The efficacy of psychodynamic psychotherapy: an up-to-date review

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Mental disorders represent a significant public health concern, owing to their prevalence, associated impairment, and economic impact (Wittchen et al., 2011). Psychotherapy is the first-line treatment option for most of these disorders. Various forms of psychotherapy are available, such as cognitive-behavioral therapy (CBT), interpersonal therapy, and psychodynamic therapy. Although psychodynamic therapy is frequently used in clinical practice (Cook, Biyanova, Elhai, Schnurr, & Coyne, 2010; Norcross, Hedges, & Castle, 2002), early reviews reported limited evidence for its use with specific mental disorders (Connolly Gibbons, Crits-Christoph, & Hearon, 2008; DeRubeis & Crits-Christoph, 1998; Task Force on Promotion and Dissemination of Psychological Procedures, 1995). For this reason, the Task Force on Promotion and Dissemination of Psychological Procedures concluded in 1995 that "it is critical that more efficacy evidence on the outcome of psychodynamic therapies for specific disorders be obtained if this clinically verified treatment is to survive in today's market" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 2). Meanwhile, the empirical status of psychodynamic therapy has improved considerably. For most of the common mental disorders, randomized controlled trials (RCTs) are available, providing evidence for the efficacy of psychodynamic therapy (Abbass et al., 2014; Fonagy, 2015; Leichsenring, Leweke, Klein, & Steinert, 2015; Leichsenring, Luyten, et al., 2015; Shedler, 2010).

Evidence-based medicine and empirically supported treatments

Several proposals have been made to grade the available evidence of both medical and psychotherapeutic treatments (Canadian Task Force on the Periodic Health Examination, 1979; Chambless & Hollon, 1998; Clarke & Oxman, 2003; Cook, Guyatt, Laupacis, Sacket, & Goldberg, 1995). Apart from other differences,

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all available proposals regard RCTs as the gold standard for the demonstration that a treatment is effective. The most stringent test of efficacy is achieved by comparison with rival treatments, thus controlling for specific and unspecific therapeutic factors (Chambless & Hollon, 1998). For psychotherapy, the most rigorous criteria for efficacy were proposed by Chambless and Hollon (1998). For a designation of efficacious, there must be at least two RCTs, controlled single-case experiments, or equivalent time sampling designs carried out in independent research settings in which the respective treatment is superior to no treatment, placebo, or alternative treatments or equivalent to an already established treatment, with sufficient power to detect moderate differences. In addition, the use of a treatment manual or logical equivalent is required, as are reliable and valid procedures to assess diagnosis and outcome and appropriate data analysis. If there is conflicting evidence, the preponderance of the data must support the treatment's efficacy. For a designation of possibly efficacious, one RCT (with a sample size of three or more in the case of single-case experiments) suffices in the absence of conflicting evidence. A treatment can be considered efficacious and specific if it has been shown to be superior to placebo or to an alternative bona fide treatment in at least two independent research settings (Chambless & Hollon, 1998)[1].

The RCT methodology is viewed as the gold standard, but it has both strengths and certain weaknesses (Seshia & Young, 2013). For example, a randomized controlled *efficacy* study maximizes the internal validity of a study, that is, the observed effects can be causally related to the applied treatments, at the possible expense of external validity, that is, generalizability to real-world conditions of clinical practice. In contrast, *effectiveness* studies investigate the effects of an intervention in routine clinical care and therefore have high external validity but at the possible expense of internal validity. Thus efficacy and effectiveness studies address different research questions. For treatments that have been evaluated in RCTs, benchmarking studies are needed to investigate their effectiveness in real-life conditions (Leichsenring, 2004). Because of their gold standard status, however, we will include only RCTs in this review.

Definition of psychodynamic psychotherapy

Psychodynamic therapy is an umbrella concept for treatments that operate on an interpretive-supportive continuum (Luborsky, 1984). Through interpretive interventions, insight into wishes, affects, object relations, or defense mechanisms is enhanced. Supportive interventions include fostering a therapeutic alliance, setting goals, or strengthening psychosocial capacities such as reality testing or impulse control (Luborsky, 1984). The use of more supportive or more interpretive (insight-enhancing) interventions is tailored to the patient's needs (Luborsky, 1984). A range of manualized psychodynamic therapies applying the above-mentioned

[1] We would like to thank Dr. Chambless for some clarifications with regard to the criteria.

principles exists (Leichsenring, Leweke, et al., 2015; Leichsenring, Luyten, et al., 2015). These therapies vary in the extent to which they focus more on supportive or expressive elements.

The empirical status of psychodynamic therapy

Several meta-analyses have provided evidence for the efficacy of psychodynamic therapy. The Cochrane report by Abbass et al. (2014) showed that psychodynamic therapy is superior to control conditions in common mental disorders. The most recent meta-analysis showed that psychodynamic therapy is as efficacious as treatments with established efficacy, including CBT (Steinert, Munder, Rabung, Hoyer, & Leichsenring, 2017). This meta-analysis applied the logic of equivalence testing and controlled for research allegiance on the level of both individual studies and the meta-analysis itself (Steinert, Munder, et al., 2017). Furthermore, efficacy of the comparator in the respective disorder was ensured, that is, RCTs demonstrating its efficacy were required. Results were not affected by diagnostic group.

For this chapter we have updated previous reviews on the efficacy of psychodynamic psychotherapy for specific mental disorders (Abbass et al., 2014; Fonagy, 2015; Leichsenring, Leweke, et al., 2015; Leichsenring, Luyten, et al., 2015). In most RCTs, short- to medium-term psychodynamic therapy, encompassing 8–40 sessions, was studied (Table 4.1). Several studies also included long-term psychodynamic therapy (LTPP) with a duration between 12 and 36 months.

Depressive disorders

In several RCTs, psychodynamic therapy was superior to waiting list control conditions or alternative treatments with regard to improving depression (Table 4.1) (Ajilchi, Nejati, Town, Wilson, & Abbass, 2016; Knekt et al., 2008; Maina, Forner, & Bogetto, 2005; Thompson, Gallagher, & Breckenridge, 1987). In addition, psychodynamic therapy was superior to treatment as usual in treatment-resistant depression (Town, Abbass, Stride, & Bernier, 2017) and in specific groups of depressed patients: patients with maternal depression (Cooper, Murray, Wilson, & Romaniuk, 2003) and patients with breast cancer (Beutel et al., 2014). Internet-guided psychodynamic self-help was reported to be superior to internet-delivered structured support (Johansson et al., 2013, 2012). Furthermore, in major depressive disorder, psychodynamic therapy combined with pharmacotherapy was found to be superior to pharmacotherapy alone or combined with supportive therapy (Burnand, Andreoli, Kolatte, Venturini, & Rosset, 2002; de Jonghe, Kool, van Aalst, Dekker, & Peen, 2001; Maina, Rosso, Crespi, & Bogetto, 2007). A small pilot study reported large effect sizes in favor of psychodynamic therapy compared to treatment as usual, but the study was not sufficiently powered for a superiority trial, and the differences did not achieve statistical significance (Connolly Gibbons et al., 2012).

Table 4.1 Randomized controlled studies of manual-guided psychodynamic psychotherapy in specific mental disorders.

Study	*N* (psychodynamic therapy)	Comparison group	Duration of psychodynamic therapy
Major depressive disorder			
Ajilchi et al. (2016)	16	Waiting list: $N = 16$	15 sessions (mean)
Barber et al. (2012)	51	Pharmacotherapy: $N = 55$Placebo: $N = 50$	20 sessions, 16 weeks
Barkham et al. (1996)	18	CBT: $N = 18$	8 vs 16 sessions
Connolly Gibbons et al. (2012)	21	TAU: $N = 19$	12 sessions
Driessen et al. (2013)	177	CBT: $N = 164$	16 sessions
Connolly et al. (2016)	118	CBT: $N = 119$	16 sessions
Cooper et al. (2003)	50	CBT: $N = 43$ Counseling: $N = 48$ TAU: $N = 52$	10 sessions
de Jonghe et al. (2004)	106	Psychodynamic therapy plus pharmacotherapy: $N = 85$	16 sessions
Johansson et al. (2012)	46	Structured support: $N = 46$	10 weeks
Salminen et al. (2008)	26	Fluoxetine: $N = 25$	16 sessions
Shapiro et al. (1994)	58	CBT: $N = 59$	8 vs 16 sessions
Thompson et al. (1987) and Gallagher-Thompson et al. (1990)	24	BT: $N = 25$ CBT: $N = 27$ Waiting list: $N = 19$	16–20 sessions
Town et al. (2017)	30	TAU: $N = 30$	20
Depressed caregivers			
Gallagher-Thompson and Steffen (1994)	30	CBT: $N = 36$	16–20 sessions
Dysthymic disorder			
Maina et al. (2005)	10	Supportive therapy: $N = 10$ Waiting list: $N = 10$	15–30 sessions, $M = 19.6$
Depressive disorders in patients with breast cancer			
Beutel et al. (2013)	78	TAU: $N = 79$	Up to 25 sessions

(*Continued*)

Table 4.1 (Continued)

Study	*N* (psychodynamic therapy)	Comparison group	Duration of psychodynamic therapy
Psychodynamic therapy combined with pharmacotherapy for major depressive disorder			
Burnand et al. (2002)	35	Comipramine: $N = 39$	10 weeks
de Jonghe et al. (2001)	72	Pharmacotherapy: $N = 57$	16 sessions
Maina et al. (2007)	18	Brief supportive therapy combined with pharmacotherapy: $N = 17$	15–30 sessions
Mixed samples of patients with depressive and/or anxiety disorders			
Bressi et al. (2010)	30	TAU: $N = 30$	40 sessions, 1 year
Johansson et al. (2013)[a]	50	Supportive interventions: $N = 50$	10 weeks
Knekt et al. (2008)[a]	STPP: 101 LTPP: 128	Solution-focused therapy (SFT): $N = 97$	LTPP: 232 sessions STPP: 18.5 sessions SFT: 9.8 sessions
Complicated grief			
McCallum and Piper (1990)	27	Waiting list: $N = 27$	12 sessions
Piper et al. (2001)	53	Supportive therapy: $N = 54$	12 sessions
Social anxiety disorder			
Bögels et al. (2014)	22	CBT: $N = 27$ Waiting list: $N = 27$	36 sessions
Knijnik et al. (2004)	15	Credible placebo control group: $N = 15$	12 sessions
Leichsenring, Salzer, Beutel et al. (2013) and Leichsenring et al. (2014)	207	Cognitive therapy: $N = 209$ Waiting list: $N = 79$	30 sessions

(*Continued*)

Table 4.1 (Continued)

Study	*N* (psychodynamic therapy)	Comparison group	Duration of psychodynamic therapy
Psychodynamic therapy combined with pharmacotherapy for social anxiety disorder			
Knijnik et al. (2008, 2009)	29	Pharmacotherapy: $N = 29$	12 sessions
Generalized anxiety disorder			
Leichsenring, Salzer, et al. (2009)	28	CBT: $N = 29$	30 sessions
Andersson et al. (2012)	27	ICBT: $N = 27$ Waiting list: $N = 27$	8 weeks
Panic disorder			
Milrod et al. (2007)	26	Applied relaxation: $N = 23$	24 sessions
Beutel et al. (2013)	36	CBT: $N = 18$	24 sessions
Milrod et al. (2015)	80	CBT: 81, Applied relaxation: 39	19–24 sessions
Psychodynamic therapy combined with pharmacotherapy for panic disorder			
Wiborg and Dahl (1996)	20	Pharmacotherapy alone ($N = 20$)	15 sessions
Psychodynamic therapy combined with pharmacotherapy for obsessive-compulsive disorder			
Maina et al. (2010)	27	Pharmacotherapy: $N = 30$	10–16 sessions
Posttraumatic stress disorder			
Brom et al. (1989)	29	Desensitization: $N = 31$ Hypnotherapy: $N = 29$ Waiting list: 23	18.8 sessions
Steinert et al. (2016, 2017)	53	Waiting list: $N = 33$	5 sessions
Somatoform disorders			
Creed et al. (2003)	59	Paroxetine: $N = 43$ TAU: $N = 86$	8 sessions
Faramarzi et al. (2013)	24	Medical treatment: $N = 25$	16 sessions

(*Continued*)

Table 4.1 (Continued)

Study	*N* (psychodynamic therapy)	Comparison group	Duration of psychodynamic therapy
Guthrie et al. (1991)	50	Supportive listening: $N = 46$	8 sessions
Hamilton et al. (2000)	37	Supportive therapy: $N = 36$	7 sessions
Guthrie et al. (1993)	50	Supportive listening: $N = 46$	8 sessions
Monsen and Monsen (2000)	20	TAU/no therapy: $N = 20$	33 sessions
Sattel et al. (2012)	107	Enhanced medical care: $N = 104$	12 sessions
Bulimia nervosa			
Fairburn et al. (1986)	11	CBT: $N = 11$	19
Bachar et al. (1999)	17	Cognitive therapy: $N = 17$ Nutritional counseling: $N = 10$	46 sessions
Garner et al. (1993)	25	CBT: $N = 25$	19 sessions
Poulsen et al. (2014)	34	CBT: $N = 36$	PP: 73 sessions CBT: 20 sessions
Binge eating disorder			
Tasca et al. (2006)	48	Group CBT: $N = 47$ Waiting list: $N = 40$	16 sessions
Anorexia nervosa			
Dare et al. (2001)	21	Cognitive-analytic therapy: $N = 22$ Family therapy: $N = 22$ Routine treatment: $N = 19$	$M = 24.9$ sessions
Zipfel et al. (2013)	80	Enhanced CBT (E-CBT): $N = 80$ Optimized TAU (O-TAU): $N = 82$	Psychodynamic therapy: 39.9 sessions E-CBT: 44.8 sessions O-TAU: 50.8 sessions

(*Continued*)

Table 4.1 (Continued)

Study	*N* (psychodynamic therapy)	Comparison group	Duration of psychodynamic therapy
Opiate addiction			
Woody et al. (1983, 1990)	31	Drug counseling (DC): $N = 35$ CBT + DC: $N = 34$	12 sessions
Woody, Luborsky, McLellan, and O'Brien (1995)	57	DC: $N = 27$	26 sessions
Cocaine dependence			
Crits-Christoph et al. (1999, 2001)	124	CBT + group DC: $N = 97$ Individual DC: $N = 92$, Individual DC + group DC: $N = 96$	Up to 36 individual and 24 group sessions, 4 months
Borderline personality disorder			
Bateman and Fonagy (1999, 2001)	19	TAU: $N = 19$	18 months
Bateman and Fonagy (2009)	71	Structured clinical management: $N = 63$	18 months
Clarkin et al. (2007) and Levy et al. (2006)	30	Dialectical-behavioral therapy: $N = 30$ Supportive psychodynamic therapy: $N = 30$	12 months
Doering et al. (2010)	43	Treatment by experienced community therapists: $N = 29$	1 year
Giesen-Bloo et al. (2006)	42	CBT: $N = 44$	3 years with sessions twice a week
Gregory et al. (2008)	15	TAU: $N = 15$	24.9 sessions (mean)

(*Continued*)

Table 4.1 (Continued)

Study	*N* (psychodynamic therapy)	Comparison group	Duration of psychodynamic therapy
Cluster C personality disorders			
Muran et al. (2005)	22	Brief relational therapy: $N = 33$ CBT: $N = 29$	30 sessions
Svartberg et al. (2004)	25	CBT: $N = 25$	40 sessions
Avoidant personality disorder			
Emmelkamp et al. (2006)	23	CBT: $N = 21$ Waiting list: $N = 18$	20 sessions
Heterogeneous personality disorders			
Abbass et al. (2008)	14	Minimal contact, $N = 13$	27.7 sessions (mean)
Hellerstein et al. (1998)	25	Brief supportive psychotherapy, $N = 24$	40 sessions
Vinnars et al. (2005)	80	Community-delivered psychodynamic therapy, $N = 76$	40 sessions
Winston et al. (1994)	25	Brief adaptive psychotherapy, $N = 30$; Waiting list, $N = 26$	40 weeks, $M = 40.3$ sessions
High utilizers of psychiatric services			
Guthrie et al. (1999)	55	TAU: $N = 55$	8 sessions
Marital distress			
Snyder and Wills (1989) and Snyder et al. (1991)	30	Behavioral marital therapy: $N = 29$ Waiting list: $N = 20$	Up to 25 sessions

BT, Behavior therapy; *CBT*, cognitive-behavioral therapy; *DC*, drug counseling; *ICBT*, internet cognitive-behavioral therapy; *LTPP*, long-term psychodynamic therapy; *SFT*, solution-focused therapy; *STPP*, Short-term psychodynamic therapy; *TAU*, treatment as usual.

[a]The outcome was evaluated separately for depressive and anxiety disorders; only results of STPP was included in this review as for LTTP no manuals were used.

With regard to comparisons with established treatments such as CBT or pharmacotherapy, three studies were sufficiently powered to test for equivalence or noninferiority (Connolly Gibbons et al., 2016; de Jonghe et al., 2004; Driessen et al., 2013). No statistically significant differences in outcome were found in these RCTs. However, the first study did not apply the two one-sided test procedure but instead used the traditional two-sided test (de Jonghe et al., 2004); the other RCT tested for noninferiority (Driessen et al., 2013). In this RCT, noninferiority of psychodynamic therapy compared with CBT was not shown for remission rates (21% vs 24%) but was shown for continuous measures of depression posttreatment (Driessen et al., 2013); the difference in remission rates (21% vs 24%) is minimal from a clinical perspective. In the third study, psychodynamic therapy proved to be noninferior to CBT (Connolly Gibbons et al., 2016).

In addition, several RCTs have reported no differences in outcome between psychodynamic therapy and treatments with established efficacy, but these were not sufficiently powered to demonstrate equivalence if a criterion of at least 70 patients per group, as previously suggested (Leichsenring, Luyten, et al., 2015), is applied (Barber, Barrett, Gallop, Rynn, & Rickels, 2012; Barkham, 1996; Gallagher-Thompson & Steffen, 1994; Salminen et al., 2008; Shapiro et al., 1994).

Meta-analyses of even relatively few studies achieve a higher statistical power than individual studies; thus it is of note that several meta-analyses found individual psychodynamic therapy to be efficacious for depressive disorders with no differences compared to other bona fide treatments (Abbass & Driessen, 2010; Cuijpers, van Straten, Andersson, & van Oppen, 2008; Driessen et al., 2010).

Complicated grief

The efficacy of psychodynamic therapy for complicated grief was demonstrated in two RCTs (McCallum & Piper, 1990; Piper, McCallum, Joyce, & Ogrodniczuk, 2001). In these studies, psychodynamic therapy was superior to a waiting list condition or a supportive treatment.

Anxiety disorders

Several RCTs have provided evidence for the efficacy of psychodynamic therapy in the treatment of anxiety disorders (Table 4.1). For *panic disorder*, psychodynamic therapy was superior to applied relaxation (Milrod et al., 2007). In a recent RCT by Milrod et al. (2015) comparing psychodynamic therapy, CBT, and applied relaxation for panic disorder, a significant site-by-treatment interaction was found, with CBT being superior in one site. When overall response rates were taken into account, no significant differences between CBT and psychodynamic therapy were found (63% vs 59%; 46% for applied relaxation). In another

RCT comparison of psychodynamic therapy and CBT for panic disorder, no significant differences in remission rates were found, but the study was not sufficiently powered to show equivalence (Beutel et al., 2013). For *social anxiety disorder*, psychodynamic therapy was superior to a credible placebo or as efficacious as CBT (Bögels, Wijts, Oort, & Sallaerts, 2014; Knijnik, Kapczinski, Chachamovich, Margis, & Eizirik, 2004), and a recent RCT found psychodynamic therapy to be superior to a waiting list condition and to be as efficacious as CBT in all outcomes, including social anxiety, general psychopathology, and defense mechanisms (Bögels et al., 2014). In the latter study, which the authors reported to be sufficiently powered to detect medium differences (Bögels et al., 2014, p. 370), success rates were above 50% and were found to be stable at the 3- and 12-month follow-ups. In a large multicenter RCT, both psychodynamic therapy and CBT were superior to a waiting list condition (Leichsenring, Salzer, et al., 2013); no differences between psychodynamic therapy and CBT were found with regard to response rates and reduction of depression. CBT was superior with regard to remission rates, self-reported social anxiety and interpersonal problems, yet these differences were small and below the threshold defined a priori as clinically meaningful (Leichsenring, Salzer, et al., 2013). Furthermore, no differences were found with regard to long-term effects on any outcome measure 6, 12, and 24 months after the end of therapy (Leichsenring et al., 2014). Although originally designed as a superiority study to detect small differences in outcome, this study was sufficiently powered to test for equivalence if the criteria proposed above are applied. A review of social anxiety disorder was recently provided by Leichsenring and Leweke (2017).

For *generalized anxiety disorder* an RCT reported no significant differences between psychodynamic therapy and CBT in the primary outcome measure (Hamilton Anxiety Rating Scale), but the study was not sufficiently powered for an equivalence trial (Leichsenring et al., 2009). For secondary measures (e.g., worry, depression), CBT achieved significantly better outcomes (Leichsenring et al., 2009; Salzer, Winkelbach, Leweke, Leibing, & Leichsenring, 2011). Treatment effects were stable 12 months after the end of therapy (Salzer et al., 2011). In another RCT, internet-guided psychodynamic self-help proved to be superior to a waiting list control condition for generalized anxiety disorder (Andersson et al., 2012). No differences compared to internet-guided CBT were reported, but this study was not sufficiently powered to demonstrate equivalence (Table 4.1).

For a mixed sample including the various categories of anxiety disorders, short-term psychodynamic therapy was superior to LTPP (and as efficacious as solution-focused therapy) with regard to recovery at 7-month follow-up (Knekt et al., 2008). In a mixed sample of patients with depressive and/or anxiety disorders, psychodynamic therapy was superior to treatment as usual (pharmacotherapy) (Bressi, Porcellana, Marinaccio, Nocito, & Magri, 2010). The combination of psychodynamic therapy plus pharmacotherapy was shown to be superior to pharmacotherapy alone in the treatment of both social anxiety disorder (Knijnik et al., 2008, 2009) and panic disorder (Wiborg & Dahl, 1996). For panic disorder, psychodynamic therapy combined with pharmacotherapy was superior to

pharmacotherapy alone with regard to rates of remission and relapse prevention (Wiborg & Dahl, 1996).

In a recent meta-analysis, psychodynamic therapy was superior to inactive control conditions in anxiety disorders (Keefe, McCarthy, Dinger, Zilcha-Mano, & Barber, 2014); no differences were found between psychodynamic therapy and other bona fide treatments (Keefe et al., 2014). For this meta-analysis the authors reported that large and medium effect sizes between psychodynamic therapy and alternative active treatments at termination would be detected with a power of about 1.00 regardless of the degree of heterogeneity (Keefe et al., 2014).

Posttraumatic stress disorder

For posttraumatic stress disorder (PTSD) an RCT (Brom, Kleber, & Defares, 1989) found no statistically significant differences in outcome between psychodynamic therapy, hypnotherapy, or CBT. However, this study was not sufficiently powered to show equivalence (Table 4.1). Psychodynamic therapy was superior to a waiting list condition in two of three measures and achieved the largest within-group effect sizes at follow-up. In a recent RCT carried out in Cambodia (Steinert et al., 2016; Steinert, Bumke, et al., 2017), resource-oriented psychodynamic therapy proved to be efficacious compared to a waiting list condition.

Somatoform disorders or somatic symptom disorder

There is a substantial body of evidence for the efficacy of psychodynamic therapy in somatoform disorders, now referred to as somatic symptom disorder in DSM 5 (Table 4.1). Evidence from RCTs is available for irritable bowel syndrome (Creed et al., 2003; Guthrie, Creed, Dawson, & Tomenson, 1991; Guthrie, Creed, Dawson, & Tomenson, 1993), functional dyspepsia (Faramarzi et al., 2013; Hamilton et al., 2000), and somatoform pain disorder (Monsen & Monsen, 2000; Sattel et al., 2012). In each of these RCTs, psychodynamic therapy was found to be superior to treatment as usual or supportive therapy. A meta-analysis found psychodynamic therapy to be efficacious in patients with somatic disorders (Abbass, Kisely, & Kroenke, 2009).

Eating disorders

For bulimia nervosa, one study found that psychodynamic therapy was superior to cognitive therapy and nutritional counseling (Bachar, Latzer, Kreitler, & Berry, 1999). Two other studies found no difference between psychodynamic therapy and CBT with regard to the primary outcome measure (bulimic episodes, vomiting) (Fairburn, Kirk, O'Connor, & Cooper, 1986; Garner et al., 1993); but again, these

studies were not sufficiently powered to demonstrate equivalence (Table 4.1). Differences in favor of CBT were found in secondary measures (Fairburn et al., 1986; Garner et al., 1993). In a recent RCT, CBT was found to be superior to psychodynamic therapy (Poulsen et al., 2014). The study was controversial because the psychodynamic therapy was manualized but not symptom focused, potentially disadvantaging the psychodynamic treatment (Poulsen & Lunn, 2014; Tasca, Hilsenroth, & Thompson-Brenner, 2014).

Two studies provide evidence for psychodynamic therapy in anorexia nervosa (Dare, Eisler, Russel, Treasure, & Dodge, 2001; Zipfel et al., 2013). One RCT compared manual-guided psychodynamic therapy, enhanced CBT, and optimized treatment as usual in the treatment of anorexia nervosa (Zipfel et al., 2013). At the end of treatment, significant improvements were found in all treatments, with no differences in the primary outcome measure (body mass index). At 12-month follow-up, however, psychodynamic therapy was significantly superior to optimized treatment as usual on rates of recovery, whereas enhanced CBT was not (Zipfel et al., 2013). Recovery rates were 35% for psychodynamic therapy, 19% for enhanced CBT, and 13% for optimized treatment as usual. This study was sufficiently powered to show equivalence (Table 4.1). For binge-eating disorder, psychodynamic therapy was found to be superior to a waiting list condition and to be as efficacious as CBT (Tasca et al., 2006). Two of the studies were not sufficiently powered to demonstrate equivalence to active treatments (Table 4.1) (Dare et al., 2001; Tasca et al., 2006). For the comparison with routine treatment (Dare et al., 2001) and a waiting list condition (Tasca et al., 2006), these studies were apparently sufficiently powered to show superiority.

Personality disorders

Cluster C personality disorders

Evidence for the use of psychodynamic therapy for cluster C personality disorders was reported by two RCTs with no differences in outcome relative to CBT (Muran, Safran, Samstag, & Winston, 2005; Svartberg, Stiles, & Seltzer, 2004). These studies were not sufficiently powered to demonstrate equivalence (Table 4.1). Another RCT reported CBT as more effective than a waiting list control condition and psychodynamic therapy in the treatment of avoidant personality disorder (Emmelkamp et al., 2006). The study has attracted controversies because of possible biases (Emmelkamp, 2007; Leichsenring & Leibing, 2007), for example, whether a disorder-specific, manual-guided, bona fide version of psychodynamic therapy was used (Emmelkamp, 2007; Leichsenring & Leibing, 2007).

Cluster B personality disorders

Several RCTs show that borderline personality disorder can be successfully treated with psychodynamic therapy (Bateman et al., 1999; Bateman & Fonagy, 2009;

Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Doering et al., 2010; Gregory et al., 2008; Levy et al., 2006) In their initial RCT, Bateman and Fonagy (1999) found psychodynamic therapy (mentalization-based therapy, MBT) to be superior to typical treatment. In a subsequent RCT, MBT was found to be superior to a manual-guided structured clinical management (Bateman & Fonagy, 2009). MBT was superior with regard to self-reported and clinically significant problems, including suicide attempts and hospitalization. Clarkin et al. (2007) compared two types of psychodynamic therapy (transference focused therapy, TFP, and supportive psychodynamic therapy, SPT) to dialectical-behavioral therapy (DBT). No differences were found between the three treatments across several outcome measures, but TFP was superior to DBT with regard to improvements in reflective functioning and attachment (Levy et al., 2006). Only TFP and SPT were associated with improvements in anger and impulsivity, and only TFP was associated with change in irritability and verbal and direct assault (Clarkin et al., 2007). TFP demonstrated significant improvements in 10 of 12 outcome measures, DBT in 5 of 12 measures, and SPT in 6 of 12 measures (Clarkin et al., 2007). The efficacy of TFP was corroborated by another RCT showing that TFP was superior to treatment by experienced community therapists (Doering et al., 2010). Gregory et al. (2008) reported psychodynamic therapy (deconstructive therapy) to be superior to a treatment as usual condition for borderline personality disorder patients with cooccurring alcohol use disorder. Another RCT compared psychodynamic therapy (TFP) with schema-focused therapy (Giesen-Bloo et al., 2006). The authors reported statistically and clinically significant improvements for both treatments. However, schema-focused therapy was found to be superior to TFP in several outcome measures. Furthermore, a significantly higher dropout was reported for TFP. Several concerns have been raised about this study, most prominently regarding the treatment integrity of TFP (Giesen-Bloo & Arntz, 2007; Yeomans, 2007). The two studies comparing psychodynamic therapy to another active treatment were both insufficiently powered to show equivalence, but both of them reported superiority of psychodynamic therapy or the comparison condition at least in some measures (Giesen-Bloo et al., 2006; Levy et al., 2006).

Heterogeneous samples of patients with personality disorders

In two RCTs, psychodynamic therapy was superior to waiting list or minimal contact conditions in samples with heterogeneous personality disorders (Abbass, Sheldon, Gyra, & Kalpin, 2008; Winston et al., 1994). Another RCT found no differences in outcome between psychodynamic therapy and brief supportive therapy (Hellerstein et al., 1998). However, two of these studies (Hellerstein et al., 1998; Winston et al., 1994) were not sufficiently powered to detect possible differences between psychodynamic therapy and the comparator treatments. In a sufficiently powered study, manual-guided psychodynamic therapy was as effective as community-delivered psychodynamic therapy (Vinnars, Barber, Noren, Gallop, & Weinryb, 2005). Several meta-analyses found psychodynamic therapy to be efficacious in the treatment of personality disorders (Barber, Muran, McCarthy, & Keefe, 2013; Town, Abbass, & Hardy, 2011).

Substance-related disorders

For opiate dependence, two RCTs provided evidence for the efficacy of psychodynamic therapy in several outcomes, including days worked, drug use, illegal income, depression, and general psychiatric symptoms (Woody et al., 1983; Woody et al., 1995). In one of these RCTs (Woody et al., 1983), both psychodynamic therapy and CBT were superior to drug counseling (standard treatment). No differences were found between psychodynamic therapy and CBT, but the studies were not sufficiently powered to test for equivalence. In the second study (Woody et al., 1995), psychodynamic therapy was superior to drug counseling. Thus psychodynamic therapy proved to be efficacious in opiate addiction. In contrast, both psychodynamic therapy and CBT were reported to be inferior to individual drug counseling for cocaine dependence (Crits-Christoph et al., 1999, 2001).

Obsessive-compulsive disorder

In the only RCT of psychodynamic therapy for obsessive-compulsive disorder, psychodynamic therapy combined with pharmacotherapy was not superior to pharmacotherapy alone (Maina, Rosso, Rigardetto, Chiado Piat, & Bogetto, 2010).

High utilizers of psychiatric services

Psychodynamic therapy was superior to a treatment as usual condition in high utilizers of psychiatric services (Guthrie et al., 1999). The sample primarily included patients with depressive and anxiety disorders.

Relationship distress: marital therapy

No significant differences were found between a psychodynamic therapy and a behavioral couple therapy with regard to individual and relationship functioning (Snyder & Wills, 1989). Both treatments were superior in this regard to a waiting list control group. Effects were maintained at 6-month follow-up. At 4-year follow-up, significantly more couples in the behavioral condition than in psychodynamic therapy had divorced (38% vs 3%) (Snyder, Wills, & Grady-Fletcher, 1991). The study was sufficiently powered for showing superiority but not equivalence.

Long-term psychodynamic therapy for complex mental disorders

In several meta-analyses, LTPP—defined as involving at least 50 sessions or lasting for at least 1 year—was shown to be superior to shorter or less intensive forms of

treatment in patients with complex mental disorders, defined as chronic mental disorders, personality disorders, or multiple comorbid disorders (Leichsenring, Abbass, et al., 2013; Leichsenring & Rabung, 2008, 2011b). Superiority was found for improvements in target problems, general psychiatric symptoms, personality, and social functioning. These results are consistent with data on dose-effect relations, which suggest that for many patients with chronic mental disorders or personality disorders, short-term psychotherapy is not sufficient (Howard, Kopta, Krause, & Orlinsky, 1994). For these patients, long-term treatments seem to be more effective. The results of this meta-analysis were controversially discussed, for example, with regard to statistical analysis and the included comparison conditions (Bhar et al., 2010). Several responses have addressed these concerns (Leichsenring, Abbass, et al., 2013; Leichsenring & Rabung, 2011a,b). The results of the previous meta-analysis were corroborated if, for example, only active comparison conditions were included, studies previously not included were considered, or between-group effect sizes were analyzed (Leichsenring, Abbass, et al., 2013; Leichsenring & Rabung, 2011b). Thus in complex mental disorders, LTPP again proved to be superior to shorter or less intensive treatments. Analogously, we expect other forms of long-term psychotherapy to be superior to shorter forms of these treatments in treating complex mental disorders. DBT or schema-focused therapy for borderline personality disorders, for example, are also long-term treatments (Clarkin et al., 2007; Giesen-Bloo et al., 2006).

Discussion

Psychodynamic therapy is frequently used in clinical practice (Norcross & Rogan, 2013). Efficacy research, however, has been neglected in psychodynamic therapy for a long time. There remain concerns among some psychodynamic therapists and researchers about applying the methodology of RCTs to psychodynamic therapy (Westen, Novotny, & Thompson-Brenner, 2004). While it is true, for example, that studying unconscious conflicts or processes poses a unique challenge to research on psychodynamic therapy, the outcome of psychodynamic therapy in the form of observable manifestations of improvement may be studied. With regard to the problem of treatment manualization, the available RCTs using treatment manuals show that the complex interpersonal process of psychodynamic therapy can be manualized (Table 4.1), but treatment manuals should not be mistaken as cookbooks. Current manuals allow for a wide range of flexibility in therapist behavior (Leichsenring & Salzer, 2014; Leichsenring & Schauenburg, 2014; Leichsenring & Steinert, 2017b). Even LTPP may be manual-guided, as shown by the RCTs by Bateman and Fonagy (2009), Clarkin et al. (2007), and Vinnars et al. (2005) Furthermore, the methodological quality of studies of psychodynamic therapy was shown to be comparable to those of CBT (Gerber et al., 2011; Thoma et al., 2012), demonstrating that the methodology of RCTs may be as adequately applied to psychodynamic therapy as to CBT.

In recent years, efficacy research on psychodynamic therapy has caught up, and evidence is beginning to accumulate (Abbass et al., 2014; Barber et al., 2013; Steinert, Munder, et al., 2017). According to the results presented in this review, there is substantial evidence for the efficacy of psychodynamic therapy in depressive, anxiety, somatoform, eating, substance-related, and personality disorders. This is consistent with a recent Cochrane Report that found psychodynamic therapy to be efficacious in common mental disorders (Abbass et al., 2014). Effects of psychodynamic therapy were found to be stable or even increased in follow-up assessments (Abbass et al., 2009, 2014; Leichsenring & Rabung, 2008).

Although there is a growing body of evidence for the efficacy of psychodynamic therapy, there are also some limitations. Only a few studies exist that are sufficiently powered to show equivalence to an alternative treatment (Leichsenring, Luyten, et al., 2015). However, this is true for CBT as well (Cuijpers, 2016). With regard to the comparison of psychodynamic therapy and CBT, no substantial differences in efficacy were found in the studies that were sufficiently powered for testing equivalence (Crits-Christoph et al., 1999; Driessen et al., 2013; Leichsenring, Luyten, et al., 2015; Leichsenring et al., 2014; Zipfel et al., 2013). Equivalence of psychodynamic therapy to treatments established in efficacy was recently explicitly tested and demonstrated (Steinert, Munder, et al., 2017). If future research confirms that there are no substantial differences in outcome between the different forms of bona fide psychotherapy in common mental disorders, the next question becomes which patients benefit more from which kind of therapy, such as is addressed by Piper et al. (2001).

In the RCTs included here, various methods of psychodynamic therapy were used (Table 4.1). However, from an empirical perspective, it is not clear how "different" the various approaches really are. For the treatment of anxiety disorders and depressive disorders, the various approaches were shown to be consistent with each other and to overlap to a high degree (Leichsenring & Salzer, 2014; Leichsenring & Schauenburg, 2014; Leichsenring, & Steinert, 2018). Thus developing unified or transdiagnostic protocols for the psychodynamic treatment of major mental disorders is possible and may be an important target for future research and practice.

Nevertheless, open questions remain requiring further research on psychodynamic therapy. For specific mental disorders, further RCTs are required. This applies, for instance, to obsessive-compulsive disorder and PTSD. For PTSD, only two RCTs exist (Brom et al., 1989; Steinert, Bumke, et al., 2017). Further, more adequately powered equivalence trials are needed. In future studies of psychodynamic therapy, not only measures of symptoms or DSM criteria should be applied, but also measures more specific to psychodynamic therapy. Future studies should also examine whether there are specific gains achieved only by psychodynamic therapy; this is known as the question of "added value." Such an added value was demonstrated, for example, by Levy et al. (2006) comparing psychodynamic therapy to DBT with regard to improvements in reflective functioning and attachment. Research should address the mechanisms of change not only of psychodynamic

therapy, but also of other bona fide treatments beyond brand names of treatment. This is important to further improve the treatments. Last but not least, more attention needs to be devoted to the question of what works for whom with regard to patient characteristics beyond the diagnosis.

At present, no method of psychotherapy may claim to be the gold standard (Leichsenring & Steinert, 2017a). Monocultures have rarely proved to be successful. A plurality of (evidence-based) therapies is to be welcomed, both in treatment and research. Only plurality allows for bridging the gaps between the different approaches and for learning from each other to further improve the treatment of patients with mental disorders (Roy-Byrne, 2017).

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