodynamic therapy. They are calling attention to existing efficacy data and encouraging others to design studies, said Gabbard, a member of Psychiatric Times' editorial board and director of the Baylor Psychiatry Clinic.

Several studies have supported the use of psychodynamic therapy for personality disorders, major depression, anxiety disorders, and some eating disorders, he said, as well as posttraumatic stress disorder, panic disorder, somatoform disorders, and substance use disorders.

September's Harvard Mental Health Letter1 discussed some cumulative evidence for psychodynamic psychotherapy.

"There is now enough research to support the claim that psychodynamic therapy is an evidence-based treatment

with effect sizes similar to or superior to those reported for other psychotherapies," the undisclosed authors said in the article.

The article included summarizations and discussions of both randomized controlled studies and meta-analyses.

Shedler's review

Earlier in 2010, *American Psychologist*, the journal of the American Psychological Association, published a review article by Jonathan Shedler, PhD, associate professor of psychiatry at the University of Colorado Denver, School of Medicine, which explored the efficacy of psychodynamic psychotherapy.

Shedler described distinctive features of psychodynamic technique—focus on affect and expression of emotion; exploration of attempts to avoid distressing thoughts and feelings; identification of recurring themes and patterns; discussion of past experiences to shed light on current psychological difficulties; focus on interpersonal and therapy relationships; and exploration of fantasy life.

He also emphasized that being an effective psychopharmacologist involves many of the same skills that psychoanalytic psychotherapy requires, such as the ability to build rapport and "to understand the patient's fantasies and resistances that almost invariably get stirred up around taking psychotropic medication."

Beyond those aspects, Shedler's article discussed the efficacy of both psychotherapy and psychodynamic therapy.

"The cumulative body of data that Shedler covers is very persuasive," Gabbard said, explaining that it consists primarily of summarizing meta-analyses. Shedler reviewed 8 meta-analyses (comprising 160 studies) of psychodynamic therapy, plus 10 meta-analyses of other psychological treatments and antidepressant medications. He focused on effect size: 0.8 is considered a large effect; 0.5, a moderate effect; and 0.2, a small effect. The overall mean effect size for antidepressant medications approved by the FDA between 1987 and 2004 was 0.31. The effect sizes for psychodynamic therapy and other psychotherapies were much higher.

One methodologically rigorous meta-analysis of psychodynamic therapy, published by the Cochrane Library, included 23 randomized controlled trials of 1431 patients with a range of common mental disorders.2 The studies compared patients who received short-term (less than 40 hours) psychodynamic therapy with controls (wait list, minimal treatment, or treatment as usual). The overall effect size was 0.97 for general symptom improvement. The effect size increased by 50%, to 1.51, when patients were reevaluated 9 or more months after therapy ended.

Extended release

Several studies of psychodynamic therapy have indicated that the benefits of this therapy increase with time, even after completion of treatment—the so-called extended-release phenomenon.

"After treatment completion, there is an internalization of the therapist-patient relationship whereupon the patient goes on thinking and reflecting in a specific way that he or she learned in therapy," Gabbard said. "That's been my experience as a clinician."

Gabbard described how many of his patients return years after completing therapy and report that not only did they benefit, but they also have continued to make profound changes since therapy ended. When confronted with a difficult situation, they reflect back on previous discussions with Gabbard that occurred during treatment.

"So there is a process set in motion of a particular way of reflecting and thinking about one's experience and feelings and relationships that goes on and on," Gabbard said.

Emerging research

Asked about emerging research involving psychodynamic therapy, Gabbard said, "A lot of imaging research and neurobiological research is confirming long-standing psychoanalytic ideas. For example, neurobiological research repeatedly points out that most of mental life is unconscious, which is a premise of psychodynamic therapy. It also is showing that genes alone don't determine who we are. Rather, it is genes in interaction with early environmental influences that produce who the person is. Certain kinds of trauma can turn genes on and off. This is a fundamental psychoanalytic developmental notion that is now being confirmed by rigorous research."

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5. **"National Trends in Outpatient Psychotherapy"** (excerpts)

Olfson, M.and Marcus, S., *American Journal of Psychiatry*, Aug. 4, 2010, Vol. 167, pp. 1456-1463

Psychotherapy has traditionally been regarded as a central feature of mental health service in the United States. It is widely viewed as a core clinical activity of psychiatrists, psychologists, social workers, and other mental health care professionals. Some evidence suggests that the role of psychotherapy in community treatment has diminished in recent years. According to the National Ambulatory Medical Care Survey, visits to office-based psychiatrists that include psychotherapy declined from 44.4% in 1996-1997 to 28.9% in 2004-2005. Although the survey includes clinical diagnoses reported by the treating physicians, it offers no information about psychotherapy delivered by other mental health specialists and no person-level data on psychotherapy use. As measured by the Medical Expenditure Panel Survey (MEPS), the percentage of Americans treated with antidepressants who also received psychotherapy decreased from 31.5% in 1996 to 19.9% in 2005. There has also been a decrease in employer-sponsored health plans that cover outpatient psychotherapy. Over this period, however, Americans have become more comfortable talking with health care professionals about personal problems, and concerns about antidepressant-associated suicidality may have led more depressed adults to pursue psychotherapy.

There is a paucity of information about recent national trends in use of psychotherapy in the United States. The most recent national profile of psychotherapy use indicated that in 1997 approximately 3.6% of Americans received at least one psychotherapy visit and most of those who received psychotherapy (61%) were also treated with a psychotropic medication. The scarcity of data on basic patterns in psychotherapy use contrasts with a relative abundance of information on patterns of psychotropic medication use.

In this study, we investigated recent national trends in the use of outpatient psychotherapy. We examined changes in who receives, provides, and pays for outpatient psychotherapy in the United States between 1998 and 2007.

We also considered trends in the outpatient treatment of mental disorders with psychotherapy alone, psychotropic medication but not psychotherapy, and a combination of psychotherapy and psychotropic medication…..

[end excerpt]

The findings included: "The percentage of persons using outpatient psychotherapy was 3.37% in 1998 and 3.18% in 2007 (adjusted odds ratio=0.95, 95% CI=0.82 - 1.09). Among individuals receiving outpatient mental health care, use of only psychotherapy (15.9% and 10.5% in 1998 and 2007, respectively; adjusted odds ratio=0.66, 95% CI=0.48 - 0.90) as well as psychotherapy and psychotropic medication together (40.0% and 32.1%; adjusted odds ratio=0.73, 95% CI=0.59 - 0.90) declined while use of only psychotropic medication increased (44.1% and 57.4%; adjusted odds ratio=1.63, 95% CI=1.32 - 2.00). Declines occurred in annual psychotherapy visits per psychotherapy patient (mean values, 9.7 and 7.9; adjusted = - 1.53, $p<0.0001$), mean expenditure per psychotherapy visit ($122.80 and $94.59; =28.21, $p<0.0001$), and total national psychotherapy expenditures ($10.94 and $7.17 billion; $z=2.61$, $p=0.009$).

Discussion

When viewed from the perspective of the general population, the rate and pattern of psychotherapy use remained quite stable between 1998 and 2007. When considered within the context of U.S. outpatient mental health care, however, an increase in pharmacotherapy led to a decrease in the portion of mental health care devoted to psychotherapy. We discuss these trends in psychotherapy use from both perspectives.

During the study period, overall rates of psychotherapy were little changed. Extending back over a 20-year period, the percentage of Americans who use psychotherapy each year has remained remarkably stable: 3.24% in 1987, 3.37% in 1998, and 3.19% in 2007. The previously reported decrease in number of psychotherapy visits in office-based psychiatric practices is likely a consequence of fewer psychotherapy visits per treatment episode. Stability is also evident in the general socio-demographic pattern and characteristics of psychotherapy patients. Higher rates of use have been consistently reported by females than males, middle-aged adults than children or older adults, unmarried than married persons, and unemployed than employed individuals. Practitioner surveys further reveal consistency in the format of psychotherapy, with a predominance of individual over group or family psychotherapy and a strong predominance of eclectic/integrative and psychodynamic approaches.

National rates and general patterns of psychotherapy use have remained remarkably consistent despite important changes in the private and public financing of mental health care. Beginning on January 1, 1998, the federal Mental Health Parity Act prohibited employer-based group health plans with more than 50 workers from having different annual lifetime benefit limits for mental health and general medical illnesses. Alongside federal and state legislative reforms aimed at increasing access to mental health services, there has been rapid growth in specialty mental health care organizations that manage

behavioral health care services. It has been estimated that the number of Americans who receive their coverage of mental health services through managed behavioral health organizations increased from 53 million in 1994 to 170 million in 2007. This rise of managed care, rather than a shift to less costly psychotherapists, such as social workers and psychologists, may have led to the decline in average expenditures per psychotherapy visit during the study period. Yet despite these and other changes in insurance arrangements and in the organization of payment and delivery of mental health services, the segment of the public that consumed psychotherapy in 1998 closely resembles the segment that did so in 2007.

The distribution of mental health outpatients across treatment modalities has shifted in recent years toward medication-only regimens and away from psychotherapy alone and combined treatment regimens. Little is known about the most clinically efficacious and cost-efficient allocation of patients across these treatment modalities. For some conditions, such as major depression, there is evidence that psychotherapy in combination with antidepressant medication is associated with greater improvement than medication alone.

Recent research has also questioned the superiority of antidepressants over placebo for patients with less severe depression. However, third-party coverage of antidepressants and other psychotropic medications is typically generous, while significant limits exist on coverage of psychotherapy services….

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6. "**Transference-Focused Psychotherapy v. Treatment by Community Psychotherapists for Borderline Personality Disorder: Randomised Controlled Trial"** (abstract)

Stephan Doering, Susanne Horz, Michael Rentrop, Melitta Fischer-Kern, Peter Schuster, Cord Benecke, Anna Buchheim, Philipp Martius and Peter Buchheim, *The British Journal of Psychiatry* (2010),196, 389–395.

Background Transference-focused psychotherapy is a manualised treatment for borderline personality disorder.
Aims To compare transference-focused psychotherapy with treatment by experienced community psychotherapists.
Method In a randomised controlled trial (NCT00714311) 104 female out-patients were treated for 1 year with either transference-focused psychotherapy or by an experienced community psychotherapist.
Results Significantly fewer participants dropped out of the transference-focused psychotherapy group (38.5% v. 67.3%) and also significantly fewer attempted suicide (d = 0.8, P = 0.009). Transference-focused psychotherapy was significantly superior in the domains of borderline symptomatology (d = 1.6, P = 0.001), psychosocial functioning (d = 1.0, P = 0.002), personality organisation (d = 1.0, P = 0.001) and psychiatric in-patient admissions (d = 0.5, P = 0.001). Both groups improved significantly in the domains of depression and anxiety and the transference-focused psychotherapy group in general psychopathology, all without significant group differences (d = 0.3–0.5). Self-harming behaviour did not change in either group.
Conclusions Transference-focused psychotherapy is more efficacious than treatment by experienced community psychotherapists in the domains of borderline symptomatology, psychosocial functioning, and personality organisation. Moreover, there is preliminary evidence for a superiority in the reduction of suicidality and need for psychiatric in-patient treatment.

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7. "**Beyond 'ESTs': Problematic Assumptions in the Pursuit of Evidence-Based Practice"** (excerpts)

Paul Wachtel, PhD, *Psychoanalytic Psychology*, Vol. 27, #3, October, 2010.

….Increasingly, in recent years, there have been calls for establishing the practice of psychotherapy on an evidence-based foundation. In principle, this is a salutary development. Unfortunately, however, the "empirically supported treatments" (EST) movement, which has largely dominated discussion of evidence-based practice in recent years, has been characterized by a set of assumptions that impede sound understanding of the sources of therapeutic change and generate biased conclusions regarding what therapeutic approaches are actually helpful to patients.

I aim in this paper to examine closely these "EST" assumptions and to indicate an alternative view of how clinical practice can be rooted in respect for evidence. The reader will notice that I have placed the terms "empirically supported" and "EST" in quotation marks. I do so throughout this article because I do not wish to further contribute to the misconceptions that result when the concepts of empirical validation or empirical support are ceded to the advocates of a particular tendentious definition of those ideas.

It reflects a problematic acceptance of faulty premises when critics of this parochial methodology say things like "it is important that training programs teach therapeutic approaches other than ESTs as well." Such statements seem to accept the idea that "ESTs" are the only therapies that are empirically supported, and then try to battle for some space for therapies that are not "ESTs," as if those other therapies, though not empirically supported, have some other virtue. In fact, as I shall argue in this article, there are serious flaws in the empirical support for many "ESTs" as therapies applicable to the majority of patients who seek therapy and, conversely, there is often evidence at least as strong or stronger supporting therapeutic approaches not on the "EST" lists that have been promulgated (see, e.g., Shedler, 2010)……

One good indicator of the conceptual confusion and ideological scrambling that has characterized much of the literature on the empirical foundations of therapeutic practice is the shifting vocabulary that has characterized the debate. In 1995, the Task Force on Promotion and Dissemination of Psychological Procedures, a group originating in the clinical psychology division of the American Psychological Association (APA), published a list of treatments that were deemed to be "well-established" or "probably efficacious" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). In the relatively few years since this list appeared, the nom de guerre of the movement created by these activists has mutated with some regularity. The first shift in the rhetoric was from "well established" or "probably efficacious" to "empirically validated." Before long, however, this terminology too gave way, under pressure from critics who noted that it was not consistent with a genuinely scientific attitude to claim that the approaches on the list had been "validated" when the cumulative findings of research over time so often lead us to modify our initial enthusiasms.

Thus, a new version of the list then appeared--though with little change in the criteria for inclusion or exclusion--under the name "empirically supported" treatments. Presently, that terminology too is in the process of being jettisoned, with "evidence-based practice" the rhetoric du jour……

In considering where the criteria advocated by the various task forces and committees fall considerably short of adequate science, there are at least four features that require our attention. I will discuss in succession the emphasis on patients in a study being limited to a single diagnostic category, on manualization, and on randomized, controlled trials (RCTs). After explicating the ways in which each of these three criteria can be misused to both restrict and misrepresent the available evidence, I will then turn to a fourth characteristic of the movement I have been discussing--the dichotomous thinking that leads to the promulgation of lists of treatments that are empirically validated and to a clearly implied shadow list of those that purportedly are not…..

In an interesting irony--because many of the leading "EST" advocates represent therapeutic orientations that originated as a challenge to the purported "medical model" of psychoanalysis--"EST" advocates insist that all valid conclusions about the efficacy of any particular therapeutic approach must rest on a methodology that essentially mimics the structure of drug trials in medical research. However, they do so without considering sufficiently what makes the RCT methodology appropriate to that realm of investigation. The use of RCTs in drug trials almost always also includes, as an essential element, the employment of a double-blind methodology. Neither the patient nor the doctor administering the medication knows whether any particular patient is receiving the medication under investigation or a placebo coated to be identical in appearance. Indeed, when the side effects of the active medication are such that they are readily detected by either party, the internal validity of the study is seriously compromised. In contrast, in studies of psychotherapy, no one is unaware of which treatment is being offered or received. Without this crucial feature of the drug studies that the "EST" methodology attempts to mimic, the "gold standard" looks more like painted tin.

The absence of (and indeed, in most cases, the virtual impossibility of) a double-blind methodology in psychotherapy outcome studies is probably one important factor contributing to the finding by Luborsky, et al. (1999) that most studies end up demonstrating the superiority of whatever approach the investigator is most closely allied to. The knowledge, not only by the investigator but by the therapist, of which procedure is being administered, introduces powerful--and impossible to measure--influences on what actually transpires in the room when the therapist is practicing one approach or another…….

A...feature of the standard "EST" criteria is perhaps even more problematic--the requirement that the treatment be manualized. Here again, proponents of these criteria offer a reasonable sounding rationale--to evaluate whether the treatment being investigated in any particular study was effective, we need to know what the actual treatment was. But here again, what has emerged has been a tendentiously conceived and

extraordinarily narrow investigative strategy. Instead of being viewed as one of a variety of possible solutions to the scientific challenge of specifying the actual therapy employed in a study, manualization has increasingly become a requirement by granting agencies for funding research, and training in "manualized treatment" has become widely (and falsely) equated with training in therapeutic approaches that are based upon solid and reliable evidence.

Most problematically, the question-begging logic of the "EST" paradigm essentially implies that a non-manualized therapy cannot by definition be empirically validated or supported since (with very limited and grudging exceptions) manualization has been treated as a fundamental requirement for empirical support per se. This is not a championing of science; it is an abdication of science, a decision not to investigate non-manualized treatments that bespeaks at best a poverty of imagination in addressing methodological challenges. It might be objected that the "EST" paradigm does not strictly require a manual.

Chambless and Ollendick (2001), for example, in an influential statement of the "EST" approach, depict as the requirement "treatment manuals or their equivalent in the form of a clear description of the treatment." Now, I am as in favor as they are of clear description, but this seemingly more open and reasonable statement is not consistent with the actual history of the "EST" movement, whose proponents have consistently dismissed an enormous body of evidence supporting the therapeutic impact of treatments other than those on the "EST" lists. This dismissive approach to uncongenial data was evident as early as the original Division 12 Task Force on Promotion and Dissemination of
Psychological Procedures (1995). In their first published statement, attempting to discredit the influential review by Smith, Glass, and Miller (1980), which they noted
had "convinced many that substantial evidence demonstrated the efficacy of psychosocial treatments," the task force publication stated, "Finally, and *perhaps most important*, the studies in the Smith et al. review predated the standardization of treatments in research studies *through the use of treatment manuals*" (p. 3, italics added). The two italicized phrases reveal the degree to which manuals were made the linchpin of an effort to prescribe one and only one methodology for psychotherapy outcome research and to dismiss or ignore evidence gathered in other ways, however careful, methodologically sophisticated, and appropriate to the problem at hand.

The second Division 12 Task Force (Chambless et al., 1996) states quite explicitly that manualization was virtually a sine qua non for them to regard a treatment as empirically validated, with only "specific and *rare* exceptions" (p. 6, italics added). My point is not that the creation of therapy manuals is never appropriate or useful. A considerable range of therapies (including some fairly complex psychodynamic and humanistic approaches) have been manualized for research purposes, and I do not mean to deride the efforts of these investigators. Rather my point is that to make manualization a requirement for regarding a treatment approach as evidence-based is not a reflection of commitment to scientific rigor, but a political ploy that effectively excludes from the lists of evidence-based treatments a variety of treatments for which there is in fact a very substantial body of evidence (see below), but which do not happen to have approached the task of empirical validation via the particular investigative strategies that the "EST" movement advocates.

Part of their Wal-Mart approach to mental health care is that "ESTs" are cheap because "many of these interventions can be disseminated without highly trained and expensive personnel." Turning specifically to CBT, which is clearly the approach with which they are strongly identified, they state, as a virtue, that "CBT is effective even when delivered by non-doctoral therapists or by health educators with little or no prior experience with CBT who received only a modest level of training in that technique" (p. 38).

In this they give short shrift to the large body of research attesting to the importance of the therapeutic relationship and to the skillfulness of the therapist, especially in the treatment of more difficult cases (e.g., Beutler et al., 2006; Gilbert & Leahy, 2007; Hofman & Weinberger, 2007; Norcross, 2002; Wampold, 2008).

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8. **"A Quality-Based Review of Randomized Controlled Trials of Psychodynamic Psychotherapy"** (abstract)

Andrew J. Gerber, M.D., Ph.D., James H. Kocsis, M.D., Barbara L. Milrod, M.D., Steven P. Roose, M.D., Jacques P. Barber, Ph.D., Michael E. Thase, M.D., Patrick Perkins, Ph.D., and Andrew C. Leon, Ph.D., *American Journal of Psychiatry*, September 15, 2010

OBJECTIVE: The Ad Hoc Subcommittee for Evaluation of the Evidence Base for Psychodynamic Psychotherapy

of the APA Committee on Research on Psychiatric Treatments developed the Randomized Controlled Trial Psychotherapy Quality Rating Scale (RCT-PQRS). The authors report results from application of the RCT-PQRS to 94 randomized controlled trials of psychodynamic psychotherapy published between 1974 and May 2010. *METHOD:* Five psychotherapy researchers from a range of therapeutic orientations rated a single published paper from each study.
RESULTS: The RCT-PQRS had good inter-rater reliability and internal consistency. The mean total quality score was 25.1 (SD=8.8). More recent studies had higher total quality scores. Sixty-three of 103 comparisons between psychodynamic psychotherapy and a nondynamic comparator were of "adequate" quality. Of 39 comparisons of a psychodynamic treatment and an "active" comparator, six showed dynamic treatment to be superior, five showed dynamic treatment to be inferior, and 28 showed no difference (few of which were powered for equivalence). Of 24 adequate comparisons of psychodynamic psychotherapy with an "inactive" comparator, 18 found dynamic treatment to be superior. *CONCLUSIONS:* Existing randomized controlled trials of psychodynamic psychotherapy are promising but mostly show superiority of psychodynamic psychotherapy to an inactive comparator. This would be sufficient to make psychodynamic psychotherapy an "empirically validated" treatment (per American Psychological Association Division 12 standards) only if further randomized controlled trials of adequate quality and sample size replicated findings of existing positive trials for specific disorders. We do not yet know what will emerge when other psychotherapies are subjected to this form of quality-based review.

9. "**Merits of Psychodynamic Psychotherapy"** (complete text)

Harvard Medical Journal, August 28, 2010.

Cognitive behavioral therapy (CBT) has emerged, both in the research literature and in the media as a "first among equals" in psychotherapy – most often studied and frequently cited in news reports. CBT seeks to change conscious thoughts and observable behaviors by making patients more aware of them. But considerable research has also supports the efficacy of other types of psychotherapy, in particular psychodynamic psychotherapy. In fact, a review on *American Psychologist* cited evidence that psychodynamic therapy is just as effective as CBT, and that the benefits can increase over time.

Psychodynamic psychotherapy has its roots in psychoanalysis, the long-term "talking cure." Like psychoanalysis, psychodynamic therapy recognizes that the relationships and circumstances of early life continue to affect people as adults, that human behavior results from unconscious as well as conscious or rational motives, that the act of talking about problems can help people find ways to solve them or at least bear them.

Both psychoanalysis and psychodynamic therapy rely on the therapeutic alliance in order to work. The therapeutic alliance is the personal connection between therapist and patient that enables them to work in tandem so that the patient can gain insight into aspects of experience that may be difficult to talk and think about. As the therapeutic alliance deepens, a therapist helps patients to understand themselves in new ways, and to become more mindful of a greater range of their thoughts, feelings, perceptions, and experiences. Dr. Glen Gabbard, professor of psychiatry and psychoanalysis ay Baylor College of Medicine, has called the therapeutic alliance the "envelope" within which psychodynamic therapy takes place.

Although modern therapists frequently question the distinction, it is useful to note that psychodynamic psychotherapy and psychoanalysis differ in some ways. During psychoanalysis, patients generally attend meetings three to five times a week, whereas in psychodynamic psychotherapy, a patient typically sees a therapist once or twice a week. Thus the intensity of the therapeutic relationship is greater with psychoanalysis. Both psychoanalysis and the long-term form of psychodynamic therapy may be conducted in an open-ended manner, over many years, with the patient and the therapist/analyst taking as much time as they need to decide about the duration of treatment. Short-term treatment with psychodynamic therapy, in contrast, is time-limited and usually lasts less than six months.

Key points

- Psychodynamic therapy is an option for patients with a variety of mental health disorders and personality disorders.
- Although it is similar in some ways to psychoanalysis, psychodynamic therapy may be shorter in duration or intensity.
- Several reviews suggest that psychodynamic therapy is as effective as cognitive behavioral therapy.

Gaining self-knowledge

A paper compared psychodynamic therapy to CBT. It highlighted notable differences between these two forms of therapy.

Acknowledging emotion. Whereas CBT focuses on thoughts and beliefs, psycho dynamic therapy encourages a patient to explore and talk about emotions as well – including those that are contradictory, threatening, or not immediately apparent. The focus is on using therapy to gain emotional, as well as intellectual, insight. Ideally, insight enables a patient to consider life patterns that once seemed inevitable or uncontrollable, and leads to identification of new choices and options. The insight may lead a patient to feel more ready to make changes.

Understanding avoidance. Psychodynamic therapy helps patients to recognize and overcome ingrained and often automatic ways in which they avoid distressing thoughts and feelings. Therapy may bring avoidance into high relief – such as when patients cancel therapy appointments, arrive late, or tiptoe around emotionally charged topics. Psychodynamic therapists point out that such psychological maneuvers often involve painful compromises between the wish to attend sessions in order to get help, and the fear of what may emerge during therapy. Psychodynamic therapy can help a patient become more aware of these maneuvers, which are likely to manifest outside of therapy as well, with the aim of nurturing more flexible and adaptive ways of coping.

Identifying patterns. Psychodynamic therapy recognizes that in mental life, the past is often prologue. Early-life experiences, especially with parents, caregivers, and other authority figures, shape present-day outlook and relationships. The goal of psychodynamic therapy is not to dwell on the past but to explore how prior relationships may provide insight into current psychological problems. A psychodynamic therapist may work with a patient to identify recurring patterns in relationships, emotions, or behaviors (such as being drawn to a verbally abusive partner) to help the patient recognize them. At other times the patient may already be painfully aware of self-defeating patterns but needs help to understand why they keep recurring and how to overcome psychological obstacles to making changes. The aim of this work is to give patients greater freedom to direct their lives.

Focusing on relationships. Interpersonal relationships – with loved ones, friends, and colleagues – are the core focus of psychodynamic therapy. A person's characteristic responses to other people often emerge in relation to the therapist, a phenomenon known as transference. For example, a patient who experiences hostility or dependency in an early important relationship may find the same feelings arise during the therapy session. Thus the therapeutic relationship provides a window into the dynamics of the patient's relationships outside the office, and offers an opportunity to recognize and change self-defeating patterns.

Psychodynamic therapy often addresses not just transference, but also the therapist's own responses to the patient, often called "countertransference." Such reactions may reflect the therapist's own formative relationships, but they often signify the "pull" the therapist feels to play out the patient's relationship patterns. Either way, the psychodynamic therapist tries to help patients understand how they contribute both to beneficial and painful relationship patterns, and how such relationships originate within the self, yet foster the tendency to see the outside world (including relationships) as the exclusive source of disappointment or other painful emotion.

Encouraging free associations. In CBT and other structured therapies, the clinician tends to lead the discussion. In psychodynamic therapy, the clinician encourages a patient to speak as freely as possible about thoughts, desires, dreams, fears, and fantasies, as they come to mind. Psychodynamic therapists believe this unstructured, uncensored

process of reporting provides access to thoughts and feelings that might otherwise remain outside of awareness. These thoughts and feelings might then become the raw material for helpful insight, or be reworked in ways that expand freedom and choice. However, it is not true that psychodynamic therapy is entirely "non-directive." For example, good dynamic therapists direct the attention of their patients to issues that they are avoiding.

Benefits Improve Over Time

Randomized controlled studies are the ideal way to evaluate treatments in medicine, but psychodynamic therapy, with its individualized technique and complex aims, has not lent itself readily to this type of study. It is not surprising that it has taken longer for researchers to develop and validate rigorous methods for studying this treatment. Nevertheless, randomized controlled studies support the use of psychodynamic therapy for anxiety, borderline personality disorder, depression, eating disorders, post-traumatic stress disorder, panic disorder, somatoform disorders, and substance-use disorders.

Meta-analyses are another way to judge efficacy of treatment. These reviews convert findings from multiple studies using different methods and populations into a common metric, most often an "effect size" that estimates overall treatment benefit.

Short-term therapy. A meta-analysis by the Cochrane Collaboration, an international group of experts, included 23 randomized controlled studies involving a total of 1,431 patients with varying diagnoses, most often depression and anxiety. All underwent short-term psychodynamic therapy (defined in this review as less than 40 hours in duration.) When compared with controls (a waiting list, minimal treatment, or treatment as usual), short-term psychodynamic therapy significantly improved symptoms, with modest to moderate clinical benefits. When patients were assessed nine months or more after treatment ended, to determine long-term outcomes, the effect size of psychodynamic therapy had increased, suggesting that therapy led to lasting psychological changes that yielded more benefits as time went on.

Long-term therapy. A meta-analysis published in *The Journal of the American Medical Association* compared long-term psychodynamic therapy (defined in this paper as lasting at least a year or consisting of at least 50 sessions) with various short-term psychotherapies. It included 11 randomized controlled trials and 12 observational studies (included to provide results of psychodynamic therapy as practiced in real-world clinical settings.) The studies enrolled 1,053 patients diagnosed with personality disorders or hard-to-treat mood or anxiety disorders. The analysis showed that long-term psychodynamic therapy significantly benefited patients with complex psychiatric disorders, and that patients continued improving after the therapy ended.

Another meta-analysis, published in the *Harvard Review of Psychiatry*, included 27 studies of long-term psychoanalytic therapy (most often psychodynamic therapy), enrolling more than 5,063 patients and lasting an average of 150 sessions. Only one of the studies was a randomized controlled study, five were surveys, and 21 were epidemiological studies (most of them prospective). Diagnoses included anxiety, depression, and personality disorders, but often were unspecified. Based on a comparison of effect sizes, this meta-analysis concluded that long-term psychoanalytic therapy may be particularly useful for patients with severe personality disorders, who benefited more from the treatment than those with mixed or moderate pathology.

Challenges and Conclusions

One ongoing challenge in the research is that the studies of psychodynamic therapy often involve patients with different diagnoses, making it hard to draw conclusions about how effective this approach will be for individual patients. Moreover, many studies provide inadequate details about treatment methods or use, i.e., "control situations" (such as a waiting list) that don't actually control for the benefits of active intervention, no matter what technique is being employed.

Nevertheless, there is now enough research available to support the claim that psychodynamic therapy is an evidence-based treatment with effect sizes similar to or superior to those reported for other psychotherapies. In the current reimbursement environment, however, a significant practical challenge is whether psychodynamic therapy will also prove to be cost-effective – especially in the "real world," where practitioners vary in terms of skills and experience, and patients vary in terms of commitment to continuing therapy.

Yet it is encouraging that the benefits of psychodynamic therapy not only endure after therapy ends, but increase with time. This suggests that insights gained during psychodynamic therapy may equip patients with psychological skills that grow stronger with use.

De Maat S, et al. "The Effectiveness of Lon-Term Psychoanalytic Therapy: A Systematic Review of Empirical Studies," *Harvard Review of Psychiatry* ((Jan.-Feb. 2009): Col. 17, No. 1, pp. 1-23.
Gabbard GO, ed. *Textbook of Psychotherapeutic Treatments* (American Psychiatric Publishing, 2009).
Shedler, J. "The Efficacy of Psychodynamic Psychotherapy," American Psychologist (Feb.-Mar. 2010): Vol. 65, No. 2, pp. 98-109.

For more references, please see www.health.harvard.edu/mentalextra

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10. **"The Efficacy of Psychodynamic Psychotherapy"** (complete text)

Jonathan Shedler, PhD, University of Colorado, Denver, 2009
American Psychological Association Journal, www.apa.org/journals

Empirical evidence supports the efficacy of psychodynamic psychotherapy. Effect sizes for psychodynamic psychotherapy are as large as those reported for other therapies that have been actively promoted as "empirically supported" and "evidence based." Additionally, patients who receive psychodynamic therapy maintain therapeutic gains and appear to continue to improve after treatment ends. Finally, non-psychodynamic therapies may be effective in part because the more skilled practitioners utilize techniques that have long been central to psychodynamic theory and practice. The perception that psychodynamic approaches lack empirical support does not accord with available scientific evidence and may reflect selective dissemination of research findings.

There is a belief in some quarters that psychodynamic concepts and treatments lack empirical support, or that scientific evidence shows that other forms of treatment are more effective. The belief appears to have taken on a life of its own. Academicians repeat it to one another, as do healthcare administrators, as do healthcare policy makers. With each repetition, its apparent credibility grows. At some point, there seems little need to question or revisit it because "everyone" knows it to be so.

The scientific evidence tells a different story: considerable research supports the efficacy and effectiveness of psychodynamic psychotherapy. The discrepancy between perceptions and evidence may be due, in part, to biases in the dissemination of research findings. One potential source of bias is a lingering distaste in the mental health professions for past psychoanalytic arrogance and authority. In decades past, American psychoanalysis was dominated by a hierarchical medical establishment that denied training to non-MDs and adopted a dismissive stance toward research. This did not win friends in academic circles. When empirical findings emerged that supported non-psychodynamic treatments, many academicians greeted them enthusiastically and were eager to discuss and disseminate them. When empirical evidence supported psychodynamic concepts and treatments, it was often overlooked.

This article brings together findings from several empirical literatures that bear on the efficacy of psychodynamic treatment. It will first outline the distinctive features of psychodynamic psychotherapy. It will next review empirical evidence for the efficacy of psychodynamic treatment, including evidence that patients who receive psychodynamic psychotherapy not only maintain therapeutic gains but continue to improve over time. Finally, it will consider evidence that non-psychodynamic therapies may be effective in part because the more skilled practitioners utilize interventions that have long been central to psychodynamic theory and practice.

Distinctive Features of Psychodynamic Technique

Psychoanalytic or *psychodynamic psychotherapy:*1 refers to a range of treatments based on psychoanalytic concepts and methods that involve less frequent meetings and may be considerably briefer than *psychoanalysis* proper. Session frequency is typically once or twice per week and the treatment may be either time limited or open ended. The essence of psychodynamic psychotherapy is exploring those aspects of self that are not fully known, especially as they are manifested and potentially influenced in the therapy relationship.

Undergraduate textbooks too often equate psychoanalytic or psychodynamic therapies with some of the more outlandish and inaccessible speculations made by Sigmund Freud roughly a century ago, rarely presenting

mainstream psychodynamic concepts as understood and practiced today. Such presentations, along with caricatured depictions in the popular media, have contributed to widespread misunderstanding of psychodynamic treatment (for discussion of how clinical psychoanalysis is represented and misrepresented in undergraduate curricula, see Bornstein, 1988, 1995; Hansell, 2005; Redmond & Schulman, 2008). To help dispel possible myths and facilitate greater understanding of psychodynamic practice, this section reviews core features of contemporary psychodynamic technique.

Blagys & Hilsenroth (2000) conducted a search of the *PsycLit* database to identify empirical studies that compared the process and technique of manualized psychodynamic psychotherapy with that of manualized cognitive behavioral therapy. Seven features reliably distinguished psychodynamic therapy from other therapies, *as determined by empirical examination of actual session recordings and transcripts* (note that these features concern process and technique only, not underlying principles that inform these techniques; for a discussion of concepts and principles, see Shedler, 2006; McWilliams, 2004; Gabbard, 2004):

1. Focus on affect and expression of emotion. Psychodynamic psychotherapy encourages exploration and discussion of the full range of a patient's emotions. The therapist helps the patient describe and put words to feelings, including contradictory feelings, feelings that are troubling or threatening, and feelings that the patient may not initially be able to recognize or acknowledge (this stands in contrast to a cognitive focus, where the greater emphasis is on thoughts and beliefs; Blagys & Hilsenroth, 2002; Burum & Goldfried, 2007). There is also a recognition that *intellectual* insight is not the same as emotional insight which resonates at a deep level and leads to change (this is one reason why many intelligent and psychologically minded people can explain the reasons for their difficulties, yet their understanding does not help them overcome those difficulties).

2. Exploration of attempts to avoid distressing thoughts and feelings. People do a great many things, knowingly and unknowingly, to avoid aspects of experience that are troubling. This avoidance (in theoretical terms, defense and resistance) may take coarse forms, such as missing sessions, arriving late, or being evasive. It may take subtle forms that are difficult to recognize in ordinary social discourse, such as subtle shifts of topic when certain ideas arise, focusing on incidental aspects of an experience rather than on what is psychologically meaningful, attending to facts and events to the exclusion of affect, focusing on external circumstances rather than one's own role in shaping events, and so on. Psychodynamic psychotherapists actively focus on and explore avoidances.

3. Identification of recurring themes and patterns. Psychodynamic psychotherapists work to identify and explore recurring themes and patterns in patients' thoughts, feelings, self-concept, relationships, and life experiences. In some cases, a patient may be acutely aware of recurring patterns that are painful or self-defeating but feel unable to escape them (e.g. a man who repeatedly finds himself drawn to romantic partners who are emotionally unavailable; a woman who regularly sabotages herself when success is at hand). In other cases, the patient may be unaware of the patterns until the therapist helps him or her recognize and understand them.

4. Discussion of past experience (developmental focus). Related to the identification of recurring themes and patterns is the recognition that past experience, especially early experiences of attachment figures, affects our relation to, and experience of, the present. Psychodynamic psychotherapists explore early experiences, the relation between past and present, and the ways in which the past tends to "live on" in the present. The focus is not on the past for its own sake, but rather on how the past sheds light on *current* psychological difficulties. The goal is to help patients free themselves from the bonds of past experience in order to live more fully in the present.

5. Focus on interpersonal relations. Psychodynamic psychotherapy places heavy emphasis on patients' relationships and interpersonal experience (in theoretical terms, object relations and attachment). Both adaptive and nonadaptive aspects of personality and self-concept are forged in the context of attachment relationships, and psychological difficulties often arise when problematic interpersonal patterns interfere with a person's ability to meet emotional needs.

6. Focus on the therapy relationship. The relationship between therapist and patient is itself an important interpersonal relationship, one that can become deeply meaningful and emotionally charged. To the extent that there are repetitive themes in a person's relationships and manner of interacting, these themes tend to emerge in some form in the therapy relationship. For example, a person prone to distrust others may view the therapist with suspicion; a person who fears disapproval, rejection, or abandonment may fear rejection by the therapist, whether knowingly or unknowingly; a person who struggles with anger and hostility may struggle with anger toward the therapist; and so on (these are relatively crude examples; the repetition of interpersonal themes in the therapy relationship is often more complex and subtle than these examples suggest). The recurrence of interpersonal themes in the therapy relationship (in theoretical terms, transference and countertransference) provides a unique opportunity to explore and rework them *in vivo*. The goal is greater flexibility in interpersonal relationships and an enhanced capacity to meet interpersonal needs.

7. Exploration of wishes and fantasies. In contrast to other therapies where the therapist may actively structure sessions or follow a predetermined agenda, psychodynamic psychotherapy encourages patients to speak freely about whatever is on their minds. When patients do this (and most patients require considerable help from the therapist before they can truly speak freely), their thoughts naturally range over many areas of mental life, including desires, fears, fantasies, dreams, and daydreams (which in many cases the patient has not previously attempted to put into words). All of this material is a rich source of information about how the person views self and others, interprets and makes sense of experience, avoids aspects of experience, or interferes with a potential capacity to find greater enjoyment and meaning in life.

The last sentence hints at a larger goal that is implicit in all of the others: The goals of psychodynamic psychotherapy include, but extend beyond, symptom remission. Successful treatment should not only relieve symptoms (i.e., get *rid* of something) but also foster the positive presence of psychological capacities and resources. Depending on the person and the circumstances, these might include the capacity to have more fulfilling relationships, make more effective use of one's talents and abilities, maintain a realistically based sense of self esteem, tolerate a wider range of affect, have more satisfying sexual experiences, understand self and others in more nuanced and sophisticated ways, and face life's challenges with greater freedom and flexibility. Such ends are pursued through a process of self reflection, self exploration, and self discovery that takes place in the context of a safe and deeply authentic relationship between therapist and patient.

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11. ***Handbook of Evidence-Based Psychodynamic Psychotherapy: Bridging the Gap Between Science and Practice***. (summary)

Edited by Raymond Levy and J. Stuart Ablon. Totowa, NJ: Humana Press, 2009.

The importance of conducting empirical research for the future of psychodynamics is presented in this excellent new volume. In *Handbook of Evidence Based Psychodynamic Psychotherapy: Bridging the Gap Between Science and Practice*, the editors provide evidence that supports this type of research for two primary reasons. The first reason concerns the current marginalization of psychodynamic work within the mental health field. Sound empirical research has the potential to affirm the important role that psychodynamic theory and treatment have in modern psychiatry and psychology. The second reason that research is crucial to the future of psychodynamic work concerns the role that systematic empirical investigations can have in developing and refining effective approaches to a variety of clinical problems. Empirical research functions as a check on subjectivity and theoretical alliances in on-going attempts to determine the approaches most helpful in working with patients clinically. *Handbook of Evidence Based Psychodynamic Psychotherapy: Bridging the Gap Between Science and Practice* brings together a panel of distinguished clinician-researchers who have been publishing their findings for decades. This important new book provides compelling evidence that psychodynamic psychotherapy is an effective treatment for many common psychological problems.

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12. **"Effectiveness of Psychoanalytic Psychotherapy for Adolescents with Serious Mental Illness: 12 Month Naturalistic Follow-up Study"** (abstract)

Bruce John Tonge; Jill Marie Pullen Georgina Catherine Hughes; Jeanette Beaufoy, *Australian and New Zealand Journal of Psychiatry*, Volume 43, Issue 5 May 2009 , pages 467 – 475.

OBJECTIVE: The aim of this naturalistic longitudinal study was to examine the effectiveness of individual psychoanalytic psychotherapy in reducing symptoms and improving overall functioning for adolescents with severe mental illness beyond the changes observed with treatment as usual. Changes to family functioning were also examined.
METHOD: Participants at 12 month follow up were 55 of an initial group of 80 Child and Adolescent Mental Health Services patients with complex, severe mental illness (32 female, mean age = 15.11 years). At initial assessment 40 participants were offered psychoanalytic psychotherapy when a psychotherapist became available; 23 accepted and

received once- or twice-weekly psychoanalytic psychotherapy for 4-12 months. Out of the initial 57 participants who received Child and Adolescent Mental Health Services treatment as usual, 33 were reassessed at 12 months. Self-reported depressive symptoms, parent-reported social and attention problems and researcher-evaluated overall functioning and family functioning were measured at initial assessment and 12 months later.
RESULTS: At 12 months, psychotherapy was associated with a greater reduction in depressive, social and attention problems than treatment as usual, alone, if these problems were initially in the clinical range. There was no effect on participant overall functioning or family functioning.
CONCLUSIONS: This naturally occurring sample of seriously ill adolescents referred to Child and Adolescent Mental Health Services for assessment were suffering complex mental illness and poor mental health. Empirical evidence is presented that psychoanalytic psychotherapy is an effective addition to Child and Adolescent Mental Health Services treatment as usual for mental illness in adolescence, particularly for more severe and complex cases. The naturalistic study design and participant attrition are possible study limitations.

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13. **"The Effectiveness of Long-Term Psychoanalytic Therapy: A Systematic Review of Empirical Studies"**

Saskia de Maat; Frans de Jonghe; Robert Schoevers; Jack Dekker, *Harvard Review of Psychiatry*, February. 2009, Vol. 17, Issue 1, pp. 1 – 23.

ABSTRACT
Background: There is a gap in the research literature on the effectiveness of long-term psychoanalytic therapies (LPT).
Aim: To present a systematic review of studies dealing with LPT effectiveness and published from 1970 onward.
Methods: A systematic literature search for studies dealing with the effectiveness of individual LPT in ambulatory, adult patients. Data about the overall effectiveness of LPT, its impact on symptom reduction, and its effect on personality changes were pooled both at treatment termination and at follow-up, using effect sizes (ESs) and success rates.
Results: We found 27 studies (*n* = 5063). Psychotherapy yielded large mean ESs (0.78 at termination; 0.94 at follow-up) and high mean overall success rates (64% at termination; 55% at follow-up) in moderate/mixed pathology. The mean ES was larger for symptom reduction (1.03) than for personality change (0.54). In severe pathology, the results were similar. Psychoanalysis achieved large mean ESs (0.87 at termination; 1.18 at follow-up) and high mean overall success rates (71% at termination; 54% at follow-up) in moderate pathology. The mean ES for symptom reduction was larger (1.38) than for personality change (0.76).
Conclusion: Our data suggest that LPT is effective treatment for a large range of pathologies, with moderate to large effects.

14. "**Effectiveness of Long-term Psychodynamic Psychotherapy: A Meta-analysis"** (abstract)

Falk Leichsenring, Sven Rabung, *Journal of the American Medical Association.* 2008: 300(13):1551-1565.

CONTEXT: The place of long-term psychodynamic psychotherapy (LTPP) within psychiatry is controversial. Convincing outcome research for LTPP has been lacking.
OBJECTIVE: To examine the effects of LTPP, especially in complex mental disorders, ie, patients with personality disorders, chronic mental disorders, multiple mental disorders, and complex depressive and anxiety disorders (ie, associated with chronic course and/or multiple mental disorders), by performing a meta-analysis.
DATA SOURCES: Studies of LTPP published between January 1, 1960, and May 31, 2008, were identified by a computerized search using MEDLINE, PsycINFO, and Current Contents, supplemented by contact with experts in the field.
STUDY SELECTION: Only studies that used individual psychodynamic psychotherapy lasting for at least a year, or 50 sessions; had a prospective design; and reported reliable outcome measures were included. Randomized

controlled trials (RCTs) and observational studies were considered. Twenty-three studies involving a total of 1053 patients were included (11 RCTs and 12 observational studies).
DATA EXTRACTION: Information on study characteristics and treatment outcome was extracted by 2 independent raters. Effect sizes were calculated for overall effectiveness, target problems, general psychiatric symptoms, personality functioning, and social functioning. To examine the stability of outcome, effect sizes were calculated separately for end-of-therapy and follow-up assessment.
RESULTS: According to comparative analyses of controlled trials, LTPP showed significantly higher outcomes in overall effectiveness, target problems, and personality functioning than shorter forms of psychotherapy. With regard to overall effectiveness, a between-group effect size of 1.8 (95% confidence interval [CI], 0.7-3.4) indicated that after treatment with LTPP patients with complex mental disorders on average were better off than 96% of the patients in the comparison groups ($P = .002$). According to subgroup analyses, LTPP yielded significant, large, and stable within-group effect sizes across various and particularly complex mental disorders (range, 0.78-1.98).
CONCLUSIONS: There is evidence that LTPP is an effective treatment for complex mental disorders. Further research should address the outcome of LTPP in specific mental disorders and should include cost-effectiveness analyses.

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15. "**Evaluating Three Treatments for Borderline Personality Disorder: A Multiwave Study"** (abstract)

Clarkin JF, Levy KN, Lenzenwerger MF, Kernberg OF *American Journal of Psychiatry,* 2007, Vol. 164, pp. 922-928. (abstract)

This article compares DBT, mentalization, and transference-focused, i.e. psychodynamic, treatment approaches and shows all to be successful, with psychodynamic treatment more effective in the longer term.

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16. "**That was Then, This is Now: Psychoanalytic Psychotherapy for the Rest of Us"** (link)

Jonathan Shedler, 2006; available for download at http://psychsystems.net/shedler.html

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17. ***The Efficacy of Psychotherapy: Focus on Psychodynamic Psychotherapy as an Example***
Kenneth N. Levy, Johannes C. Ehrenthal, Frank E. Yeomans, and Eve Caligor

Psychodynamic Psychiatry, 42(3) 377–422, 2014 The American Academy of Psychoanalysis and Dynamic Psychiatry

Abstract: The growing number of individuals seeking treatment for mental disorders calls for intelligent and responsible decisions in health care politics. However, the current relative decrease in reimbursement of effective psychotherapy approaches occurring in the context of an increase in prescription of psychotropic medication lacks a scientific base. Using psychodynamic psychotherapy as an example, we review the literature on meta-analyses and recent outcome studies of effective treatment approaches. Psychodynamic psychotherapy is an effective treatment for a wide variety of mental disorders. Adding to the known effectiveness of other shorter treatments, the results indicate

lasting change in many cases, especially for complex and difficult to treat patients, ultimately reducing health-care utilization. Research-informed health care decisions that take into account the solid evidence for the effectiveness of psychotherapy, including psychodynamic psychotherapy, have the potential to promote choice, increase mental health, and reduce society's burden of disease in the long run.

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18. ***The Cost-Effectiveness of Psychotherapy for the Major Psychiatric Diagnoses***

Susan G. Lazar

Psychodynamic Psychiatry, 42(3) 497–556, 2014, The American Academy of Psychoanalysis and Dynamic Psychiatry

Abstract: Psychotherapy is an effective and often highly cost-effective medical intervention for many serious psychiatric conditions. Psychotherapy can aso lead to savings in other medical and societal costs. It is at times the first-line and most important treatment and at other times augments the efficacy of psychotropic medication. Many patients are in need of more prolonged and intensive psychotherapy, including those with personality disorders and those with chronic complex psychiatric conditions often with severe anxiety and depression. Many patients with serious and complex psychiatric illness have experienced severe early life trauma in an atmosphere in which family members or caretakers themselves have serious psychiatric disorders. Children and adolescents with learning disabilities and those with severe psychiatric disorders can also require more than brief treatment. Other diagnostic groups for whom psychotherapy is effective and cost-effective include patients with schizophrenia, anxiety disorders (including posttraumatic stress disorder), depression, and substance abuse. In addition, psychotherapy for the medically ill with concomitant psychiatric illness often lowers medical costs, improves recovery from medical illness, and at times even prolongs life compared to similar patients not given psychotherapy.
While "cost-effective" treatments can yield savings in healthcare costs, disability claims, and other societal costs, "cost-effective" by no means translates to "cheap" but instead describes treatments that are clinically effective and provided at a cost that is considered reasonable given the benefit they provide, even if the treatments increase direct expenses.
In the current insurance climate in which Mental Health Parity is the law, insurers nonetheless often use their own non-research and non-clinically based medical necessity guidelines to subvert it and limit access to appropriate psychotherapeutic treatments. Many patients, especially those who need extended and intensive psychotherapy, are at risk of receiving substandard care due to inadequate insurance reimbursement. These patients remain vulnerable to residual illness and the concomitant sequelae in lost productivity, dysfunctional interpersonal and family relationships, comorbidity including increased medical and surgical services, and increased mortality.

19. ***Workplace Effectiveness and Psychotherapy for Mental, Substance Abuse, and Subsyndromal Conditions***
William H. Sledge and Susan G. Lazar

Psychodynamic Psychiatry, 42(3) 497–556, 2014, The American Academy of Psychoanalysis and Dynamic Psychiatry

Abstract: While it is known that psychiatric illness and subclinical psychiatric illness can be very disabling, their impact on workers' productivity has been little appreciated or appropriately addressed. Complex variables are involved in fashioning an appropriate policy to ameliorate the impact of mental illness on productivity including the identification of effective treatments and potential negative effects of controlling patients' access to them. The cost-effectiveness of such treatments is considered from the differing perspectives and goals of the various stakeholders involved, including employers, insurers, and workers with psychiatric illness. Depression in workers leads to significant absenteeism, "presenteeism" (diminished capacity due to illness while still present at work), and significantly increased medical expenses in addition to the costs of psychiatric care. In addition to the specific usefulness of psychotropic medication, there are a variety of studies on the cost-effectiveness of different psychotherapeutic treatments that improve health and productivity in psychiatrically ill workers. Research indicates the usefulness of approaches including employee assistance programs, specialized cognitive-behavioral treatments, and brief and longer term psychodynamic interventions. It is clear that substance abuse disorders and especially depression and subsyndromal depression have a profound negative effect on work productivity and increases in medical visits and expenses. The current system of mental health care suffers from ignorance of the negative effects of psychiatric illness in workers, from a lack of subtle awareness of which treatments are most appropriate for which diagnoses and from the reluctance by payers to invest in them. Access to evidence-based appropriate treatment can improve the negative impact on productivity as well as workers' health. This article considers these issues and argues for a role of psychotherapy in the treatment of mental illness and substance abuse from the perspective of worker productivity.