**ADVANCED TRAINEES IN PSYCHOTHERAPY**

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**CLINICAL GUIDELINES IN PSYCHOTHERAPY:**

**PSYCHODYNAMIC PSYCHOTHERAPY**

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**A.) INTRODUCTION**

This is the first in a series of clinical guidelines in psychotherapy which aim to correct the pronounced negative bias that psychotherapies remain either untested or are less effective than other treatment approaches. This first article focuses on short and long-term psycho-dynamically oriented approaches (including psychoanalysis).

Psychodynamic psychotherapies (PDT) is an umbrella concept for frequently used treatments that operate on an supportive- interpretive continuum. 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 useful for the type of patients with chronic, severe and complex illness that psychiatrists often see.

Overall, the effect sizes from meta-analytic studies suggest 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 is presently lacking for obsessive-compulsive, posttraumatic stress, 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.

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).

* **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 (14) is particularly useful with comorbid personality disorder, since reviews suggest that anxiety complicated by personality disorders shows less benefits with standard CBT(15).
* For generalized anxiety disorder no differences were found between short-term psychodynamic psychotherapy and CBT (16).
* Regarding social phobia, a large multicenter RCT comparing STPP with CBT found both treatments to be equally effective (17).

**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.
	+ 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 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 awaits 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 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, this series of articles will hopefully begin to rebalance our bio-psycho-socio-cultural approach.

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