# **Clinical Updates in Psychotherapy: Psychodynamic Psychotherapy**

Dr Jeffrey Streimer**,** RANZCP Director of NSW Advanced Training in the Psychotherapies**;** Principal of the Amaranth Psychotherapy Centre; Clinical Senior Lecturer University of Sydney; Co-ordinator Consultation-Liaison Psychiatry ServiceRoyal North Shore Hospital, St Leonards, NSW 2065

A/Professor Loyola McLean, Associate Professor Course Coordinator, Brain and Mind Centre, University of Sydney; Psychotherapy Educator and Coordinator, Sydney West and Greater Southern Psychiatry Network, WSLHD; HMO Research Psychiatrist, Consultation and Liaison Psychiatry, Royal North Shore Hospital, ST LEONARDS, NSW 2065

**CLINICAL UPDATES IN PSYCHOTHERAPY:**

**PSYCHODYNAMIC PSYCHOTHERAPY**

**ABSTRACT**

**OBJECTIVES:** This brief update of the evidence base in dynamic psychotherapy, aims to correct the still prevalent negative bias that psychotherapies remain either untested or less effective than other treatment approaches. This article focuses on short and long-term psycho-dynamically oriented approaches (including psychoanalysis).

**CONCLUSIONS:** Overall studies demonstrate that psychodynamic psychotherapy is more effective than placebo, likely more effective than antidepressants and at least as effective as CBT in indicated conditions. Psychodynamic psychotherapies (PDT) are included among 13 separate evidence-based psychotherapy treatments for depression, five treatments for various anxiety disorders, and four treatments for borderline personality disorder.

**A. INTRODUCTION**

This is one of a series of brief updates of the evidence base in psychotherapy, aiming to correct the still prevalent negative bias that psychotherapies remain either untested or are less effective than other treatment approaches. This article focuses on short and long-term psycho-dynamically oriented approaches (including psychoanalysis).

Psychodynamic psychotherapies (PDT) is an umbrella concept for treatments that operate on a supportive- interpretive continuum, in a variety of models that acknowledge the importance of unconscious and developmental experiences in shaping coping style. They aim to address relevant precipitating, predisposing, and perpetuating factors in a patient’s presentation through active and reflective use of the therapeutic relationship. For a summary of common elements across models see Shedler (1). They have re-emerged as effective first-line treatments with a growing evidence base, demonstrating ongoing long-term effects that compare favorably with both psychopharmacological and other psychological modalities (1, 2). Further there is an extensive literature demonstrating PDT’s cost effectiveness, particularly due to enduring outcomes (3). They are particularly useful for the group of patients with chronic, severe and complex illness that psychiatrists often see.

Overall, the effect sizes from meta-analytic studies demonstrate that psychodynamic

psychotherapy is more effective than placebo, likely more effective than antidepressants and at least as effective as CBT in indicated conditions. PDTs are included among 13 separate psychotherapy treatments for depression, five treatments for various anxiety disorders, and four treatments for borderline personality disorder (4,5)

**B. INDICATIONS**

PTD is indicated for a wide variety of diagnostic conditions and can presently be designated as efficacious in major depressive disorder (MDD), borderline and heterogeneous personality disorders, somatoform pain disorder, social anxiety disorder and anorexia nervosa. PDT can be considered as possibly efficacious in dysthymia, complicated grief, panic disorder, generalized anxiety disorder and substance abuse/dependence.

* Personality disorders:

Personality Disorders respond to PDT. They are a major treatment challenge and complicate the treatment outcomes of depression, anxiety and other disorders.

* Depression:

The evidence now suggests that PDT is equally effective as CBT for depression. The majority of depressed patients have comorbidity which both excludes them from RCT trials and which contributes to high rates of treatment failure, lower rates of treatment response and lower rates of remission compared with patients who did not have such comorbidity (6).

* Anxiety disorders:

Overall, the evidence is positive for the effectiveness of PDT for a range of anxiety disorders as indicated by recent large meta-analysis including 14 RCTs (7).

* Other conditions:

Eating disorders, substance abuse, marital discord and somatic symptom disorders also have demonstrated response to PDT (5). Evidence at the highest levels is presently lacking for obsessive-compulsive, posttraumatic stress disorders of the more discrete variety (versus chronic complex trauma), bipolar and schizophrenia spectrum disorders (8).

**C. OUTCOMES**.

* **HETEROGENEOUS PERSONALITY DISORDERS**

The evidence robustly supports psychotherapy for heterogeneous personality disorders (9,10). PDT demonstrates stronger long-term effectiveness with large effect sizes and greater enduring benefits than effective structured psychotherapy alternatives.

* **BORDERLINE PERSONALITY DISORDER (BPD)**

Four psychodynamic treatments for BPD now have significant empirical support (5):

* + Transference Focused Psychotherapy (TFP)
  + Mentalization Based Therapy (MBT)
  + Deconstructive Dynamic Psychotherapy (DDP) and
  + The Conversational Model (CM)

The first three have demonstrated efficacy in RCTs while CM’s efficacy has been demonstrated when compared with a treatment as usual (TAU) waitlist. A current RCT of CM therapy versus DBT is underway in the Hunter area (Trial ID ACTRN12612001187831). TFP, a modification of object relations based psychodynamic therapy has accumulating evidence for effectiveness and efficacy. TFP effect sizes are large and equal to those demonstrated by other BPD treatments. Further TFP improves reflective function and attachment security, underlying psychological processes that mediate lasting and ongoing positive adjustment. CM’s results demonstrate strong real world validity, importantly maintained at five-year follow-up.

* **DEPRESSION**:

Recent studies have shown that psychodynamic treatment of depression is as effective as other modalities (5,11).   
In the largest RCT of psychotherapy for depression to date (12), patients randomized to either short-term psychodynamic psychotherapy (STPP) or CBT found both treatments equally effective.

Effect sizes for psychodynamic psychotherapy are large (between

0.90 and 2.80) with the average depressed patient treated in psychodynamic

psychotherapy better off than 82% to 100% of depressed patients before therapy. This compares with low effect sizes (between 0.24 - 0.31) for antidepressants (13). Long-term psychoanylaitc psychotherapy (LTPP) for treatment resistant/treatment refractory depression has been shown to have effects that continue to improve outcome well beyond the end of the therapy (14)

* **ANXIETY**

Overall, the evidence is positive for the effectiveness of PDT for a range of anxiety disorders (7). Results show PDT’s efficacy in anxiety disorders with similar effect sizes and, in some studies, a lower dropout rate than typical in CBT.

* Importantly a PDT for panic that explores panic determinants, like unacknowledged anger and conflicts over autonomy and dependence (15) is particularly useful with comorbid personality disorder, since reviews suggest that anxiety complicated by personality disorders shows less benefits with standard CBT (16).
* For generalized anxiety disorder no differences were found between short-term psychodynamic psychotherapy and CBT (17).
* Regarding social phobia, a large multicenter RCT comparing STPP with CBT found both treatments to be equally effective (18).

**D) CLINICAL PRACTICE**

* Overall psychodynamic psychotherapy appears to be as effective as other psychological treatments, often more effective than antidepressants and sometimes more effective than other psychotherapies particularly when personality factors are obvious comorbidities.
* Despite mounting evidence for PDT as a first-line treatment, it is often omitted or reserved for tertiary referral.
* In direct opposition to studies that report clear preference for psychotherapy by many over medications, there has been a decrease in the number of outpatients receiving psychotherapy and an increase in the number receiving medication despite limited

evidentiary support (5).

* The most severely ill patients need intensive (more than once weekly) and extended (more than 20 sessions) psychotherapy treatment, being those with chronic, complex disorders like severe longstanding depression and anxiety, significant personality disorders as well as multiple chronic psychiatric disorders. Personality disorders, especially BPD robustly predict the persistence of major depressive disorder and anxiety suggesting that treatment of personality disorders is essential in these patients. Several reasons suggest the clinical value of longer-term and more intensive psychodynamic treatments:
  + Long-term outcome and relapse rates strongly suggest the need for more intensive treatments addressing predisposing personality or coping style.
  + An established literature shows that short-term psychotherapy ameliorates symptoms but does not produce changes in personality and functioning.
* Meta-analyses have found large effects for longer-term treatments.
* Finally the established superiority for longer-term as compared to short-term PDT.
* There is strong evidence that adding psychodynamic psychotherapy usefully augments pharmacological treatment of a range of disorders. Moreover, good psychotherapeutic skills aid in the effective administration of medication. Although common practice, data are unclear whether medication augmentation of psychotherapy is useful (5).

**E) DISCUSSION:**

In Australia, psychological treatment particularly psychodynamic psychotherapy by psychiatrists has followed US trends and diverged from United Kingdom and other European approaches. It has awaited revival after a generational decline. This no doubt reflects many factors including increasing medicalization and unbalanced promotion of psychopharmacology, relatively slow emergence of supportive evidence for PDT, an emphasis on short-term approaches and short-term evaluation despite short-lived effectiveness and fiscal imperatives promoting psychiatrist’ provision of assessment over effective treatment. These factors have distorted and limited psychotherapy educational opportunities, depriving many psychiatrists of vital tools and knowledge. Supporting a strong revival of interest among recently graduating psychiatrists, the series of articles, of which this is one will hopefully begin to rebalance our bio-psycho-socio-cultural management towards a more holistic approach.

**REFERENCES**

1. Shedler, J. (2010) The efficacy of psychodynamic psychotherapy. American Psychologist,

65(2), 98-109.

2. Shedler, J. (2015) Where is the Evidence for “Evidence-Based” Therapy? Journal of Psychological Therapies in Primary Care, 4 (5), 47–59.

3. Lazar, S. (2014) The Cost-Effectiveness of Psychotherapy for the

Major Psychiatric Diagnoses. Psychodynamic Psychiatry, 42(3), 423–458.

4. Susan G. Lazar and Frank E. Yeomans. (2014). Introduction to the Special Issue

on Psychotherapy, the Affordable Care Act, and Mental Health Parity:Obstacles to Implementation. Psychodynamic Psychiatry, 42(3) 347–352.

5. Levy, K.N.,. Ehrenthal, J.C., Yeomans, F.E. and Caligor, E. (2014).The Efficacy of Psychotherapy: Focus on Psychodynamic Psychotherapy as an Example. Psychodynamic Psychiatry, 42(3) 377–422.

6. Wisniewski, S.R., Rush, A.J., Nierenberg, A.A., Gaynes, B.N., Warden, D., Luther,

J. F. et al. (2009). Can phase III trial results of antidepressant medications

be generalized to clinical practice? A STAR\*D report. The American Journal of

Psychiatry, 166(5), 599-607.

7. Keefe, J. R., McCarthy, K. S., Dinger, U., Zilcha-Mano, S., & Barber, J. P. (2014). A

meta-analytic review of psychodynamic therapies for anxiety disorders. Clinical

Psychology Review, 34(4), 309-323.

8. Leichsenring, F., [Klein, S](http://www.ncbi.nlm.nih.gov/pubmed/?term=Klein%20S%5BAuthor%5D&cauthor=true&cauthor_uid=25833321). and [Steinert, C](http://www.ncbi.nlm.nih.gov/pubmed/?term=Steinert%20C%5BAuthor%5D&cauthor=true&cauthor_uid=25833321). (2015) The empirical status of psychodynamic psychotherapy - an update. Psychotherapy Psychosomatics. 84(3)129-48.

9. Budge, S. L., Moore, J. T., Del Re, A. C., Wampold, B. E., Baardseth, T. P., & Nienhuis,

J. B. (2013). The effectiveness of evidence-based treatments for personality

disorders when comparing treatment-as-usual and bona fide treatments. Clinical

Psychology Review, 33(8), 1057-1066.

10. Leichsenring, F., & Leibing, E. (2003). The effectiveness of psychodynamic therapy

and cognitive behavior therapy in the treatment of personality disorders: A

meta-analysis. American Journal of Psychiatry, 160(7), 1223-1232.

11. Thase, M. E. (2013). Comparative effectiveness of psychodynamic psychotherapy

and cognitive-behavioral therapy: It’s about time, and what’s next? American

Journal of Psychiatry, 170, 953-956.

12. Driessen, E., Van, H. L., Don, F. J., Peen, J., Kool, S., Westra, D., et al. (2013). The

efficacy of cognitive-behavioral therapy and psychodynamic therapy in the

outpatient treatment of major depression: A randomized clinical trial.

American Journal of Psychiatry, 170, 1041-1050.

13. Turner, E. H., Matthews, A. M., Linardatos, E., Tell, R. A., & Rosenthal, R. (2008).

Selective publication of antidepressant trials and its influence on apparent

efficacy. New England Journal of Medicine, 358, 252-260.

14. Fonagy, P., Rost, F., Carlyle, J-A., McPherson, S., Thomas, R.,& Taylor, D. (2015). Pragmatic randomized controlled trial of long-term psychoanalytic psychotherapy for treatment-resistant depression: the Tavistock Adult Depression Study. World Psychiatry 14(3), 312–321.

15. Milrod, B. L., Leon, A. C., Barber, J. P., Markowitz, J. C., & Graf, E. (2007). Do comorbid

personality disorders moderate panic-focused psychotherapy?: An exploratory examination of American Psychiatric Association practice guideline. Journal of Clin Psychiatry, 68(6), 885-891.

16. Mennin, D. S., & Heimberg, R. G. (2000). The impact of comorbid mood and personality

disorders in the cognitive-behavioral treatment of panic disorder. Clinical Psychology Review, 20(3), 339-357.

17. Salzer, S., Winkelbach, C., Leweke, F., Leibing, E., & Leichsenring, F. (2011). Longterm

effects of short-term psychodynamic psychotherapy and cognitive-behavioral

therapy in generalized anxiety disorder: 12-month follow-up. Canadian

Journal of Psychiatry, 56, 503-508.

18. Leichsenring, F. (2013). Psychodynamic therapy and cognitive therapy in social phobia—Results from the Social Phobia Psychotherapy Research Network. Paper - 44th International Annual Meeting of Society for Psychotherapy Research (SPR), Brisbane, Australia.

.