

The outcome of psychodynamic psychotherapy for psychological disorders

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Abstract

Notwithstanding a history of over 100 years, psychoanalytically informed psychological therapies have a poor evidence base. This paper provides a selective review of trials of brief psychodynamic psychotherapies and an overview of mostly follow-up or follow-along studies of long-term more intensive psychoanalytic therapy. In relation to the treatment of mood disorders, particularly depression, anorexia nervosa and some personality disorders, there is evidence to suggest that brief psychodynamic psychotherapy is comparable in effectiveness to empirically supported treatments. No trial has shown it to be superior to alternative treatment. Notwithstanding the small number of studies, independent replications of the same version of short-term therapy are totally lacking. This survey of the literature underscores the urgent need for innovative therapeutic interventions based on psychoanalytic models of mental functioning which are specific to the clinical problems they aim to address.

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Keywords: Psychoanalysis; Psychodynamic psychotherapy; Outcome; Empirically supported therapy

1. Introduction

This review is based on exhaustive reviews of the psychotherapy outcomes literature, undertaken originally at the instigation of the UK Department of Health by Roth and Fonagy [1] and recently updated [2] to identify all studies of psychoanalytic psychotherapy. The usual methods for identifying studies were employed, enabling us to identify all studies of psychoanalytic psychotherapy (see [2,3]). The key questions that should be asked of this literature given the current state of research in this area (also see [4]) are: (1) are there any disorders for which short-term psychodynamic psychotherapy (STPP) can be considered evidence-based; (2) are there any disorders for which STPP is uniquely effective as either the only evidence based treatment or as a treatment that is more effective than alternatives, and (3) is

there any evidence base for long-term psychodynamic psychotherapy (LTPP) either in terms of achieving effects not normally associated with short-term treatment or addressing problems which have not been addressed by STPP? In this context, short-term therapy is conceived of as a treatment of around 20 sessions delivered usually once weekly.

From the standpoint of psychodynamic psychotherapy, the database of research studies has significant limitations. Westen and colleagues [4] recently offered a powerful critique of the research methods used to assign the status of ‘empirically supported or unsupported therapies’. Research that is considered empirically supported tends to have three characteristics: (1) studies address a single disorder (usually Axis I) with diagnostic assessments to ensure homogeneity of samples, (2) treatments are manualised and are of brief and fixed duration to ensure the integrity of the ‘experimental manipulation’, and (3) outcome assessments focus on the symptom(s) that represent the declared priority of the study (and often the intervention). The underlying aim is the maximisation of internal validity by random

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assignment, controlling confounding variables, and standardising procedures. Westen et al. [4] identify four poorly supported assumptions underpinning the application of randomised controlled trial (RCT) methodology to psychotherapy research: (1) that psychopathology is so malleable that a brief intervention is likely to change it permanently, (2) that most patients can be treated for a single disorder or problem, (3) that psychiatric disorders can be treated with psychosocial interventions without regard to personality factors that are less likely to change with brief treatments, (4) that experimental methods provide a helpful ‘gold standard’ for evaluating these packages. In reality, most forms of psychopathology encountered in specialist centres are treatment resistant (e.g. [5]) and comorbid with other disorders (e.g. [6]) which need to be tackled in the broader context of the patient’s personality structure (e.g. [7]) and experimental methods need to be supplemented by correlational analyses to ascertain the effective components of treatment [8].

2. Major depression

About 20 psychodynamic psychotherapy trials have been published dealing with the treatment of depressive and anxiety disorders or symptoms [9,10]. Along with other therapies, it has been shown to have better effectiveness in open trials or compared to waiting list [11] or outpatient treatment in general [12]. In the light of relatively readily available alternative treatments, the critical demonstrations concern that of an equivalence, or perhaps even superiority, to alternative treatment approaches.

There have been two recent relevant reviews of the literature [10,13]. In addition, the National (England and Wales) Institute for Clinical Excellence (NICE) is conducting a systematic review in order to produce guidelines for treatment of depression within the National Health Service. The Churchill review concerned treatments for depression of 20 sessions or less published up to 1998. Of the studies suitable to include in meta-analysis six involved psychodynamic therapy. Improvement was found to be over twice as likely with CBT as it was with psychodynamic therapy. However, to conclude from this that CBT is superior to psychoanalytic psychotherapy in the treatment of depression may be premature in the light of the following considerations. (1) There was no superiority of CBT over other therapies where follow-up was available. (2) Differences between CBT and other therapies were limited in severely depressed groups. (3) A number of therapies identified in the review as ‘psychodynamic’ were not ‘bona fide’ therapies [14]. In an earlier meta-analysis by Gloaguen et al. [15] which similarly concluded that CBT was superior to other therapies, the superiority of CBT could no longer be demonstrated once interventions without scientific base were removed from the comparisons [16].

A more positive picture apparently emerges from the review by Leichsenring [10]. This review identified six RCTs that contrasted manualised STPP and CBT [17–24]. The review concludes that the two forms of therapy are not substantially different as only one of the studies reviewed suggests a possible superiority of CBT. A meta-analytic comparison of follow-up data available for these studies actually reveals a slight superiority for CBT (RR=0.82, 95% CI: 0.70, 0.96; $z=2.52$, $P=0.01$).

We should consider the possibility of selection bias in this review. Leichsenring includes the NIMH Collaborative Depression Trial in the meta-analysis, which is, to say the least controversial, as IPT was included as an STPP merely because the therapist was psychodynamically trained [18,23]. As neither the developers nor other reviewers consider IPT to be a psychodynamic therapy, it seems wiser not to include it in reviews of STPP. Even if this study is excluded, the superiority for CBT over STPP remains. However, the remaining four studies include a trial of social skills training relative to STPP [20] and a study of CBT offered to carers [19] neither of which seem relevant to the assessment of the relative effects of CBT for depression. Of the two studies remaining, one was group rather than individual therapy carried out with an older adult population [24]. The most appropriate conclusion at this stage might be that a meta-analysis of this literature is premature.

The current evidence base of psychodynamic therapy for depression is weak relative to the number of psychoanalytic therapists and the rate at which evidence is accumulating for other approaches. The psychodynamic approach may be marginalised, not by its relative lack of effectiveness, but by the sparseness of compelling demonstrations of its comparability to ‘empirically supported’ alternatives. There is some evidence relating to brief psychodynamic therapy (up to 24 sessions) [21,22,25–29] but no evidence for long-term therapy or psychoanalysis, despite the fact that data from trials of depression indicate the need for more intensive treatment [30]. However, none of the therapies appear to differ from each other markedly. In the two cases where brief psychodynamic therapy was compared with CBT or problem solving therapy [21,26], the observed size of the effects were similar in the groups contrasted and in turn similar to results reported in other studies of CBT, IPT, couples therapy [2].

An appropriate future strategy for psychodynamic psychotherapy research on depression might be to compare the effectiveness of relatively long-term psychodynamic psychotherapy with alternative forms of intervention in patients who are non-responders in trials of CBT, IPT or pharmacotherapy.

3. Anxiety disorders

Research on anxiety disorders is normally subdivided into research on phobia, generalised anxiety disorder, panic disorder (with and without agoraphobia), PTSD and OCD.

These, often co-morbid with depression [31], are the most commonly encountered disorders either in community surveys or in primary mental health services. Anxiety disorders are central to psychoanalytic theory [32] and are probably the most common presenting complaints in psychodynamic therapeutic practice. Disappointingly, for at least two of the most common anxiety problems (social phobias and specific phobias) there are no diagnosis-specific controlled trials of psychodynamic therapy. The field is dominated by CBT packages that combine a range of approaches with almost no studies of non-behavioural approaches except for a small trial of interpersonal therapy [33].

Anxiety treatment research represents the ‘home base’ of cognitive behavioural approaches. GAD represents its most significant challenge. The superiority of CBT over other approaches is probably limited, as shown by reduced effect sizes in controlled trials that have active placebo treatments [34]. The challenge for a psychodynamic approach is to identify a way to address limitations in CBT, either in terms of long-term efficacy [35] or a more pervasive impact on social functioning. Interestingly, evidence from the Helsinki trial [26], where this was a focus of investigation, did not support the view that short-term psychodynamic therapy had a wider impact on social functioning than problem-focused treatments [27–29]. Evidence on the treatment of PTSD is also sparse. Available controlled studies concern complicated grief and bereavement reactions, and not exposure to trauma [36–39]. Nonetheless, findings from such trials are generally positive although by no means showing STPP to be uniquely effective.

It is striking that little research has been done to establish the pertinence of psychodynamic approaches to anxiety, which is so central to both psychoanalytic theory and practice. Possibly psychodynamic therapists do not consider anxiety symptoms important enough as Freud’s term ‘signal anxiety’ might suggest. It requires an approach such as Barbara Milrod’s, which retains focus on the symptom at the same time as exploring unconscious determinants, to achieve rapid change. The importance of anxiety-related problems demand that further studies should be initiated.

4. Eating disorders

There have been four trials of psychodynamic psychotherapy for anorexia nervosa (AN) [40–43] all of which found it to be as effective as other treatments, including intensive behavioural and strategic family therapy. None of the trials were powered adequately to distinguish conclusively between alternative treatments. Taking the results together it seems that relative to TAU, psychodynamic therapy for AN holds its own. The trials were performed in two London specialist units, but the particular brands of psychoanalytic psychotherapy practised were not comparable, so they cannot be considered replications.

STPP fares less well in the treatment of bulimia. One trial indicated that STPP was somewhat less effective than CBT [44], while in another study the superiority of STPP is based on a tiny sample size and an unusual implementation of cognitive therapy [45]. In a trial exploring combined pharmacological and psychosocial treatments [46], non-specific supportive STPP turned out to be less effective than CBT in enhancing the effect of medication.

Overall, as in other contexts, when STPP is modified for a specific clinical problem it is far more likely to be effective. It is comparable to a similarly refined cognitive behavioural approach. As a generic supportive treatment it is unlikely to be an appropriate recommendation for any of the eating disorders considered, but as a specific approach it is perhaps more likely to be of benefit.

5. Substance misuse

For alcohol problems of low severity brief interventions seem to be the interventions of choice [47,48]. Psychodynamic psychotherapy along with other formal psychological therapies appears not to be particularly helpful when offered as a stand-alone treatment. On the whole, successful interventions appear to be targeted at drinking behaviour and testable psychodynamic protocols of this kind have not yet been developed.

Again, for low levels of cocaine dependency, briefer treatments appear to be appropriate [49]. But for individuals with more severe problems, both engaging with treatment and maintaining commitment to formal psychotherapy appears problematic [50]. Supportive expressive psychotherapy appears of almost no value in the context of cocaine misuse [51–53]. In fact treatments that do not engage with clients in the community context appear to be of limited relevance [2]. It is an obvious question if STPP could be modified to incorporate community involvement.

A different picture emerges in the context of opiate abuse where psychodynamic treatment was shown to be efficacious in two trials [54–57], unfortunately (from the standpoint of EST criteria) carried out by the same team. However, in this context, there is a *prima facie* case for the unique effectiveness of supportive expressive therapy as neither IPT [58] nor certain cognitive therapies [59,60] appear to have quite the same impact. Nevertheless, generic counselling or certain types of family based interventions may enhance the effectiveness of methadone treatment just as STPP appears to. In this area there is urgent need for replication by an independent group of workers willing to implement the supportive-expressive therapeutic strategy.

If a place is to be found for psychodynamic psychotherapy in substance abuse protocols it is unlikely to be in offering formal therapy as a primary treatment. Rather, taking the lead from the opiate work, a niche needs to be found where psychodynamic intervention provides appropriate support for what is ultimately a physical dependency

requiring physical treatment. There is urgent need to identify protocols that sequence traditional forms of psychosocial treatments with interventions for physical dependence within a single integrated package.

6. Personality disorders

Personality disorders represent a special challenge for outcomes research because of the high level of comorbidity between Axes I and II diagnoses and within Axis II diagnoses [61,62]. Treatment research is somewhat limited, powerfully enhanced by recent activity in new approaches to cognitive behavioural therapy [63–65] as well as psychodynamic [66–69] treatments.

There have been two meta-analyses of psychological therapies. Perry and colleagues [70] identified 15 studies, including six randomised trials. Substantial effect sizes were identified pre- to post-treatment (E.S.=1.1–1.3) which reduced to around 0.7 in studies where active control treatments were used. A more focused meta-analysis [71] considered only trials which used either CBT or psychodynamic therapy and identified 22 studies, 11 of which were RCTs. Pre–post effect size for psychodynamic therapy was 1.31 based on eight studies and for CBT was 0.95 based on four studies. There was an insignificant correlation between treatment length and outcome.

The limited number of studies, compounded by heterogeneity of clinical populations and methods applied, suggests that meta-analysis at this stage may be premature. Further, many of the studies included in these meta-analyses did not have the aim of treating Axis II disorders. Notwithstanding these limitations, the broad conclusion from these aggregated figures would be that CBT and psychodynamic therapy are equally effective.

6.1. Borderline PD

There are more studies of borderline personality disorder than of other PDs. There have been a number of uncontrolled open trials of the psychodynamic treatment of borderline personality disorder. The Menninger Study of 42 patients carried out in the 1950s [72,73] was a study of psychoanalysis and expressive or supportive psychodynamic psychotherapy. The study's findings are complex but broadly imply that more mature personalities with better interpersonal relationships responded well to expressive interpretive therapy, whereas those with low ego strength responded better to supportive interventions. There have been a number of other naturalistic studies [74–79]. These studies with varied sample sizes speak to the relative efficacy of various forms of psychodynamic therapy but had too little in common in terms of treatment protocols to permit conclusions concerning the effectiveness of this approach.

An Australian uncontrolled trial stands out in terms of methodological rigour [80–82]. In this open trial 48 patients

received twice weekly interpersonal self-psychological psychodynamic outpatient therapy over 12 months. The contrast was with patients on a waiting list for 12 months. Unfortunately, allocation was not random and severity in the waiting list group was slightly less. Thirty percent of the treatment group no longer met criteria for BPD at the end of 1 year. There was little indication of change in the control group. However, intent to treat calculations would only estimate a 19% remission rate, which is comparable with the spontaneous change in follow-along studies. A waiting list control group is problematic and sometimes referred to as a 'nocebo' group as the implicit contingencies of being on a waiting list imply no change.

A further large scale uncontrolled trial of psychodynamic psychotherapy is worth singling out. Dolan and colleagues [83] reported on the outcome of a therapeutic community run on strictly democratic principles. Of 598 patients referred, 239 were admitted and 137 (23%) returned assessment questionnaires at 1-year follow-up. About equal numbers of admitted and non-admitted patients returned the questionnaires, about 80% of whom met diagnostic criteria for BPD. Clinically significant change on self-reported borderline symptomatology was seen in 43% of the treated and 18% of the untreated patients (30 versus 12). Length of stay was associated with improvement. The comparison group places profound limitations on the study, not just because of the absence of randomisation and the varied reasons for being in the no treatment group, but also because the pre–post time period covered in the treatment group was significantly longer (19 versus 12 months). Nevertheless, the study provides data concerning the likely change to be observed in a specialist but routine service context.

The Cornell group [67] reported the outcomes of 23 female patients treated in transference focused psychotherapy. The trial which was a pilot for the Personality Disorders Institute Borderline Personality Disorder Research Foundation RCT [68] was a carefully conducted follow-along study of 23 female patients. After 1 year of treatment suicidal behaviour substantially decreased and the pre–post comparison of inpatient days suggested significant cost savings.

Gabbard and colleagues [84] reported a prospective, naturalistic study of consecutive patients admitted to the Menninger Hospital. Only 35% of the 216 completed in the sample were diagnosed with BPD. About half the patients had mixed PD or PD NOS. An important feature of the study was the telephone follow-up at 1 year. GAF scores increased: only 3.7% had GAF scores above 50 on admission, which increased to 55% at discharge and 66% at follow-up. Other measures reflected a similar pattern. The study suggests that inpatient treatment can initiate improvement even in relatively severely dysfunctional patients. But the absence of a comparison group and the unknown selection bias introduced by limited participation reduces the generalisability of the data. Further the treatment package offered, whilst relatively consistent across patients,

was not monitored in relation to each discipline. Given the wide diversity of length of stay it is hard to link progress to psychotherapeutic experience.

Chiesa and colleagues [85–88] reported a further controlled but not randomised trial of inpatient psychodynamic treatment. Two forms of hospital-based treatment were contrasted with a general community based psychiatric treatment model. In the first protocol, patients were admitted for approximately 12 months with no aftercare. In the second, patients were admitted for only six months but this was followed by 12 months outpatient therapy with community support. The third arm received community psychiatric care (medication and brief hospital admissions as necessary). Two hundred and ten patients with at least one diagnosis of PD were allocated according to geographical criteria into the three groups. Outcome was evaluated at 6, 12 and 24 months on self-harm and suicide attempts, and self-reports of symptom severity and social adaptation. At 24 months only the phased or step-down condition showed improvements, while patients in the long-term residential model showed no improvements in self-harm, attempted suicide and number of readmissions. There were significant reductions in symptom severity, improvements in social adaptation and global functioning. Patients in the general psychiatric group showed no improvement in these variables, except for self-harm. Forty-seven percent of the inpatient group and 73 and 71% of the step-down and general psychiatric group, respectively, reported no self-harm in the previous 12 months. At 24 months more of the inpatient group had hospital admissions in the previous 12 months (49% for inpatient group compared to 11% for step-down and 33% for the general psychiatric care group). Thus in terms of clinical outcome the general psychiatric treatment group were somewhat inferior to the step-down group and superior to the inpatient group. The findings indicate that long-term inpatient therapy may be iatrogenic and may undermine some of the effective components of a treatment mode which results in substantial positive outcomes in more moderate doses. Only about 10–12% of the general psychiatric group showed clinically significant change in symptomatology and social adjustment compared to over half of the step-down group and only about a quarter of the inpatient group.

Bateman and Fonagy [89–91] reported on a study of 38 patients assigned to specialist partial hospitalisation or to routine care. Over 18 months, partial hospitalisation showed significant gains over controls on measures of suicidality, self-harm and inpatient stay. These became apparent at 6–12 months of treatment and increased over time. Follow-up at 18 months, which included an intent to treat analysis, demonstrated that not only did patients in the programme maintain their gains but further improvements were observed. At the end of treatment 84% of the treatment as usual and 36% of the partial hospital patients had showed self-harming behaviours in the previous 6 months. At 36 months 58% of the controls and 8% of the partial hospital

patients had self-harmed in the previous 6 months. A cost-benefit analysis suggested that in the course of the treatment additional costs of the programme are offset by reductions in inpatient and emergency room care costs as well as reduced medication. The difference in costs per patient became apparent in the follow-up period. The mean annual cost of service utilisation was \$15,500 for the TAU group and \$3,200 for the partial hospitalisation group.

The second controlled trial carried out by Clarkin, Kernberg, Levy and colleagues [92] is the most ambitious, rigorous and comprehensive trial of psychodynamic psychotherapy in any context. It contrasts transference-focused psychotherapy (TFP) [93] with dialectical behaviour therapy [94] and psychoanalytic supportive psychotherapy [95]. All therapists were experienced in relation to their modality. Of 207 patients interviewed for the trial, 109 met criteria. Nineteen refused randomisation but the remaining 90 were randomised to TFP, DBT or SPT. The baseline GAF score was about 50, quite severe for an outpatient sample. Results are available to 12 months. In all therapies GAF scores increased by about 10 points. BDI scores decreased significantly and social adjustment scores increased. There was no significant change in anxiety scores. The majority of patients showed improvement in their suicidality. Only a minority appeared to be getting worse. Hierarchical linear modelling showed that TFP and DBT significantly improved suicidality but patients in SPT treatment did not significantly improve, and that all three treatment groups improved significantly in terms of global functioning and depression. On the Adult Attachment Interview (AAI) [96] ratings of coherence (closely related to attachment security) improved for all three groups. The improvement was most marked for the TFP group but this difference was not statistically significant. Reflective function scores [97], based on the AAI and related to mentalisation, showed slight improvements in the other two treatments but was only significant for the transference focused psychotherapy group [98]. Other than this significant interaction there were no differences between the treatment groups, except for a significantly higher early termination rate from DBT that could reflect more rapid improvement or lower acceptability of this treatment with this group.

6.2. Antisocial PD

There are no trials of psychodynamic treatment of antisocial PD and a small number of observational studies of individuals detained in high security settings (e.g. [99]). It is likely that at least some of these individuals would meet criteria for ASPD but this cannot be assumed. The studies are reviewed by Warren and colleagues [100]. In general improvements are noted but the methodology is too weak to permit generalisation.

More recently, Saunders [101] contrasted CBT and STPP. The treatment was offered to men who were violent with their partners and of the 136 participants 40% met

criteria for ASPD. No differences are reported between the groups in terms of recidivism and in the absence of a no treatment control group it is difficult to judge if either treatment was effective. A prison service in the UK (Grendon) is currently run along relatively coherent psychodynamic principles. Taylor [102] describes outcomes from a 7 year follow-up of 700 individuals who participated in this therapeutic community. The comparison groups in the report consist of demographically matched individuals who were never admitted to Grendon from the wait list group and 1400 individuals treated from a general prison population. Attendance at the psychodynamic therapeutic community at Grendon was associated with a reduced rate of re-offending. Further there was a link between length of stay at Grendon and outcome. However, when prior criminal histories are controlled for the apparent impact of Grendon is reduced. Thornton and colleagues [103] looked at a sub-group who were sex offenders. When matched with a group with similar forensic histories, those at the chronic end of the severity spectrum (at least two previous convictions for sex offences) had better outcomes.

6.3. Cluster C (anxious-fearful) personality disorder

Cluster-C personality disorders include avoidant personality disorder (social discomfort, timidity), dependent personality disorder (dependent on reassurance), obsessive–compulsive personality disorder. These are the most prevalent personality disorders in the general population (10%) [104].

We know of only one open trial of psychodynamic therapy that explicitly focuses on avoidant PD [105]. They used supportive expressive psychotherapy in the treatment of 38 individuals, 2/3 with avoidant and 1/3 with obsessive–compulsive PD. Attrition was high, with 50% of the avoidant PDs leaving therapy prematurely. Forty percent of those with avoidant PD who stayed with therapy retained their diagnosis. Those with obsessive–compulsive PD had better retention rates and better outcomes.

A small Norwegian trial [106] compared STPP with cognitive therapy for outpatients with cluster C personality disorder. Fifty-one patients were randomly allocated to receive 40 weekly sessions of dynamic therapy (Malan's approach) or cognitive therapy (Beck's approach). Sessions were videotaped and adherence and integrity checks were performed on both therapies. Only two patients did not attend follow-up assessments at 6, 12 and 24 months. Both groups improved and continued to improve after treatment both symptomatologically and in terms of personality profile (Millon's Clinical Multiaxial Inventory). The group differences on the Millon are probably trivial but the differences on the SCL-90 may be of clinical significance. Sadly, the study is underpowered to detect more than a large effect size which is unlikely to be observed in this kind of context.

A randomised trial compared STPP for predominantly cluster C personality disordered individuals along the lines

developed by Malan and Davanloo ($n=31$) with brief adaptive psychotherapy (BAP) developed by the authors [107] ($n=32$). There was also a waiting list control group ($n=26$). The former form of STPP is believed by the authors to be more confrontational but both appear to address defensive behaviour and elicit affect in interpersonal contexts. Twenty-five completed STPP and 30 BAP. Mean treatment length was 40 sessions but the waiting list control group lasted only 15 weeks. A large number of therapists participated. Treatment manuals were employed and videotaping for adherence checks. A variable length follow-up reached about two thirds of the treated group. The two treated groups both showed significant change on the GSI of the SCL-90 of approximately one standard deviation and some change on the social adjustment scale. There were no significant differences between the two treated groups—not surprising given the similarity of the approaches. The study was under-powered to look at specific benefits of each therapy in relation to particular PD types. An earlier study by the same group [108] contrasting the same therapies reported essentially the same results with similar effect sizes on the GSI and the SAS. A more robust follow-up of this study at 18 months [107] indicated that gains were maintained.

7. Long term psychotherapy

In the previous sections, we considered evidence available to support therapeutic interventions which are derivatives of psychoanalysis. However, there is a certain degree of disingenuity in psychoanalysis embracing these investigations. Most analysts would consider that the aims and methods of short-term once a week psychotherapy are not comparable to 'full analysis'. What do we know about the value of intensive and long term psychodynamic treatment? Here the evidence base becomes somewhat patchy and we cannot restrict the review to randomised controlled trials.

The Boston Psychotherapy Study [109] compared long term psychoanalytic therapy (two or more times a week) with supportive therapy for clients with schizophrenia in a randomised controlled design. On the whole clients who received psychoanalytic therapy fared no better than those who received supportive treatment. The partial-hospital RCT [91] included in the psychoanalytic arm of the treatment included therapy groups three times a week as well as individual therapy once or twice a week over an 18 month period. A further controlled trial of intensive psychoanalytic treatment of children with chronically poorly controlled diabetes reported significant gains in diabetic control in the treated group which was maintained at 1 year follow-up [110]. Experimental single case studies carried out with the same population supported the causal relationship between interpretive work and improvement in diabetic control and physical growth [111]. The work of

Chris Heinicke also suggests that four or five times weekly sessions may generate more marked improvements in children with specific learning difficulties than a less intensive psychoanalytic intervention [112].

One of the most interesting studies to emerge recently was the Stockholm Outcome of Psychotherapy and Psychoanalysis Project [113–115]. The study followed 756 persons who received national insurance funded treatment for up to 3 years in psychoanalysis or psychoanalytic psychotherapy. The groups were matched on many clinical variables. Four or five times weekly analysis had similar outcomes at termination when compared with one to two sessions per week psychotherapy. During the follow-up period, psychotherapy patients did not change but those who had had psychoanalysis continued to improve, almost to a point where their scores were indistinguishable from those obtained from a non-clinical Swedish sample. While the results of the study are positive for psychoanalysis, certain findings are quite challenging. For example, therapists whose attitude to clinical process most closely resembled that of a ‘classical analyst’ (neutrality, exclusive orientation to insight) had psychotherapy clients with the worst, commonly negative, outcomes.

The German Psychoanalytic Association undertook a major follow-up study of psychoanalytic treatments undertaken in that country between 1990 and 1993 [116–118]. A representative sample ($n=401$) of all the patients who had terminated their psychoanalytic treatments with members of the German Psychoanalytical Association (DPV) were followed up. Between 70 and 80% of the patients achieved (average 6.5 years after the end of treatment) good and stable psychic changes according to the evaluations of the patients themselves, their analysts, independent psychoanalytic and non-psychoanalytic experts, and questionnaires commonly applied in psychotherapy research. The evaluation of mental health costs showed a cost reduction through fewer days of sick leave during the 7 years following the end of long-term psychoanalytic treatments. Qualitative analysis of the data also pointed to the value that patients continued to attach to their analytic experience. In the absence of pre-treatment measures it is impossible to estimate the size of the treatment effect.

Another large pre–post study of psychoanalytic treatments has examined the clinical records of 763 children who were evaluated and treated at the Anna Freud Centre, under the close supervision of Freud’s daughter [119–122]. Children with certain disorders (e.g. depression, autism, conduct disorder) appeared to benefit only marginally from psychoanalysis or psychoanalytic psychotherapy. Interestingly, children with severe emotional disorders (three or more Axis I diagnoses) did surprisingly well in psychoanalysis, although they did poorly in once or twice a week psychoanalytic psychotherapy. Younger children derived greatest benefit from intensive treatment. Adolescents appeared not to benefit from the increased frequency of sessions. The importance of the study is perhaps less in

demonstrating that psychoanalysis is effective, although some of the effects on very severely disturbed children were quite remarkable, but more in identifying groups for whom the additional effort involved in intensive treatment appeared not to be warranted.

The Research Committee of the International Psychoanalytic Association has recently prepared a comprehensive review of North American and European outcome studies of psychoanalytic treatment [123]. The committee concluded that existing studies failed to unequivocally demonstrate that psychoanalysis is efficacious relative to either an alternative treatment or an active placebo. A range of methodological and design problems was identified including absence of intent to treat controls, heterogeneous patient groups, lack of random assignments, the failure to use independently administered standardized measures of outcome, etc. Nevertheless, the report, which ran to several hundred pages and briefly describes more than 50 studies, is encouraging to psychoanalysts. Another overview [124] suggested that psychoanalytic treatments may be necessary when other treatments proved to be ineffective. The authors concluded that psychoanalysis appears to be consistently helpful to patients with milder disorders and somewhat helpful to those with more severe disturbances. More controlled studies are necessary to confirm these impressions. A number of studies testing psychoanalysis with ‘state of the art’ methodology are ongoing and are likely to produce more compelling evidence over the next years. Despite the limitations of the completed studies, evidence across a significant number of pre–post investigations suggests that psychoanalysis appears to be consistently helpful to patients with milder (neurotic) disorders and somewhat less consistently so for other, more severe groups. Across a range of uncontrolled or poorly controlled cohort studies, mostly carried out in Europe, longer intensive treatments tended to have better outcomes than shorter, non-intensive treatments (demonstration of a dose–effect relationship). The impact of psychoanalysis was apparent beyond symptomatology, in measures of work functioning and reductions in health care costs.

8. Conclusions

This review clearly illustrates that STPP is very unlikely to be effective as a generic treatment. All instances where it is consistently seen as comparable with CBT are in contexts where special efforts have been made to modify a generic psychodynamic approach to address a particular presenting problem or condition. We may pause to wonder why psychodynamic clinicians could ever assume that generic STPP could be applied to any disorder. CBT clinicians have tended to be more willing than psychodynamic clinicians to modify their approach radically in relation to the problems at hand. This may be rooted in the behavioural origins of CBT, where underlying mechanisms were considered

unimportant and a pragmatic positivist approach actively precluded modifications other than those dictated by systematic observation of the patient's reaction to interventions. There is a different relationship between theory and technique amongst those following a psychodynamic tradition [125,126]. It is almost as though it was assumed that technique could and should be readily generated from high-level psychoanalytic theoretical assumptions without regard to close observations from the clinical context in which the therapist works. Thus, little attention has been paid to refining technique to fit a particular problem area. The paradoxical consequence of this idealisation of the correspondence between theory and practice has been the mushrooming of variants of psychodynamic theory in response to clinical experience probably driven by a kind of 'reverse engineering' where the clinicians try to pinpoint the modifications of general theory and practice that might justify what they feel to be technically appropriate for a specific group. (Of course, the radical modification of theory in relation to practice is felt to be sanctioned by Freud's own dramatic reconfiguring of theory in response to clinical observation.) This admittedly speculative analysis might explain why so many different generic short term therapy models have been tested in relation to a small number of disorders, so that no two trials in the entire corpus appear to test the same therapy with the same patient group by independent groups of investigators and why there is such a dearth of disorder specific psychodynamic manuals.

There can be no excuse for the thin evidence base of psychoanalytic treatment. In the same breath that psychoanalysts often claim to be at the intellectual origin of other talking cures (e.g. systemic therapy, cognitive behaviour therapy), they also seek shelter behind the relative immaturity of the discipline as an account for the absence of evidence for its efficacy. Yet the evidence base of these 'derivatives' of psychoanalytic therapy has been far more firmly established than evidence for the approach at the root of the psychotherapy movement [127]. Of course there are reasons for this—reasons such as the long term nature of the therapy, the subtlety and complexity of its procedures, the elusiveness of its self-declared outcome goals, and the incompatibility of direct observation and the need for absolute confidentiality. None of these reasons can stand up to careful scrutiny. A more likely reason for the absence of psychoanalytic outcome research lies in the fundamental incompatibilities in the world view espoused by psychoanalysis and most of current social science [128] that will require a shift in epistemology on the part of psychoanalytic psychotherapists.

There are several components to this attitude change: (1) the incorporation of data gathering methods beyond the anecdotal, methods that are now widely available in social and biological science; (2) moving psychoanalytic constructs from the global to the specific which will facilitate cumulative data gathering and identifying the pathological psychological mechanisms with which accounts for change

in psychodynamic therapy; (3) routine consideration of alternative accounts for behavioural observations of change; (4) increasing psychoanalytic sophistication concerning social and contextual influences on pathological behaviour and its response to treatment; (5) ending the splendid isolation of psychoanalysis by undertaking active collaboration with other scientific and clinical disciplines; (6) using the knowledge-base of psychoanalysis to generate innovative treatment approaches to currently treatment resistant conditions; (7) integrating successful psychotherapeutic manipulations from other disciplines into a psychodynamic approach; (8) identifying clinical groups for whom the psychodynamic method is particularly effective and (9) adopting a scientific attitude that celebrates the value of the replication of observations rather than their uniqueness. Rather than fearing that fields adjacent to psychoanalysis might destroy the unique insights offered by long term intensive individual therapy, psychoanalysts must embrace the rapidly evolving 'knowledge chain', focused at different levels of the study of brain-behaviour relationships. As Kandel [129,130] pointed out, this may be the only route to the preservation of the hard-won insights of psychoanalysis.

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