Are psychodynamic and psychoanalytic therapies effective?: A review of empirical data

Falk Leichsenring

There is a need for empirical outcome research in psychodynamic and psychoanalytic therapy. However, both the approach of empirically supported therapies (EST) and the procedures of evidence-based medicine (EBM) have severe limitations making randomised controlled trials (RCTs) an absolute standard. After a critical discussion of this approach, the author reviews the empirical evidence for the efficacy of psychodynamic psychotherapy in specific psychiatric disorders. The review aims to identify for which psychiatric disorders RCTs of specific models of psychodynamic psychotherapy are available and for which they are lacking, thus providing a basis for planning further research. In addition, results of process research of psychodynamic psychotherapy are presented. As the methodology of RCTs is not appropriate for psychoanalytic therapy, effectiveness studies of psychoanalytic therapy are reviewed as well. Studies of psychodynamic psychotherapy published between 1960 and 2004 were identified by a computerised search using Medline, PsycINFO and Current Contents. In addition, textbooks and journal articles were used. Twenty-two RCTs were identified of which 64% had not been included in the 1998 report by Chambless and Hollon. According to the results, for the following psychiatric disorders at least one RCT providing evidence for the efficacy of psychodynamic psychotherapy was identified: depressive disorders (4 RCTs), anxiety disorders (1 RCT), post-traumatic stress disorder (1 RCT), somatoform disorder (4 RCTs), bulimia nervosa (3 RCTs), anorexia nervosa (2 RCTs), borderline personality disorder (2 RCTs), Cluster C personality disorder (1 RCT), and substance-related disorders (4 RCTs). According to results of process research, outcome in psychodynamic psychotherapy is related to the competent delivery of therapeutic techniques and to the development of a therapeutic alliance. With regard to psychoanalytic therapy, controlled quasi-experimental effectiveness studies provide evidence that psychoanalytic therapy is (1) more effective than no treatment or treatment as usual, and (2) more effective than shorter forms of psychodynamic therapy. Conclusions are drawn for future research.

In these times of evidence-based medicine and empirically supported treatments, there is a need for empirical outcome research in psychodynamic and psychoanalytic therapy (Gunderson and Gabbard, 1999). In a first part, this article presents a review of the available randomised controlled trials of short-term and moderate-length psychodynamic psychotherapy in specific psychiatric disorders. As the methodology
of randomised controlled trials is not appropriate for psychoanalytic therapy, effectiveness studies of psychoanalytic therapy are reviewed in the second part of the article. Unlike randomised controlled trials (efficacy studies), effectiveness studies are carried out under the conditions of clinical practice.

Evidence-based medicine and empirically supported treatments

Several proposals have been made to grade the available evidence of both medical and psychotherapeutic treatments (CTFPHE (Canadian Task Force on the Periodic Health Examination), 1979; Cook et al., 1995; Guyatt et al., 1995; Nathan and Gorman, 2002; Chambless and Hollon, 1998; Clarke and Oxman, 2003; National Institute of Clinical Excellence [internet]). Apart from other differences, all available proposals regard randomised controlled trials (RCTs) as the ‘gold standard’ for the demonstration that a treatment is effective. According to these proposals, only RCTs can provide level I evidence, that is the highest level of evidence. The defining feature of an RCT is the random assignment of subjects to the different conditions of treatment (Shadish et al., 2002). Randomisation is regarded as indispensable in order to ensure that a priori existing differences between subjects are equally distributed. The goal of randomisation is to attribute the observed effects exclusively to the applied therapy (internal validity). Thus, randomisation is used to ensure the internal validity of a study (Shadish et al., 2002).

The exclusive position of RCTs as methods for demonstrating that a treatment works has recently been queried. The main argument is that it is questionable whether the results of RCTs are representative for clinical practice (Seligman, 1995; Roth and Parry, 1997; Beutler, 1998; Henry, 1998; Persons and Silberschatz, 1998; Fonagy, 1999; Leichsenring, 2004; Westen et al., 2004). Thus, the supposed strength of RCTs, especially randomisation, can turn out to be their central weakness, because RCTs create artificial conditions that are not representative of clinical practice (Seligman, 1995). This is also true for the use of therapy manuals and the treatment of specific disorders. The latter aspect promotes the tendency to study isolated disorders that, according to epidemiological studies, hardly occur in clinical practice (e.g. Kessler et al., 1994). The reduction of psychotherapy to the use of manuals developed for the treatment of specific disorders will do serious damage to the breadth of clinical training (Henry, 1998).

Furthermore, the methodology of RCT is not applicable to long-term psychotherapy lasting several years or to psychoanalytic therapy (Seligman, 1995; Wallerstein, 1999). It is neither possible to carry out a treatment according to a manual for several years, nor to offer patients who seek treatment no therapy for several years. It is also impossible to create equally credible comparison conditions over years (Seligman, 1995). Furthermore, patients who decide for a psychoanalytic therapy differ from those choosing a shorter form of psychodynamic therapy by specific personality traits (Rudolf et al., 1994). Thus, random assignment of patients to psychoanalytic therapy vs. a comparison treatment would destroy the matching between patients and treatments. In other words, randomisation would destroy the subject of research and produce misleading results. The results of a randomised study of psychoanalytic therapy would not be valid for the patients who

are usually treated with psychoanalytic therapy. Uncritically applied in such a way, randomisation is in danger of becoming a dogma and of losing its function as a useful method of research. Another debatable aspect of the EST approach is the emphasis on disorders and on symptoms (Blatt, 1995). As
Henry put it (1998, p. 129): ‘EVTs [empirically validated treatments] place the emphasis on the disorder … and not on the individual … who seeks our services’.

After all, RCTs serve only a limited function (Roth and Parry, 1997, p. 370): ‘RCTs are … an imperfect tool; almost certainly their results are best seen as one part of a research cycle’. RCTs can show that a treatment works under controlled conditions. However, if a method of psychotherapy has been shown to work under controlled conditions, this does not necessarily imply that it equally works under the conditions of clinical practice (Leichsenring, 2004). The main reason for this gap is that psychotherapy is not a drug that extensively works equally under different conditions, and the medical disease model is inadequate for complex mental illness conditions. The evidence that a treatment works in the field, can only be provided by effectiveness studies (Seligman, 1995). Thus, a distinction is necessary between EST and RCT methodology (Leichsenring, 2004; Westen et al., 2004).

Also in the realm of evidence-based medicine, a critical discussion has begun as to whether RCTs really represent the gold standard of outcome research (Benson and Hartz, 2000; Concato et al., 2000; Pocock and Elbourne, 2000). On the basis of their data, Concato et al. (2000) question the usual hierarchy of research designs with RCTs ranking at the top. The discussion of effectiveness studies will be taken up again below.

Unlike RCTs, naturalistic studies (effectiveness studies) are carried out under the conditions of clinical practice. They are highly clinically representative (Shadish et al., 2000): Patients with complex (i.e. highly co-morbid) disorders, as they usually occur in clinical practice, are treated. Therapists apply exactly those methods of psychotherapy that they usually apply and that they are experienced in. Patients themselves make a decision for a specific kind of therapy and for a specific psychotherapist, and the duration of the treatment is determined by the clinical requirements (Seligman, 1995).

Paradoxically, naturalistic studies are not accepted, for example by the American Psychological Association (APA) as methods for demonstrating that a therapy works (TFPDPP (Task Force on Promotion and Dissemination of Psychological Procedures), 1995; Chambless and Hollon, 1998; Chambless and Ollendick, 2001). The main argument against naturalistic studies refers to threats to internal validity, that is, to the reduced possibility of controlling factors influencing outcome apart from therapy. Measures to improve the internal validity of naturalistic studies will be discussed below.

Evidence for short-term psychodynamic psychotherapy

The TFPDPP (1995) judged short-term psychodynamic psychotherapy (STPP) as ‘probably efficacious’. The problem with STPP was that no two studies of independent research groups were found demonstrating efficacy of the same form of STPP in the same psychiatric disorder. The TFPDPP concluded that further evidence for STPP in specific psychiatric disorders is required if this clinically validated form of treatment is to survive in the present market.

For this reason, it is important to know, for which psychiatric disorders RCTs of specific models of both long-term and short-term psychodynamic psychotherapy are available and for which they are lacking. The aim of this article is to identify these areas. Thus, this review will provide a basis for planning further disorder-related research of psychodynamic psychotherapy. In this review, the criteria proposed
by the TFPDPP (1995) modified by Chambless and Hollon (1998) to define efficacious treatments were applied. However, this does not imply that these criteria are uncritically accepted. As described above, they have to be discussed critically with regard to its limitations. However, the aim of this review was to examine the evidence for psychodynamic psychotherapy under the requirements of ESTs.

As the method of RCTs is not appropriate for long-term psychodynamic psychotherapy and psychoanalytic therapy lasting several years, evidence from effectiveness studies will be included in this review as far as long-term treatments are concerned.

Method

Definition of psychodynamic psychotherapy

From the results of the Menninger Psychotherapy Research Project, Wallerstein (1989) has concluded that even the most interpretive therapies include supportive elements. Thus, psychoanalytic therapy—and psychodynamic psychotherapy in general—operate on an interpretive-supportive continuum, and the use of more interpretive or supportive interventions depends on the patient's needs (Wallerstein, 1989; Gunderson and Gabbard, 1999; Gabbard, 2004). For long-term psychodynamic psychotherapy the following definition given by Gunderson and Gabbard (1999, p. 685; Gabbard, 2004, p. 2) may be applied: ‘a therapy that involves careful attention to the therapist-patient interaction, with thoughtfully timed interpretation of transference and resistance embedded in a sophisticated appreciation of the therapist's contribution to the two-person field’.

With regard to duration, Gabbard (2004, p. 3) has proposed to regard therapies of more than 24 sessions or lasting longer than six months as long-term. This definition may apply to the US; in European countries, for example in Germany, therapies of 25 to 50 sessions are not regarded as long-term. This definition would imply, for example, cognitive-behavioral therapy (CBT) as it is presently applied in clinical practice in Germany, is long-term therapy. To take these differences into account, therapies with a duration of 25 to 100 sessions will be called moderate-length psychodynamic therapy in this review. Certainly, all attempts to define what is short term and what is long term will set arbitrary boundaries (see also Gabbard, 2004, p. 2). With regard to the frequency of sessions, psychodynamic and psychoanalytic therapy includes a range from one session up to five sessions per week.

With regard to short-term psychodynamic psychotherapy (STPP), different models have been developed, which are reviewed, for example, by Messer and Warren (1995). Apart from conceptual and technical differences (e.g. Messer and Warren, 1995), the different forms of STPP have some therapeutic elements in common. With regard to formal characteristics, they are time-limited (usually 16-30 sessions), performed in a face-to-face setting, with one or two sessions a week (Davanloo, 1980; Messer, 2001; Shapiro et al. 2003). Usually, therapists are more active, and the therapy is more oriented to achieve predefined goals than in long-term psychodynamic psychotherapy. STPP focuses on specific conflicts or themes which are formulated early in therapy. Therapists foster the development of a therapeutic alliance and a positive transference. The focus is on the patients' experiences here-and-now, including their symptoms, but working through pre-existing conflicts is also included (e.g. Mann, 1973; Horowitz, 1976; Luborsky, 1984). In a review of empirical studies, Blagys and Hilsenroth (2000) identified seven features that were significantly more frequently observed in STPP compared to CBT: focus on affect, on resistance, on identification of
consistent patterns (of relationships, feelings and behaviours), on past experiences, on interpersonal experiences, on the therapeutic relationship, and on wishes, dreams or fantasies.

Search for studies and inclusion criteria

In addition to the usual search for studies via reviews, meta-analyses and textbooks, a computerised search was carried out using Medline and PsycINFO with the following key words: psychotherapy, psychodynamic, psychoanalytically oriented, study. The search was carried out for the period between 1960 and 2004. Only studies that fulfilled the following criteria (Chambless and Hollon, 1998) were included in this review: (a) use of a randomised controlled design, (b) treatment of patients with a specific psychiatric disorder, (c) use of treatment manuals or manual-like guidelines, (d) use of reliable and valid measures of diagnosis and outcome, (e) comparison of treatments with a control group (placebo group, waiting list) or with another treatment. Studies of interpersonal therapy (IPT; e.g. Elkin et al., 1989; Wilfley et al., 1993) were not included because the relationship to psychodynamic therapy is controversial (e.g. Markowitz et al., 1998). According to empirical results, the interpersonal therapies applied in the National Institute of Mental Health (NIMH) treatment of depression study (e.g. Elkin et al., 1989) corresponded most strongly to the ideal prototype of CBT (Ablon and Jones, 2002). As Ablon and Jones put it: ‘Brand names of therapy can be misleading’ (2002, p. 780). Thus, this review included only studies for which there seems to be a general agreement that they represent models of psychodynamic psychotherapy. Comparable, but not identical inclusion criteria were set up in a recent Cochrane report for short-term psychodynamic therapy (Abbass et al., 2004). For example, studies in which patient samples with heterogeneous disorders were included by Abbass et al., but were excluded by the present review which followed the procedures of Chambless and Hollon (1998) including only studies of a specific psychiatric disorder.

Results

Twenty-two RCTs of STPP could be included in this review. These studies are presented in Table 1. In their 1995 report, the TFPDPP mentioned five studies

- 845 -

Table 1—Randomised controlled studies of short-term and moderate-length psychodynamic psychotherapy (PP) in specific psychiatric disorders

<table>
<thead>
<tr>
<th>Study</th>
<th>Disorder</th>
<th>N (PP)</th>
<th>Comparison group</th>
<th>Concept of PP</th>
<th>Treatment duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thompson et al., 1987</td>
<td>depression</td>
<td>24</td>
<td>BT: N = 25; CBT: N = 27; waiting list: N = 19</td>
<td>Horowitz and Kaltreider (1979)</td>
<td>16-20 sessions</td>
</tr>
<tr>
<td>Shapiro et al., 1994</td>
<td>depression</td>
<td>58</td>
<td>CBT: N = 59</td>
<td>Shapiro and Firth (1985)</td>
<td>8 vs. 16 sessions</td>
</tr>
<tr>
<td>Gallagher-Thompson and Steffen, 1994</td>
<td>depression</td>
<td>30</td>
<td>CBT: N = 36</td>
<td>Mann (1973), Rose and DelMaestro (1990)</td>
<td>16-20 sessions</td>
</tr>
<tr>
<td>Barkham et al., 1996</td>
<td>depression</td>
<td>18</td>
<td>CBT: N = 18</td>
<td>Shapiro and Firth (1985)</td>
<td>8 vs. 16 sessions</td>
</tr>
<tr>
<td>Study</td>
<td>Condition</td>
<td>N</td>
<td>Treatment</td>
<td>Control</td>
<td>Outcome</td>
</tr>
<tr>
<td>---------------------------</td>
<td>------------------------------------------------</td>
<td>---</td>
<td>---------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Brom et al., 1989</td>
<td>PTSD</td>
<td>29</td>
<td>de-sensitisation: N = 31</td>
<td>Horowitz (1976)</td>
<td>Mean = 18.8 sessions</td>
</tr>
<tr>
<td>Dare et al., 2001</td>
<td>anorexia nervosa</td>
<td>21</td>
<td>Cognitive-analytic therapy (Ryle): N = 22; family therapy: N = 22; routine treatment: N = 19</td>
<td>Malan (1976), Dare (1995)</td>
<td>Mean = 24.9 sessions</td>
</tr>
<tr>
<td>Gowers et al., 1993</td>
<td>anorexia nervosa</td>
<td>20</td>
<td>treatment as usual: N = 20</td>
<td>Crisp (1980)</td>
<td>12</td>
</tr>
<tr>
<td>Fairburn et al., 1986</td>
<td>bulimia nervosa</td>
<td>11</td>
<td>CBT: N = 11</td>
<td>Rosen (1979), Stunkard (1976), Bruch (1973)</td>
<td>19</td>
</tr>
<tr>
<td>Dare et al., 2001</td>
<td>anorexia nervosa</td>
<td>17</td>
<td>cognitive therapy: N = 17</td>
<td>Barth (1991), Goodsit (1985), Geist (1989)</td>
<td>46</td>
</tr>
<tr>
<td>Svartberg et al., 2004</td>
<td>Cluster C personality disorders</td>
<td>25</td>
<td>CBT: N = 25</td>
<td>Malan (1976), McCullough Vaillant (1976)</td>
<td>40</td>
</tr>
<tr>
<td>Munroe-Blum and Marziali, 1995</td>
<td>borderline personality disorder</td>
<td>31</td>
<td>interpersonal group therapy: N = 25</td>
<td>Kernberg (1975)</td>
<td>17</td>
</tr>
<tr>
<td>Woody et al., 1995</td>
<td>opiate dependence</td>
<td>57</td>
<td>drug counselling: N = 27</td>
<td>Luborsky (1985)</td>
<td>26</td>
</tr>
<tr>
<td>Sandahl et al., 1998</td>
<td>alcohol dependence</td>
<td>25</td>
<td>CBT: N = 24</td>
<td>Foulkes (1964)</td>
<td>15</td>
</tr>
<tr>
<td>Crits-Christoph et al., 1999, 2001</td>
<td>cocaine dependence</td>
<td>124</td>
<td>CBT + group drug counselling (DC): N = 97, individual DC: N = 92, individual DC + group DC: N = 96</td>
<td>Mark and Luborsky (1992) + group DC</td>
<td>up to 36 individual and 24 group sessions; 4 months</td>
</tr>
<tr>
<td>Guthrie et al., 1991</td>
<td>irritable bowel</td>
<td>50</td>
<td>supportive listening: N = 46</td>
<td>Hobson (1985), Shapiro and Firth (1985)</td>
<td>8</td>
</tr>
<tr>
<td>Creed et al.,</td>
<td>irritable bowel</td>
<td>59</td>
<td>paroxetine: N = 43 treatment</td>
<td>Hobson (1985)</td>
<td>8</td>
</tr>
</tbody>
</table>
of STPP. Two of these studies refer to STPP in specific psychiatric disorders: the study of Thompson et al. (1987) of the treatment of geriatric depression and the study of Woody et al. (1990) of the treatment of opiate dependence. Furthermore, the TFPDPP mentioned three studies in which patients with heterogeneous disorders were treated with STPP (Piper et al., 1990; Winston et al., 1994; Shefler et al., 1995). Fourteen of the 22 studies identified by the present review were published in 1995, that is in the year the TFPDPP report was published, or later. Thus, 64% of the studies that were identified in this review were not included in the 1995 report of the TFPDPP. In three further RCTs identified, STPP was combined with pharmacological therapy in the treatment of depression (de Jonghe et al., 2001; Burnand et al., 2002) or panic disorder (Wiborg and Dahl, 1996). These three studies showed that STPP was efficacious in interaction with medication, not that STPP alone was necessarily efficacious. This also applies to two further RCTs, which studied the treatment of prolonged or pathological grief by STPP (McCallum and Piper, 1990; Piper et al., 2001). In these studies, STPP was superior to a waiting list or a supportive group therapy. However, in both studies a considerable proportion of patients received psychopharmacological treatments (45% and 55%, respectively). Thus, the results of these studies only apply to the combined treatment of STPP and medication.

Therapy duration. In the 22 studies of psychodynamic psychotherapy, between 7 and 46 sessions were conducted (Table 1). According to the definition given above, 14 studies (64%) refer to short-term psychodynamic psychotherapy and 8 (36%) to moderate-length psychodynamic psychotherapy.

Models of psychodynamic psychotherapy. In the 22 studies, different forms of psychodynamic psychotherapy were applied (see Table 1). Most frequently, the models of psychodynamic psychotherapy developed by Horowitz (1976), Luborsky (1984), and Shapiro and Firth (1985) were applied.

**Efficacy of psychodynamic psychotherapy in specific psychiatric disorders**

The 22 studies of psychodynamic psychotherapy included in this review will be presented for the different psychiatric disorders. However, from a psychoanalytic perspective, the results of a therapy in a specific psychiatric disorder (e.g. depression, agoraphobia) are influenced by the underlying psychodynamic features (e.g. conflicts, defences, personality organisation), which may vary considerably within one category of psychiatric disorder (e.g. Kernberg, 1996). The results

---

1 However, this is true for studies of other forms of therapy as well, e.g. for CBT; for example, patients included in an RCT of CBT in the treatment of major depression may differ considerably in terms of their underlying psychodynamic features. However, CBT therapists do not take these features into
account. Although such factors are not taken into account by CBT therapists, they may influence the results in contributing to the variance of outcome. For this reason, the impact of psychodynamics is not only a problem of psychodynamic psychotherapy or psychoanalytic therapy. In RCTs, this problem is usually handled by defining inclusion and exclusion criteria, e.g. by excluding severe personality disorders. Assessing co-morbid disorders and studying their impact on outcome is another way to deal with this problem (e.g. Woody et al., 1985).

will be presented separately for short-term and moderate-length psychodynamic psychotherapy.

**Major Depression (DSM-IV 269, 300.4; ICD-10 F32, F33)**

Four RCTs provided evidence for the efficacy of STPP compared to CBT in depression (Thompson et al., 1987; Gallagher-Thompson and Steffen, 1994; Shapiro et al., 1994; Barkham et al., 1996). Different models of STPP were applied (Table 1). In these studies, STPP and CBT proved to be equally effective with regard to depressive symptoms, general psychiatric symptoms and social functioning (Leichsenring, 2001).

STPP achieved large pre-post effect sizes in depressive symptoms, general psychiatric symptoms and social functioning (Leichsenring, 2001).2 The results proved to be stable in follow-up studies (Gallagher-Thompson et al., 1990; Shapiro et al., 1995). These results are consistent with the findings of the meta-analysis of Wampold et al. (2002) who did not find significant differences between CBT and ‘other therapies’ in the treatment of depression.

**Anxiety disorders (DSM-IV 300.XX; ICD-10 F40, F41)**

Only one RCT of STPP in the treatment of anxiety disorders was identified that fulfilled the inclusion criteria, that of Bögels et al. (2003). No further RCT of psychodynamic psychotherapy alone (i.e. without additional pharmacotherapy) in the treatment of anxiety disorders was identified. In the RCT of Bögels et al. (2003) moderate-length psychodynamic psychotherapy of 36 sessions proved to be as effective as CBT in the treatment of generalised social phobia.

**Post-traumatic stress disorder (DSM-IV 309.81; ICD-10 F43.1)**

In an RCT of Brom et al. (1989), the effects of STPP, behavioural therapy (trauma de-sensitisation) and hypnotherapy in patients with post-traumatic stress disorder (PTSD) were studied. STPP proved to be as effective as trauma de-sensitisation in the reduction of trauma-related symptoms. Both forms of therapy were superior to a waiting list control group. Results of STPP were not only maintained, but continued to improve at 3-month follow-up.

**Somatoform disorders (DSM-IV 300.81; 307.80; ICD-10 F45).**

At present, three RCTs of STPP in somatoform disorders that fulfilled the inclusion criteria are available (Table 1). In the RCT of Guthrie et al. (1991) patients with irritable bowel syndrome, who had not responded to standard medical treatment over the previous 6 months, were treated with STPP in addition to standard medical treatment. This treatment was compared to standard medical treatment alone.
According to the results, STPP was feasible and effective in two-thirds of the patients. In another RCT, STPP was significantly more effective than routine care.

2 Effect sizes give the amount of change in units of standard deviations. For example, a pre-post effect size of 1.00 is indicative of a pre-post difference of one standard deviation. According to a convention proposed by Cohen (1988), an effect size of 0.80 is regarded as a large effect.

and as effective as medication (paroxetine) in the treatment of severe irritable bowel syndrome (Creed et al., 2003). During the follow-up period, STPP, but not paroxetine was associated with a significant reduction in health care costs compared with treatment as usual. In an RCT of Hamilton et al. (2000) STPP was compared to supportive therapy in the treatment of patients with chronic intractable functional dyspepsia, who had failed to respond to conventional pharmacological treatments. At the end of treatment, STPP was significantly superior to the control condition on both the gastroenterologists' and patients' total symptom score. The effects were stable in the 12-month follow-up. Monsen and Monsen (2000) compared moderate-length psychodynamic psychotherapy of 33 sessions to a control condition (no treatment or treatment as usual) in the treatment of patients with chronic pain. STPP was significantly superior to the control group on measures of pain, psychiatric symptoms, interpersonal problems and affect consciousness. The results remained stable in the 12-month follow-up, or even improved.

**Bulimia nervosa (DSM-IV 307.51; ICD-10: F50.2)**

Three RCTs of STPP in the treatment of bulimia nervosa are available (Table 1). Significant and stable improvements in bulimia nervosa after STPP were demonstrated in the RCTs of Fairburn et al. (1986, 1995) and Garner et al. (1993). In the central disorder-specific measures (bulimic episodes, self-induced vomiting), STPP was as effective as CBT (Fairburn et al., 1986, 1995; Garner et al., 1993). In another RCT, STPP was significantly superior to both a treatment as usual (TAU) group (nutritional counselling) and cognitive therapy (Bachar et al., 1999). This was true for patients with bulimia nervosa and a mixed sample of patients with bulimia nervosa or anorexia nervosa.

**Anorexia nervosa (DSM-IV 307.1; F50.0)**

In an RCT of Gowers et al. (1994), STPP combined with four sessions of nutritional advice yielded significant improvements in patients with anorexia nervosa (Table 1). Weight and body mass index (BMI) changes were significantly better than for a control condition (treatment as usual). Dare et al. (2001) compared moderate-length psychodynamic psychotherapy with a mean duration of 24.9 sessions to cognitive-analytic therapy, family therapy and routine treatment in the treatment of anorexia nervosa (Table 1). Moderate-length psychodynamic psychotherapy yielded significant symptomatic improvements, and STPP and family therapy were significantly superior to the routine treatment concerning weight gain. However, the improvements were modest, several patients being undernourished at follow-up.
Apart from this, CBT was superior to STPP in some specific measures of psychopathology (Fairburn et al., 1986; Garner et al., 1993). However, in a follow-up of the Fairburn et al. study (1986), using a longer follow-up period, both forms of therapy proved to be equally effective and were partly superior to a behavioural form of therapy (Fairburn et al., 1995). Accordingly, for a valid evaluation of the efficacy of STPP in bulimia nervosa longer-term follow-up studies are necessary.

- 849 -

**Borderline personality disorders (DSM-IV 301.83; ICD-10 F60.31)**

In an RCT, Munroe-Blum and Marziali (1995) compared STPP to interpersonal group therapy in the treatment of patients with borderline personality disorder (Table 1). STPP yielded significant improvements on measures of borderline-related symptoms, general psychiatric symptoms and depression, and was as effective as the interpersonal group therapy.

Bateman and Fonagy (1999, 2001) studied the effects of a psychoanalytically oriented partial hospitalisation treatment for patients with borderline personality disorder. The treatment lasted a maximum of 18 months, representing moderate-length psychodynamic psychotherapy by the definition applied in this review. According to the results, moderate-length psychodynamic psychotherapy was significantly superior to a standard psychiatric care, both at the end of therapy and at 18-month follow-up.

**Cluster C personality disorders**

In an RCT of Svartberg et al. (2004), moderate-length psychodynamic psychotherapy of 40 sessions was compared to CBT (Table 1). Both psychodynamic psychotherapy and CBT yielded significant improvements in patients with DSM-IV Cluster C personality disorders (i.e. avoidant, compulsive or dependent personality disorder). The improvements refer to symptoms, interpersonal problems and core personality pathology. The results were stable at the 24-month follow-up. No significant differences were found between moderate-length psychodynamic psychotherapy and CBT with regard to efficacy.

**Substance dependence (DSM IV Substance Dependence; ICD-10 F1X)**

Four RCTs of psychodynamic psychotherapy in the treatment of substance dependence are available (Table 1). Woody et al. (1983, 1990) studied the effects of STPP and CBT given in addition to drug counselling in the treatment of opiate dependence. STPP plus drug counselling yielded significant improvements on measures of drug-related symptoms and general psychiatric symptoms. At 7-month follow-up, STPP and CBT plus drug counselling were equally effective, and both conditions were superior to drug counselling alone. In another RCT, moderate-length psychodynamic psychotherapy of 26 sessions given in addition to drug counselling was also superior to drug counselling in the treatment of opiate dependence (Woody et al., 1995). By 6-month follow-up, most of the gains made by the patients who had received psychodynamic therapy remained. In the RCT of Crits-Christoph et al. (1999, 2001), moderate-length psychodynamic psychotherapy of up to 36 individual sessions was combined with 24 sessions of group drug counselling in the treatment of cocaine dependence. The combined treatment yielded significant improvements and was as effective as CBT, which was combined with group drug counselling as well. However, both CBT and psychodynamic psychotherapy plus group drug counselling was not more effective than group drug counselling alone. Furthermore, individual drug counselling was significantly superior to both forms of therapy concerning measures of drug abuse. With regard to psychological and social outcome variables, all treatments
Table 2—Controlled quasi-experimental effectiveness studies of psychoanalytic therapy (PSA)

<table>
<thead>
<tr>
<th>Study</th>
<th>Disorder (PA)</th>
<th>N</th>
<th>Comparison group</th>
<th>Outcome criteria</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dührssen and Jorswieck, 1965</td>
<td>complex 125</td>
<td>125</td>
<td>treatment as usual: N = 100</td>
<td>in-patient days</td>
<td>PSA &gt; TAU, PSA &gt; Controls</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>general population: N = 100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rudolf et al., 1994</td>
<td>complex 44</td>
<td>44</td>
<td>psychodynamic therapy: N = 56</td>
<td>symptoms, interpersonal problems</td>
<td>PSA &gt; PP PSA &gt; in-patient treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>psychodynamic in-patient therapy: N = 164</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sandell et al., 1999, 2001</td>
<td>complex 24</td>
<td>24</td>
<td>psychodynamic therapy: N = 100 low-dose treatment: N = 27</td>
<td>symptoms, sense of coherence, social adjustment</td>
<td>PSA &gt; PP PA &gt; low dose PA &gt; untreated</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>untreated patients: N = 35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rudolf et al., 2004</td>
<td>complex 32</td>
<td>32</td>
<td>psychodynamic therapy: N = 27</td>
<td>symptoms, interpersonal problems, structural changes</td>
<td>PSA &gt; PP (structural changes) PSA = PP (symptoms, interpersonal)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note:
PSA: psychoanalytic therapy
PP: psychodynamic psychotherapy
TAU: treatment as usual

were equally effective (Crits-Christoph et al., 2001). In an RCT of Sandahl et al. (1998), STPP and CBT were compared concerning their efficacy in the treatment of alcohol abuse. STPP yielded significant improvements on measures of alcohol abuse, which were stable at 15-month follow-up. STPP was significantly superior to CBT in the number of abstinent days and in the improvement of general psychiatric symptoms.

**Effectiveness of psychoanalytic therapy in patients with complex psychiatric disorders: evidence from naturalistic studies**

As noted above, the method of RCT is not applicable to long-term psychodynamic therapy of several years or to psychoanalytic therapy. For these methods of treatment, effectiveness studies (naturalistic studies) are the appropriate method of research (e.g. Seligman, 1995; Wallerstein, 1999; Leichsenring, 2004; Westen et al., 2004). The NIMH in the USA has specifically called for more effectiveness research (Krupnick et al., 1996). With regard to the appropriateness of effectiveness studies as methods for testing whether a treatment works, the results presented by Shadish at al. (2000) are relevant. Shadish at al. did not find a significant correlation between the degree of clinical representativeness (e.g. RCTs vs. naturalistic studies) and the size of the effects reported in studies of psychotherapy. These results are consistent with those reported by Benson and Hartz (2000) and Concato et al. (2000) for the
realm of evidence-based medicine. Thus, the conclusion can be drawn that effectiveness studies do not systematically overestimate the effects of psychotherapy.

**Effect sizes of psychoanalytic therapy**

With regard to psychoanalytic therapy, several effectiveness studies, which used reliable and valid outcome measures, have provided evidence that psychoanalytic therapy is effective in the field of clinical practice. The magnitude of change achieved by a treatment can be assessed, for example, in the form of effect sizes. For example, the $d$ statistic proposed by Cohen (1988) gives the amount of change in units of standard deviations. According to a convention proposed by Cohen, an effect size of $d = 0.80$ can be regarded as a large effect. It corresponds to a change of 0.80 standard deviations (see also Kazis et al., 1989).

Large effect sizes ($\geq 0.80$) for psychoanalytic therapy were reported, for example, by the studies of Dührssen and Jorswieck (1965), Rudolf, Manz and Öri (1994), Luborsky et al. (1999), Sandell et al. (1999, 2000, 2001), Brockmann et al. (2001), Rudolf et al. (2004), and Leichsenring et al. (2005). These effect sizes refer to symptoms, interpersonal problems, social adjustment, in-patient days and other outcome criteria. In the study of Leuzinger-Bohleber et al. (2003), patients retrospectively reported significant improvements in well-being and other aspects of quality of life (e.g. self-esteem, relationship to others). Furthermore, the authors showed a significant reduction in both sick leave days and in medical consultations when comparing a period 1 year before treatment and 1 year after treatment (Beutel et al., 2004). In a re-evaluation of the Menninger Psychotherapy Research Project (Wallerstein, 1989), Blatt and Shahar (2004) addressed the question of the unique nature and effectiveness of psychoanalysis. According to their results, psychoanalysis contributed significantly to the development of adaptive interpersonal capacities and to the reduction of maladaptive interpersonal behaviour, especially with more self-reflective patients. Supportive-expressive therapy, by contrast, only yielded a reduction of maladaptive interpersonal behaviour and only with dependent, unreflective patients.

**Quasi-experimental studies of psychoanalytic therapy: Superiority to control groups**

The main argument against naturalistic studies refers to threats to internal validity, that is, to the reduced possibility of controlling factors influencing outcome apart from therapy. However, the internal validity of effectiveness studies can be improved by quasi-experimental designs (Shadish et al., 2002). By definition, quasi-experimental studies do not use random assignment; they use other principles to show that alternative explanations of the observed effect are implausible. These principles include:

a) the identification and study of plausible threats to internal validity;

b) the use of additional design elements (e.g. observation at more pre-test time points, additional comparison groups) or of statistical controls; and

c) coherent pattern matching, that is, prediction of complex patterns of results (e.g. of non-equivalent dependent variables or of interactions) (Shadish et al., 2002).
In the schemes grading levels of evidence that regard RCTs as the gold standard (CTFPHE, 1979; Cook et al., 1995; Guyatt et al., 1995; Chambless and Ollendick, 2001; Nathan and Gorman, 2002), quasi-experimental studies, or effectiveness studies in general, are regarded as providing level III or, at best, level II evidence.

However, as RCTs are regarded as the gold standard, these grading schemes refer to the question of whether a treatment works under controlled (experimental) conditions. They cannot be applied to the question of whether a treatment works under naturalistic conditions. For effectiveness studies, which by definition cannot use randomisation, levels of evidence must be defined by criteria different from those of efficacy studies. Recently, a proposal was made to define levels of evidence of effectiveness studies (Leichsenring, 2004). In analogy to the proposal made by Nathan and Gorman (2002), six levels of evidence were defined taking the methodological qualities of a naturalistic study into account (Leichsenring, 2004). According to this proposal, a level-I naturalistic study which provides highest-level evidence that a treatment works under the conditions of the field is a prospective quasi-experimental study of high clinical representativeness, characterised by nonrandom comparison groups, the matching or stratifying of groups, clear descriptions of treatments, patients and their selection, the use of reliable and valid diagnostic procedures and outcome measures, the use of additional design elements, coherent pattern matching, the reporting of drop-outs, pre- and post-assessments, follow-up studies, and the reporting of relevant statistical data. Clinical representativeness is achieved by the selection of patients, therapists and treatments that are typical for clinical practice (Shadish et al., 2000). Plausible threats to internal validity are excluded by the use of additional design elements (e.g. observation at more pre-test time points, additional comparison groups), statistical controls or coherent pattern matching, that is, prediction of complex patterns of results (e.g. of non-equivalent dependent variables or of interactions).

According to this proposal, the gold standard of naturalistic studies (effectiveness studies) is a prospective quasi-experimental study of high clinical representativeness that fulfils the aforementioned criteria. Lower-level naturalistic studies differ from high-level studies in one or more of these aspects (Leichsenring, 2004). In order to judge the effectiveness of a method of therapy (in a specific disorder) in clinical practice, the existing studies have to be rated with regard to their levels of evidence according to defined criteria. Furthermore, definitions must be given similar to those of the guidelines proposed by Chambless and Hollon (1998) concerning the number of studies regarded as necessary. For a treatment to be judged as ‘effective’ in clinical practice, at least two independent high-level studies may be regarded as necessary, to be judged as ‘probably effective’ one high-level study may be regarded as necessary.

The criteria of the TFPDPP (1995; Chambless and Hollon, 1998) require that a treatment has proved to be superior to a control condition (placebo, no treatment) or as effective as an already established treatment.

Several controlled quasi-experimental effectiveness studies of psychoanalytic therapy fulfil one or other of these criteria. These studies included control groups, for which comparability with the psychoanalytic treatment group was ensured by measures of matching, stratifying or statistical control. They represent high-level (level I) effectiveness studies according to the proposal made by Leichsenring (2004). We will now review these studies.
Dührssen and Jorswieck (1965) studied the number of days spent in hospital comparing the 5-year period before and after psychoanalytic therapy. They evaluated the data of a large health insurance company (Allgemeine Ortskrankenkasse, AOK).

From these data, the authors drew a random sample of patients ($N = 125$) who were treated with psychoanalytic therapy and compared them to a randomly drawn sample of patients who had received no psychoanalytic treatment ($N = 100$). According to the results, the patients treated with psychoanalytic therapy spent significantly fewer days in hospital compared to the sample of patients who had received no psychoanalytic treatment. The difference between the two groups corresponds to a large effect size ($d = 0.78$). Furthermore, Dührssen and Jorswieck (1965) showed that the random sample of patients treated with psychoanalytic therapy spent significantly fewer days in hospital than a randomly drawn sample of subjects of the general member population of the AOK health insurance company during a period of five years after the termination of therapy. Apparently, psychoanalytic therapy led to a reduction of costs in health services.

Rudolf et al. (1994) studied the outcome of psychoanalytic therapy, moderate-length psychodynamic therapy ($M = 60$ sessions) and psychodynamic in-patient treatment. The three treatment groups were comparable with regard to psychiatric diagnoses and the severity of the disorder. According to the data of the applied self-report instruments, 76% of the patients treated with psychoanalytic therapy fulfilled the criterion of clinically significant improvement compared to only 55% of the patients treated with psychodynamic therapy and 50% of the patients treated with psychodynamic in-patient treatment. In a recent study, Rudolf et al. (2004) replicated their earlier results finding psychoanalytic therapy to be significantly more effective than moderate-length psychodynamic therapy. This was true concerning the very dimension of outcome for which a superiority of psychoanalytic therapy is to be expected, that is, concerning structural changes of personality.

Sandell and co-workers (1999, 2000, 2001) studied the effects of psychoanalytic therapy and long-term psychodynamic therapy. Differences existing before therapy were controlled for statistically. With the same base conditions, psychoanalytic therapy achieved a large effect size of 1.55 concerning the reduction of symptoms. The corresponding effect size of long-term psychodynamic therapy ($M = 233$ sessions) was 0.60 (Sandell et al., 2001). The effects of psychoanalytic therapy increased during the first and the second year after termination of therapy by about one-third; on the contrary the effects of long-term psychodynamic therapy decreased slightly during this period (Sandell et al., 1999). Furthermore, the authors investigated how many patients fulfilled the criteria of clinical cases in the applied self-report instruments. Accordingly, three years after termination of therapy more than 70% of the patients who were treated with psychoanalytic therapy were no longer regarded as clinical cases, in the group of patients treated with psychodynamic therapy the corresponding percentage was 55%.

The results of these studies can be summarised as follows:

4 Evaluation by the author using the data published by Dührssen and Jorswieck (1965).

5 In two other instruments somewhat lower effect sizes were found for both psychoanalytic and psychodynamic therapy (Sense of Coherence Scale: 1.18 and 0.40; Social Adjustment Scale: 0.40 and 0.44).
a) Psychoanalytic therapy yielded effect sizes that significantly exceeded the effects of untreated or low-dose treated comparison groups (Dührssen and Jorswieck, 1965; Sandell et al., 1999).

b) There is evidence that psychoanalytic therapy is significantly more effective than shorter forms of psychodynamic psychotherapy (Rudolf et al., 1994, 2004; Sandell et al., 1999, 2001).

c) According to the study of Rudolf et al. (2004) psychoanalytic therapy was significantly more effective than shorter-term psychodynamic psychotherapy concerning the very dimension of outcome for which a superiority of psychoanalytic therapy is to be expected, that is concerning structural changes of personality.

d) These results refer to the treatment of patients with complex psychiatric disorders.

Ongoing controlled quasi-experimental studies of psychoanalytic therapy are being carried out by Huber et al. (2001), Knekt and Lindfors (2004) and Leichsenring et al. (2005).

**Process-outcome relationship: Mechanisms of change**

The RCTs presented above have focused on outcome, not on process variables of psychodynamic psychotherapy. However, studies of psychotherapeutic processes have provided data concerning mechanisms of change of psychodynamic therapy. First, there is evidence that outcome of STPP is related to psychotherapeutic techniques and therapist skilfulness (Crits-Christoph and Connolly, 1999; Messer, 2001): accuracy of interpretation (Crits-Christoph et al., 1988), adherence of therapists' interventions to the ‘plan’ (e.g. Messer et al., 1992), and competent delivery of expressive, but not of supportive techniques (Barber et al., 1996) predicted outcomes of STPP and of moderate-length psychodynamic psychotherapy. These findings suggest that specific techniques of psychodynamic psychotherapy, as contrasted to non-specific factors of psychotherapy, account for the outcome of psychodynamic psychotherapy (Crits-Christoph and Connolly, 1999). There is less evidence that frequency of psychodynamic techniques is related to outcome (Crits-Christoph and Connolly, 1999). Second, there is evidence for an interaction of technique, outcome and patient variables: frequency of transference interpretations seems to be associated with both poor outcome and alliance in STPP of patients rated low on quality of object relations (Hoglend and Piper, 1995; Connolly et al., 1999; Ogrodniczuk et al., 1999; Piper et al., 2001). Although patients with high quality of object relations may benefit from low to moderate levels of transference interpretations, results suggest that they do not benefit from high levels of transference interpretations (Piper et al., 1991a, 1991b; Connolly et al., 1999). Third, with regard to the common factor of therapeutic alliance, there is some evidence that alliance is a modest predictor of treatment outcome in STPP (Stiles et al., 1998; Crits-Christoph and Connolly, 1999; Barber et al., 2000; Messer, 2001). Accuracy of interpretation was found to correlate significantly with therapeutic alliance in treatments of moderate length (Crits-Christoph et al., 1993). Thus, one way in which accuracy of interpretation may exert its effect could be by fostering the therapeutic alliance (Crits-Christoph et al., 1993). Fourth, with regard to patient process variables, changes in the focus...
of psychodynamic psychotherapy were shown to correlate with symptom change. In the Crits-Christoph
and Luborsky study (1990), symptom change correlated with changes in the wish and response-of-self
component of the Core Conflictual Relationship Theme (CCRT). Thus, CCRT changes may mediate
changes in presenting symptoms in psychodynamic therapy. Piper et al. (2003) presented results that
suggest that expression of affect is a mediating variable of outcome in short-term interpretive group
therapy of patients with pathological grief. Fifth, with regard to patients' variables, the following
variables were found to predict good outcome of STPP: high motivation, realistic expectations,
circumscribed focus, high quality of object relations, absence of personality disorder (Hoglend, 1993;
Messer, 2001; Piper et al., 2001). Future research should address the question for which forms of
psychodynamic psychotherapy and for which forms of psychiatric disorders these associations hold, and
for which they do not. Barber et al. (2001), for example, did not find a correlation of alliance to outcome
of psychodynamic psychotherapy in the treatment of cocaine dependence.

Discussion

In the first part of this article, the available evidence for the efficacy of psychodynamic psychotherapy in
specific psychiatric disorders was reviewed. The criteria for empirically supported therapies proposed by
Chambless and Hollon (1998) were applied. Nevertheless, the limitations of the EST approach, which
were described above, should be kept in mind: RCTs can show nothing more and nothing less than that a
therapy works under controlled (experimental) conditions (Leichsenring, 2004). Effectiveness in the
field can only be studied by effectiveness studies. For the study of the active ingredients of
psychotherapy, process studies are required which link outcome to curative factors. Furthermore, for
psychodynamic and psychoanalytic psychotherapy, it is of interest to study changes beyond symptoms
and manifest behavior (Bond and Perry, 2004; Rudolf et al., 2004).

Under the requirements of ESTs, 22 studies were identified that provided evidence for the efficacy of
psychodynamic psychotherapy in specific psychiatric disorders. The relatively short duration of the
treatments (7 to 46 sessions) that were applied in these studies reflects the fact that the method of RCT is
not appropriate for long-term psychotherapy or psychoanalysis of several years. According to the 22
RCTs identified, there is at least one RCT demonstrating efficacy of various models of short-term to
moderate-length psychodynamic psychotherapy in the following psychiatric disorders: major depression
(4 RCTs), social phobia (1 RCT), post-traumatic stress disorder (1 RCT), somatoform disorder (4
RCTs), bulimia nervosa (3 RCTs), anorexia nervosa (2 RCTs), borderline personality disorder (2 RCTs),
Cluster C personality disorders (1 RCT) and substance-related disorders (4 RCTs).

According to the criteria proposed by the TFPDPP (1995), at least two studies of independent research
groups are required for a treatment to be regarded as efficacious (Chambless and Hollon, 1998).
However, it is required that the same method of therapy has been applied in these studies. In the studies
presented above, this is not

- 856 -

the case: there are no two studies of independent research groups in which the same form of STPP was
applied to the same psychiatric disorder. This is why STPP was judged as ‘probably efficacious’ by the
TFPDPP (1995). Although 14 of the 22 studies included in this review had not been included by the
TFPDPP report (1995), this judgement still seems to hold.6

However, it is important to take psychotherapy process research into account: the caveat of Ablon and
Jones (2002, p. 780)—‘Brand names of therapy can be misleading’—may also apply to psychodynamic
psychotherapy. Ablon and Jones (2002) recently compared CBT and interpersonal therapies (IPT) as they were applied in the NIMH treatment of depression study (e.g. Elkin et al., 1989). According to the results, therapists of both the CBT and IPT treatment adhered most strongly to the ideal prototype of CBT. In addition, adherence to the CBT prototype yielded more positive correlations with outcome measures across both types of treatment. With this finding in mind, it is no longer surprising that IPT and CBT were equally effective in the NIMH treatment of depression study. In an earlier study, Goldsamt et al. (1992) compared a demonstration session carried out by Beck, Meichenbaum and Strupp with the same patient. They found as many significant differences between Beck and Meichenbaum as between Meichenbaum and Strupp. Most differences were found between Beck and Strupp. Meichenbaum was somewhere between Beck and Strupp, and raters could not differentiate between Meichenbaum and Strupp, although they represent different therapeutic approaches, that is, CBT vs. psychodynamic therapy.

According to these results, the question of whether the ‘different’ models of psychodynamic psychotherapy differ among each other empirically is open to further research. This question cannot be answered by comparing the manuals with regard to the included interventions. Empirical studies of actual therapy sessions are required. In a review of empirical studies, Blagys and Hilsenroth (2000) identified seven features that were significantly more frequently observed in psychodynamic, psychodynamic-interpersonal or interpersonal psychotherapy than in CBT. However, their review did not address the question of whether different models of STPP differ among each other and from IPT. The features that were found to discriminate IPT from CBT were characteristic of STPP as well (see Tables 1-7 of Blagys and Hilsenroth, 2000, pp. 170-84). Comparing prototypical sessions of different (manual-guided) variants of psychodynamic psychotherapy empirically would be a very interesting and promising project of research. Other forms of therapy (e.g. IPT, CBT) should be included. For this kind of research, methods like that used by Ablon and Jones (2002) can be very useful. Studies addressing the problem of similarity or dissimilarity of

---

6 Although it is true that STPP may include ‘different’ models (e.g. according to Luborsky, or Horowitz), this applies to CBT as well. The forms of CBT applied in the studies that were accepted by the TFPDPP as providing empirical evidence for the efficacy of CBT in generalised anxiety disorder are similar, but also not identical to each other (see Chambless and Gillis, 1993, p. 249). Apparently, the question of heterogeneity or similarity is not only a problem of psychodynamic psychotherapy.

7 However, if two or more methods of therapy can be reliably discriminated or identified on the basis of these features is open to further research: Significant mean differences are a necessary, but not a sufficient condition for this purpose.

- 857 -

treatments are relevant for the question of whether (some of) the ‘different’ models of psychodynamic psychotherapy are empirically close enough to be lumped together. If this is the case, empirical evidence for one model of psychodynamic psychotherapy is valid for another model that has proved to be similar enough. However, adherence to a treatment manual can be achieved with considerable differences in the underlying interpersonal processes, and it is these processes that are related to outcome (Henry et al., 1990, 1993). Differences between therapists should also be studied. Crits-Christoph and Mintz (1991), for example, have shown that individual therapists applying the same form of therapy differed concerning their efficacy. Thus, in a second step the factors that may be identified to characterise specific forms of psychodynamic psychotherapy should be related to outcome. At present, an RCT is
being performed comparing psychodynamic psychotherapy (supportive-expressive therapy according to Luborsky, 1984) to CBT (according to Beck and Emery, 1985) in the treatment of generalised anxiety disorder (Leichsenring et al., 2002). In this study, the prototypical psychotherapeutic interventions and their relation to outcome are examined across models of therapy. Furthermore, changes in the core conflictual relationship theme (Luborsky, 1984) are studied both in CBT and supportive-expressive therapy, and their relation to outcome is examined.

As there is at least one RCT of a specific form of psychodynamic psychotherapy in the psychiatric disorders listed above, only one further study applying one of the already applied forms of psychodynamic psychotherapy demonstrating efficacy is required for the respective form of psychodynamic psychotherapy to be judged as efficacious in the treatment of the respective disorder. This applies, for example, to psychodynamic psychotherapy according to Horowitz (1976) or Shapiro and Firth (1985) in the treatment of (geriatric) depression, to Luborsky's (1984) supportive-expressive therapy in bulimia nervosa or opiate/cocaine dependence, or to Shapiro and Firth's (1985) interpersonal-psychodynamic therapy in the treatment of irritable bowel syndrome, functional dyspepsia or depression (see Table 1).

On the other hand, it is important to realise for which psychiatric disorders there is not even one RCT of psychodynamic psychotherapy. This is true for dissociative disorder or for some specific forms of personality disorders (e.g. compulsive, avoidant or narcissistic). Surprisingly, this is also true for some of the anxiety disorders, for example, for panic disorder (only one study of STPP combined with medication, Wiborg and Dahl, 1996). This is the more surprising as anxiety is one of the central concepts of psychoanalytic and psychodynamic theory and therapy (Zerbe, 1990). With regard to generalised anxiety disorder, the study of Durham et al. (1994) comparing STPP and CBT did not fulfil the inclusion criteria of this review (no manual for STPP). In that study, STPP and CBT were not equally carefully carried out (e.g. no specific training of therapists, no checks of adherence and competence for STPP). 8

8 In this study, STPP served as a kind of control group, as a ‘strawman’ as Smith et al. (1980, p. 119) put it: ‘A comparison therapy might be set up as a kind of strawman over which the favored therapy would prevail. The comparison therapy (often an ‘insight therapy’) would be treated with fairly obvious disdain and would be given not much opportunity for success’—the investigator allegiance effect (Smith et al., 1980; Luborsky et al., 1999).

With regard to the treatment of borderline personality disorder, an RCT comparing Transference-Focused Psychotherapy, Dialectical Behavior Therapy and supportive psychotherapy is presently being carried out (Clarkin et al., 2004). Winston et al. (1994) compared STPP and brief adaptive psychotherapy in the treatment of predominantly Cluster C personality disorders. Both forms of therapy were significantly superior to a waiting list control group concerning target problems, general psychiatric symptoms and social adjustment. No differences between the two forms of therapy were found. Results were maintained at follow-up after an average of 1.5 years. In another RCT of the same research group, STPP yielded significant improvements in target problems, general psychiatric symptoms and social adjustment, and was as effective as a specific form of supportive therapy, both at the end of therapy and at 6-month follow-up (Hellerstein et al., 1998). Again, predominantly patients with Cluster C personality disorders were treated, but patients with Cluster A (e.g. paranoid) and B (e.g. borderline) personality disorders were also included. The inclusion of patients with Cluster A and B personality disorders...
allows for a less unambiguous interpretation of the results. This applies to both the study of Winston et al. (1994) and the study of Hellerstein et al. (1998). However, it can be supposed that patients with Cluster A and B personality disorders have less favourable results. Thus the results of Winston et al. (1994) and Hellerstein et al. (1998) can be assumed to represent conservative estimates for the outcome of patients with Cluster C personality disorders. A separate evaluation of these studies for Cluster C personality disorders only could be helpful. It is questionable whether short-term therapies are appropriate for the treatment of (severe) personality disorders (Bateman and Fonagy, 2000). Perry et al. (1999) estimated the length of treatment necessary for patients to no longer meet the full criteria for a personality disorder (recovery). According to these estimates, 50% of patients with personality disorder would recover after 1.3 years or 92 sessions, and 75% after 2.2 years or about 216 sessions (Perry et al., 1999, p. 1318).

According to the results of this review, further research of psychodynamic psychotherapy in treating specific psychiatric disorders is necessary, including assessment of both outcome and active ingredients of psychodynamic psychotherapy in treating these disorders. Comparison across different models of psychodynamic psychotherapy and other forms of therapy, for example, CBT or IPT, should be included as well. Furthermore, the question should be addressed of how effective the methods of therapy, which have been proved to work in RCTs, are in the field (effectiveness studies). The NIMH in the USA has specifically called for more effectiveness research (Krupnick et al., 1996).

Psychotherapy has been shown to be a cost-effective treatment (Gabbard et al., 1997). This applies to psychodynamic psychotherapy and psychoanalytic therapy as well (Dührssen and Jorswieck, 1965; Gabbard, 1997; Guthrie et al., 1999; Burnand et al., 2002; Abbass, 2003; Creed et al., 2003; Beutel et al., 2004).

With regard to psychoanalytic therapy, controlled quasi-experimental effectiveness studies provided evidence that psychoanalytic therapy is (1) more effective than no treatment or treatment as usual, and (2) more effective than shorter forms of psychodynamic therapy. However, further quasi-experimental controlled effectiveness studies of psychoanalytic therapy are necessary.

References


- 862 -


- 866 -


