

The Efficacy of Psychotherapy: Focus on Psychodynamic Psychotherapy as an Example

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Abstract: The growing number of individuals seeking treatment for mental disorders calls for intelligent and responsible decisions in health care politics. However, the current relative decrease in reimbursement of effective psychotherapy approaches occurring in the context of an increase in prescription of psychotropic medication lacks a scientific base. Using psychodynamic psychotherapy as an example, we review the literature on meta-analyses and recent outcome studies of effective treatment approaches. Psychodynamic psychotherapy is an effective treatment for a wide variety of mental disorders. Adding to the known effectiveness of other shorter treatments, the results indicate lasting change in many cases, especially for complex and difficult to treat patients, ultimately reducing health-care utilization. Research-informed health care decisions that take into account the solid evidence for the effectiveness of psychotherapy, including psychodynamic psychotherapy, have the potential to promote choice, increase mental health, and reduce society's burden of disease in the long run.

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With the advent of the Affordable Care Act and the focus on parity in the provision of mental health care, it is more important than ever to understand the evidence base for mental health treatments for the various types of psychological and psychiatric difficulties from which many Americans suffer. We suggest that it is incumbent for all stakeholders—government agencies that fund and supplement the provision treatment; public and private insurance companies that fund and reimburse treatments; patients and families that consume and pay for mental health services, and clinicians that provide such services—to be familiar with the evidence base supporting the efficacy of a full range of mental health interventions. In this article we review the extensive evidence for the usefulness of psychotherapy as a central and important treatment modality for a range of mental health problems and disorders.

In the United States, 31% of the population is affected by mental health problems every year; however, 67% do not receive treatment (Kessler et al., 2005). This discrepancy between those in need of mental health services and those who receive them is known as the “service gap” or “treatment gap.” Although mental health treatment utilization has increased over recent years, this increase has been accounted for by increased rates of patients receiving pharmacotherapy (Olfson & Marcus, 2009, 2010). At the same time, there is much evidence that the use of psychotherapy is on the decline. For example, although the percentage of people in the United States receiving outpatient psychotherapy has remained relatively steady over the years (3.37% in 1998, 3.18% in 2007), the use of psychotherapy as a sole intervention (15.9% to 10.5%) and psychotherapy prescribed in conjunction with medication (40% to 32.1%) have steadily decreased while the rate of medication prescribed alone (44.1% to 57.4%) has steadily increased (Olfson & Marcus, 2010; Olfson, Marcus, Druss, & Pincus, 2002). The average number of psychotherapy visits also has decreased over time, and fewer psychiatrists are delivering psychotherapy (Akincigil et al., 2011; Mojtabai & Olfson, 2008a). This decrease in the number of outpatients receiving psychotherapy and the increase in the number of outpatients receiving medication is in direct opposition to studies that report clear preference for psychotherapy over medications for many patients and families. For example, studies consistently show that patients, particularly depressed ones, prefer psychotherapy to medication (McHugh, Whitton, Peckham, Welge, & Otto, 2013; Prins et al., 2008; van Schaik et al., 2004).

Patient and family preferences aside, decisions about treatment interventions should be driven by the best evidence available. Thus it is surprising that this increase in the use of medications and decrease in the provision of psychotherapy is inconsistent and in direct contrast

with the evidence base and often leads to questionable practice. For example, antidepressants are often prescribed for subthreshold or lower levels of depression when effect sizes are lower for the use of medication alone in such depressions and psychotherapy is the preferable first-line treatment (Antonuccio, Danton, & DeNelsky, 1995; Persons, Thase, & Crits-Christoph, 1996; Wexler & Cicchetti, 1992).¹

While the decline in psychotherapy utilization no doubt reflects many factors (e.g., increasing medicalization, direct-to-consumer advertising of psychotropic drugs, increasing emphasis on short-term vs. long-term outcomes), restrictions in insurance reimbursements for psychotherapy have played an important role in psychotherapy delivery in the U.S. Insurance reimbursement practices frequently provide financial disincentives for providing psychotherapy as compared to the incentives for providing psychotropic medications (Mojtabai & Olfson, 2008a). For example, psychotherapy reimbursement rates have decreased over recent decades (Frank, Goldman, & McGuire, 2009; Rupert & Baird, 2004) while psychiatrists can bill three or four patients for 15-minute medication checks within the same time frame as the typical hour needed for a psychotherapy session. As a result rates of depression treatment by, for example, psychologists have decreased (Rupert & Baird, 2004), and fewer and fewer psychiatrists are providing psychotherapy (Druss, 2010; Mojtabai & Olfson, 2008a). At the same time treatment of psychological conditions by primary care physicians has increased (Mojtabai & Olfson, 2008b; Olfson et al., 2002). Primary care physicians, despite best intentions to help their patients, receive only 6 weeks of psychiatry training during medical school, generally do not receive training in psychosocial interventions, and thus rarely offer such options to their patients despite the evidence of the efficacy and cost-effectiveness of such treatments (Antonuccio et al., 1995; Heuzenroeder et al., 2004; Spielmans, Berman, & Usitalo, 2011; Vos et al., 2005). In contrast, in the United Kingdom and many other European countries treatment guidelines such as the U.K.'s National Institute for Health and Clinical Excellence (www.nice.org.uk) place greater value

1. At the same time, psychotropic medication is increasingly prescribed by primary care physicians instead of psychiatrists, further increasing the noted disparity as the former cannot provide psychotherapy (Mojtabai & Olfson, 2010). This is even more relevant when taking into account that psychopharmacological interventions have to be monitored carefully due to their potential of somatic side effects (e.g., De Hert, Detraux, van Winkel, Yu, & Correll, 2011). In everyday practice there is a growing trend for polypharmacy with poor risk-benefit ratios, off-label use of antipsychotic medication, for example for the treatment of anxiety syndromes (Comer, Mojtabai, & Olfson, 2011), and the widespread dissemination of medication whose long-term effects have not been adequately understood, for example concerning amphetamine-based stimulants for children with a diagnosis of ADHD.

on the provision of psychosocial treatments as first line treatments for many psychological and psychiatric conditions (Clark, 2011; Richards & Borglin, 2011).

Following the emphasis on psychosocial treatments in the U.K. and Europe, the underutilization of psychotherapy has been recognized, leading to government-based intervention to improve access. For example, the U.K. government initiated a program called Improving Access to Psychological Therapies (IAPT) for depression and anxiety. This program was aimed at training 6,000 therapists over a six-year period beginning in 2008 in order to increase access for one million people. The Swedish government also embarked on an equally ambitious shift in order to remedy the underprovision in psychotherapy for treating psychological problems (Holmqvist, Ström, & Foldemo, 2014). Efforts of this kind have been sorely lacking in the U.S. healthcare system

The declining utilization of psychotherapy in the U.S. is unfortunate from the perspective of our patients, who could benefit from the many evidence-based psychotherapeutic interventions available, but also from the perspective of long-term expenditures, especially in relation to chronic complex mental disorders such as personality disorders, which profit preferentially from psychotherapeutic intervention—often in conjunction with medication management. Declining utilization of psychotherapy in the U.S. is not at all warranted by the data on outcome. Despite common misconceptions, there is a vast evidence base for the efficacy of different forms of psychotherapy for a wide spectrum of disorders with effects that are as strong as or stronger than those of medication and without the serious side effects often found with medication use.

In this article we provide an overview of some of these outcome data. We focus on outcome of psychodynamic interventions, where negative bias in the field is most pronounced (Levy & Anderson, 2013). Many clinicians and academicians in psychiatry and psychology believe that psychodynamic treatments have either (1) not been tested or (2) that they have been found to be less effective than other treatment approaches. Although it is true that psychoanalytic and psychodynamic psychotherapies possess a smaller research base than some other approaches such as cognitive behavioral (CBT), there currently exists a strong literature on the efficacy of psychodynamic therapies (PDT) for a variety of acute and chronic mental disorders. We also focus on PDT as a case study of the misconception that psychotherapies do not have an evidence base. The reader keeps in mind that there is an equally strong or larger database for cognitive behavioral treatments and interpersonal psychotherapy (considered by some a PDT treatment; Crits-Cristoph, 1992) and emotion-focused treatments. Additionally, there

is a growing evidence base for humanistic and existential based treatments. Similarities and differences between these various treatment approaches will be briefly described in the next section.

WHAT IS PSYCHOTHERAPY?

“What is therapy?”; “What is the evidence for its efficacy?”; and “How should practitioners across all professions be trained?” These questions are essential with regard to this core clinical activity of psychiatrists, psychologists, social workers, and other mental health care professionals (Weissman et al., 2006). “Psychotherapy” can perhaps best be thought of as a plural noun given the many types and various levels of intervention by which it can be defined. For our purposes, we broadly define psychotherapy as a series of interrelated techniques or interventions designed to ameliorate mental health, emotional, behavioral, psychological, and/or psychiatric disorders based primarily on the verbal and/or nonverbal communication with an identified therapist or practitioner with an identified patient.²

The most well-known individual psychotherapies include cognitive behavioral therapy (CBT), behavioral therapy (BT), psychodynamic therapy (PDT), the latter including expressive, supportive, and depth PDTs, psychoanalysis (PSA), interpersonal therapy (IPT), Gestalt, Humanistic/Existential, experiential, client-centered (CCT), and derivative therapies such as emotion focused therapy. Within each of these modalities therapy can be conceptualized as long-term (e.g., one or more years with sessions; one or more times a week), or short-term (e.g., 6, 12, 16, or 24 sessions, usually once per week). BTs are based on the application of learning principles, the influence of reinforcement, and behavioral patterns and tend to avoid focusing on cognition, be it conscious or unconscious, although in recent years there has been more focus among BT therapists on integrating these types of processes (see Levy & Anderson, 2013). CBT techniques utilize learning principles, but in the context of conscious thought processes, particularly those that may be distorted (e.g., “I have to be excellent at everything I do or I am a failure”), and may lead to feelings of depression, anxiety, or

2. The words *client*, *patient*, and *consumer* are used differentially by various professional groups that provide treatment to refer those individuals who receive psychotherapy. In this article, we use the convention of *patient*. All three terms infer a relationship with another: a client is under the protection or receiving professional advice from an advisor; a patient is suffering from an illness and receives care from a doctor; a consumer buys services from his or her insurance plan and a managed care provider.

both. CBT treatments tend to teach patients skills and the use of homework assignments, like in BT, tends to take a more didactic stance. In contrast, humanistic/existential/CCT and PDT treatments are usually more conversational, focusing on fears, emotion, and unconscious influences. BT and CBT therapies tend to be brief (e.g., 6 to 16 weeks), although there is some evidence that many BT and CBT therapies are practiced long term in the community (Gillespie, Duffy, Hackmann, & Clark, 2002; McKay, Nudelman, McCadam, & Gonzales, 1996; Thompson-Brenner & Westen, 2005; Westen & Morrison, 2001) and that BT and CBT treatments for more severely disturbed patients such as personality disordered ones are typically conceptualized as long term (Beck, Freeman, Davis, & Associates, 2004; Linehan, 1993). In contrast PDTs tend to be longer term, although there are now a number of short-term or brief PDTs available (Abbass, Sheldon, Gyra, & Kalpin, 2008; Barber, Muran, McCarthy, & Keefe, 2013; Milrod, Leon, Barber, Markowitz, & Graf, 2007).

THE NATURE OF EVIDENCE

In order to assess and understand whether or not psychotherapy is effective and of value, we must examine the nature of evidence. There should be no disagreement regarding the need for empirical support for our interventions. There is, however, great disagreement about the nature and scope of what constitutes evidence. Some have suggested that randomized controlled trials (RCT), which involve randomizing patients to two or more treatments, including a placebo condition that controls for attention and credibility, are the gold standard of evidence. In fact, some have gone so far as to suggest that RCT is not only the gold standard, but the lone standard, the only evidence that deserves consideration. This attitude leads to an implicit but erroneous assumption that the absence of a certain type of evidence proves the lack of merit in approaches that do not have that level of evidence. At the other extreme, there are those who point to a number of important critiques of the RCT design as significant threats to both internal and external validity. These critics have noted that the controls provided by the RCT design are confounded by such factors as the use of selected samples (e.g., those willing to participate in RCTs and the use of limiting inclusion and exclusion criteria; Westen, Novotny, & Thompson-Brenner, 2004), non-random dropout (that can invalidate the randomization process; Miranda & Borkovec, 1999), lack of treatment fidelity (Ablon & Jones, 1999), and common factors, therapist factors, and investigator allegiance effects (Berman & Reich, 2010; Luborsky, Diguier, Seligman, Rosenthal, Krause, Johnson et al., 1999; Robinson, Berman, & Neimeyer,

1990) as well as other lack of controls (e.g., experiences outside the consultation room). These investigators often prefer naturalistic studies that lack randomization as an alternative (Blatt & Zuroff, 2005; Silberschatz's statement in Persons & Silberschatz, 1998; Stiles, Barkham, Mellor-Clark, & Connell, 2008). Beutler, Forrester, Gallagher-Thompson, Thompson, and Tomlins (2012) further criticize the standard RCT model by noting that the use of inclusion and exclusion criteria to create a homogenous group of patients, the focus on treatment fidelity and expert adherent therapists results in a lack of variability, that in turn reduces variance and the capacity to examine patient, therapist, and treatment characteristics as moderators of outcome.

Rather than privileging RCTs or naturalistic designs, Levy (Levy, 2012; Levy & Scott, 2007) has argued for a pluralistic approach toward levels of evidence. RCTs are very valuable, in some ways clearly a gold standard, but in some ways confounded, as such they are in no way the lone standard. Rather Levy argued that the juxtaposition and convergence of multiple types and levels of evidence constitute *the platinum standard*. The rationale is that each type of evidence speaks to different issues.³ Given the different nature of evidence provided by these different types of studies, there is a need for a diversified portfolio of evidence in which a variety of methods are juxtaposed against one another in order to protect against the introduction of non-random error. A convergence of evidence provides reliability and validity of inferences. Thus, to the degree results from experimental/RCT studies are consistent with data from naturalistic studies, process studies, and ultimately meta-analyses, we can be confident of reliable and valid findings. Furthermore, clinical interventions should be consistent with and related to what is known about developmental psychopathology and putative mechanisms of change. The true value of evidence is therefore derived from the convergence between different approaches, which, when interpreted isolated from other sources, can be problematic (for a more detailed discussion see Levy & Scott, 2007).

Additionally, important information for clinical practice can be derived from psychopathology, assessment, and epidemiological research literatures. For example, epidemiological studies have found that personality disorders are not only prevalent in their own right but are highly comorbid with other disorders such as mood disorders, anxiety disorders, and substance use disorders (Zanarini et al., 1998). Additionally, this comorbidity negatively affects the course and treatment

3. So while the RCT has excellent internal validity it suffers in terms of external validity and while naturalistic studies have excellent external validity, they suffer in terms of internal validity.

outcome for these disorders (Newton-Howes, Tyrer, & Johnson, 2006). Thus, an empirically supported principle is that clinicians should evaluate for personality disorders anytime they determine that a patient is suffering from one of these common comorbid conditions given their effects on treatment outcome. Second, when interpreting outcome data it is important to remember that there may be significant but still unidentified moderators that can influence outcome and would change our assessment of an intervention and/or provide prescriptive knowledge. For example, in June 2005 the FDA withdrew approval for the use of Gefitinib due to lack of evidence of its efficacy, however, secondary moderator analyses found that the medication was more effective for women and particularly those of Asian descent (Soo et al., 2011). Thus a medication that appeared inefficacious was highly efficacious for a subset on individuals. It is quite possible that the same kinds of moderating effects may exist with regard to psychotherapy interventions.

Findings across studies can vary quite a bit. Sometimes this variance represents random error or variance, while other times it may result from differences in study design such as sampling, treatment fidelity, or outcome measurement. For this reason reviews of groups of studies are important for understanding the broader clinical implications, and deriving evidence-based principles for clinical decision making. Some even consider systematic reviews to be the highest level of the evidence pyramid (Spring & Neville, 2010). One particularly useful method for systematically reviewing and combining findings across multiple studies is the use of meta-analysis. For each study the size of the effect or effect size (ES) is calculated and converted into a common metric to ultimately be combined. While in meta-analysis the main focus is on the direction and magnitude of the effects (ES) across studies, differences in ES between subgroups of studies can be examined too. As described in the next section, meta-analysis was developed specifically to answer questions about psychotherapy outcome but has been utilized to serve all of science. A major strength of the meta-analytic approach is that it controls for outlier findings among individual studies that may run counter to the larger body of literature.

Nonetheless meta-analysis is not without controversy, and individual meta-analyses as well as the technique itself have been criticized. There are four basic problems that need to be addressed in a meta-analysis: (1) study heterogeneity or “comparing apples with oranges”; (2) study quality, or “garbage in, garbage out”; (3) inclusion and exclusion criteria, where small conceptual differences between meta-analyses can result in vastly different answers; and (4) dissemination bias. The latter, called the “file drawer problem,” is when studies with negative results or results that counter the bias of the investigators are less likely to

be published and appear in meta-analyses. Based on these critiques a number of guidelines for conducting and reporting meta-analyses have been developed (AMSTAR; Shea et al., 2009; MARS; APA, 2008; PRISMA; Moher, Liberati, Tetzlaff, & Altman, 2009). Nevertheless, consumers of meta-analytic findings, similar to consumers of findings from individual studies, need to be aware of how these methodological issues raised have been addressed in interpreting the findings.

DOES PSYCHOTHERAPY WORK?

Controversy about the effectiveness of psychotherapy began in 1952 when the British experimental psychologist, Hans Eysenck, caused a furor when he proclaimed that psychotherapy was no more beneficial than the absence of treatment. In his report, Eysenck (1952) summarized the results of 24 reports of psychoanalytic and eclectic psychotherapies with more than 7,000 neurotic clients treated in naturalistic settings compared with two control groups. Eysenck found that the more intensive the therapy, the worse the results. In fact, Eysenck's interpretation suggested that clients in psychoanalytic treatment had significantly worse cure rates than clients who received no treatment.

It has been more than 60 years since Eysenck rocked the psychotherapy community with these claims. Despite the use of what is now considered seriously flawed research methodology (e.g., inconsistent methods, selection bias, inappropriate control groups) and a polemic tone that some feel indicated a pre-existing bias, Eysenck's article was extremely important to the field and challenged therapists to pay more systematic attention to the results of their efforts and has spurred a great deal of empirical research. Thanks in large part to researchers' response to Eysenck's charge, we now know, generally speaking, that psychotherapy does indeed help people get better (Smith, Glass, & Miller, 1980; Wampold, 2001). Numerous studies and subsequent meta-analyses have demonstrated that any number of specific psychotherapeutic approaches, either alone, or, in some cases, in combination with pharmacological approaches, are more effective than credible alternative psychological interventions containing nonspecific factors (e.g., the provision of hope, support, empathy, or interventions provided by experts) serving as "psychological placebos" (Barlow, 1996).

Early on, there were a number of critiques of Eysenck's review. The most notable were by Christie (1956), Bergin (1971), Lambert (1976), Luborsky, Singer, and Luborsky (1975), Rosensweig (1954), and Strupp (1963). However, one critique in particular revolutionized not only the field of psychotherapy and psychotherapy research but all of science.

In response to Eysenck's use of a tally method for his comprehensive review, Gene Glass (Smith & Glass, 1977) developed meta-analysis as a method for generating a common metric that could be used aggregate or combine findings across studies. As mentioned above, meta-analysis is now used in every science, applied or basic, to summarize findings across studies, and because of this capacity is considered to be able to provide the highest level of evidence available to scientists and practitioners (for a discussion from a medical perspective, see for example, Rawlins, 2008, 2011).

In the late 1970s and early 1980s, Glass and colleagues (Smith & Glass, 1977; Smith, Glass, & Miller, 1980) published a large review paper and book of their initial meta-analysis in which they summarized the findings of 375 psychotherapy outcome studies completed at that time. Based on these findings, Glass and colleagues concluded that psychotherapy did indeed convincingly lead to significant improvements in treated patients: On average, the typical therapy patient is better off than 75% of untreated individuals. Few reliable differences were found between different types of psychotherapy. Since Glass and colleagues' original meta-analysis there have been numerous meta-analytic reviews of psychotherapy in general with mixed clients, psychotherapy of specific psychotherapy orientations such as CBT (Butler, Chapman, Forman, & Beck, 2006; Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012) or PDT (Barber et al., 2013; Driessen et al., 2010; Leichsenring & Rabung, 2008, 2011), psychotherapies for specific disorders such as depression (Cuijpers, van Straten, van Oppen, & Andersson, 2008; Driessen et al., 2010), anxiety disorders (Keefe, McCarthy, Dinger, Zilcha-Mano, & Barber, 2014), personality disorders (Leichsenring & Leibing, 2003), and other disorders such as schizophrenia (Gottdiener & Haslam, 2003). The overwhelming consensus across these meta-analyses is that a number of different psychotherapies are effective, and particularly so when compared to no treatment wait-list controls or placebos. Consistent with these findings, the American Psychological Association's Division 12 Task Force on empirically supported psychotherapies now lists 13 separate psychotherapy treatments for depression, five treatments for various anxiety disorders, and four treatments for borderline personality disorder (APA, Division 12, 2013). Supporting the early findings of Smith and Glass (1977), and despite the differences in the number of studies conducted as a function of psychotherapy orientation, there are few reliable differences between orientations across meta-analytic studies. This finding in and of itself suggests that there are a number of useful and effective psychotherapy treatments available to the practicing clinician for treating patients.

As contemporary researchers increasingly agree that psychotherapy works, psychotherapy research is, nevertheless, at a critical period. A confluence of pressures both inside (e.g., evidence-supported treatment movement, practice guidelines) and outside the profession (e.g., managed care, legislation, National Alliance for the Mentally Ill) make it incumbent upon therapists to become better informed about the usefulness of psychotherapy and the evidence for it. There has been a shift toward focusing research efforts on more precise questions, including those such as: Given a patient's diagnosis, which treatment is recommended? What treatments have shown efficacy in empirical trials? Does the therapy produce results beyond simply symptom change? Do the changes achieved during the course of treatment endure with time? How does length of treatment affect the nature of long-term outcome? Which treatments that show efficacy in clinical trials have demonstrated similar effectiveness in community treatment settings?

In the following section we will examine the evidence for the use of psychodynamic psychotherapy with a range of specific psychological and psychiatric disorders. We will examine findings from (1) meta-analytic studies; (2) RCTs; (3) naturalistic studies, and (4) process-outcome studies.

EFFECTIVENESS AND EFFICACY OF PSYCHOTHERAPY FOR SPECIFIC DISORDERS

Overall, the effect sizes from meta-analytic studies suggest that psychodynamic psychotherapy is more effective than placebo, as effective as much-studied CBT, and possibly more effective than antidepressants. We will review specific studies that will illustrate particularly important findings. These relate for example to good long-term outcomes, to evidence for what has been termed a "sleeper effect" of continued improvement after treatment termination, to positive effects especially in the area of personality disorders and interpersonal difficulties, going beyond mere symptom reduction, and some evidence for possibly specific mechanisms of change.

REVIEWING STUDIES ON MAJOR DIAGNOSTIC CATEGORIES

Personality Disorders

Personality Disorders are considered a major treatment challenge in and of themselves, and they also complicate the treatment of other

disorders. For example, there are now a number of independent large-scale outcome and longitudinal studies that show that comorbid personality disorders (PD), particularly borderline personality disorder (BPD), not only affects treatment outcome of major depressive disorder (MDD) adversely (Fournier et al., 2008; Shea, Widiger, & Klein, 1992), but also lead to lower rates of remission, longer times to remission, and increased relapse rates (Grilo et al., 2010; Gunderson et al., 2004; Links, Hesgrave, Mitton, van Reekum, & Patrick, 1995; Newton-Howes et al., 2006; Skodol et al., 2011; Zanarini, Frankenburg, Hennen, & Silk, 2006). Fournier and colleagues (2008) in a comparative study of CBT with paroxetine found that treatment was less effective for those MDD patients with a comorbid PD and that almost all MDD patients with a comorbid PD relapsed upon discontinuation of medication. Although the response rate for CBT was negatively affected by the presence of a PD, in contrast to the medication condition, those that did respond to CBT tended not to relapse. Grilo et al. (2010), in a six-year prospective longitudinal study, found that a comorbid PD predicted longer time to remission in MDD and faster time to relapse compared with MDD patients without a PD. Skodol et al. (2011), in a nationally representative sample of over 5000 individuals, found that MDD patients with comorbid BPD represented approximately half of the patients who did not remit as of a three-year period. Surprisingly, there are now findings from four independent longitudinal studies (Gunderson et al., 2004; Links et al., 1995; Skodol et al., 2011; Zanarini et al., 2006) that have found the negative effects of BPD on MDD seem to work in one direction. That is, MDD does not seem to have the same negative effect on outcome in BPD. For instance, the rate of remission of BPD is not affected by whether or not patients had co-occurring MDD, or whether MDD responded to medication. For instance, Gunderson et al. (2004) in a sample of 675 found that improvements in MDD were not followed by improvements in BPD, whereas improvements in BPD were often followed by improvements in MDD. Similar findings were reported with regard to the relationship between PDs (especially BPD) with bipolar disorder (Bieling, Green, & Macqueen, 2007; Colom et al., 2000; George, Miklowitz, Richards, Simoneau, & Taylor, 2003; Gunderson et al., 2006; Kay, Altshuler, Ventura, & Mintz, 2002) and anxiety disorders (Ansell et al., 2011). Thus, personality disorders, especially BPD, given their prevalence, comorbidity, and consequences are a major health concern that clinicians need to be prepared to address.

Before reviewing the research on specific models of therapy for specific personality disorders, we point to several meta-analyses of psychotherapy for combined personality disorders that provide encouraging findings (Budge et al., 2013; Leichsenring & Leibing, 2003; Perry,

Banon, & Ianni, 1999). Perry and colleagues (1999) identified 15 studies, including six RCTs, and found pre-post effect sizes ranging from 1.1 to 1.3. In a second meta-analysis, Leichsenring and Leibing (2003) examined the efficacy of both PDT (14 studies) and CBT (11 studies) in the treatment of patients with personality disorders; 11 of the studies were RCTs. The authors reported pre-treatment to post-treatment effect sizes using the longest term follow-up data reported in the studies. For psychodynamic psychotherapy (mean length of treatment was 37 weeks), the mean follow-up period was 1.5 years after treatment end and the pre-treatment to post-treatment effect size was 1.46, indicating that psychodynamic treatment benefits endure over time. For CBT (mean length of treatment was 16 weeks), the mean follow-up period was 13 weeks, and the pre-treatment to post-treatment effect size was 1.0. The authors concluded that both PDT and CBT demonstrated effectiveness for patients with personality disorders, but that current evidence for long-term effectiveness is stronger for psychodynamic psychotherapy. In the most recent and comprehensive meta-analysis on PDs, Budge and colleagues (2013) analyzed 30 studies that compared an active psychotherapeutic treatment with treatment as usual. They found that active psychotherapeutic treatments were more efficient than treatment as usual comparisons, with medium effect size ($d = .40$). In addition, the effectiveness of PDT for individuals with personality disorders is supported by two more recent meta-analytic studies for short-term PDT (Town, Abbass, & Hardy, 2011) and for the treatment of depression with comorbid personality disorders (Abbas, Town, & Driessen, 2011).

To summarize, based on limited data, psychodynamic and CBT treatments appear to be equally effective for personality disorders, yet longer term treatments might yield better outcomes, and psychodynamic treatments may have longer lasting effects. However, findings from these meta-analyses of personality disorders are difficult to interpret due to the mixing samples that can vary quite a bit in terms of severity. Thus research on specific personality disorders is informative.

Borderline Personality Disorder (BPD)

BPD patients have traditionally taken up high levels of treatment resources (Bender, Dolan, & Skodol, 2001) and have been considered a difficult population to treat effectively. Four psychodynamic treatments for borderline personality have empirical support: Russell Meares's Interpersonal-Self Psychological approach also known as the Conversational Approach, Bateman and Fonagy's Mentalization Based Therapy

(MBT; Bateman & Fonagy, 2004), Kernberg et al.'s Transference Focused Psychotherapy (TFP; Clarkin, Yeomans, & Kernberg, 2006), and Robert Gregory's Deconstructive Dynamic Psychotherapy (DDP; Gregory & Remen, 2008). The latter three have been shown to be efficacious in RCTs.

Interpersonal-Self Psychological Approach. Meares developed an interpersonal self-psychological approach for the treatment of BPD guided by the conversational model of Hobson (1985), the main aim of which is to foster the emergence of reflective consciousness that William James called *self-consciousness* (James, 1890). A basic tenet of this approach is that self-consciousness is achieved through a particular form of conversation and reflects a deeper sense of relatedness. A pre-post study that evaluated the effects of this approach for patients with BPD found that patients at the end of treatment showed an increase in time employed and decreases in number of medical visits, number of self-harm episodes, and number and length of hospitalizations (Stevenson & Meares, 1992). Although the inferences that can be drawn from this study are limited by the lack of a control group, these findings supported the further development and study of psychodynamic treatments for BPD. In a later quasi-experimental study (Meares, Stevenson, & Comerford, 1999), researchers compared BPD patients treated twice weekly for one year with those in a treatment-as-usual (TAU) waitlist control group (all waitlisted patients received their usual treatments, which consisted of supportive psychotherapy, crisis intervention only, cognitive therapy, and pharmacotherapy). Thirty percent of patients with interpersonal-psychodynamic psychotherapy no longer met criteria for a *DSM-III* (American Psychiatric Association, 1980) BPD diagnosis at the end of the treatment year, whereas all of the TAU patients still met criteria for the diagnosis. These results demonstrated that psychotherapy based on psychodynamic principles is generally beneficial to patients with BPD in a naturalistic setting, having strong ecological validity in a real world setting. A five-year follow-up found the improvements were maintained (Stevenson, Meares, & D'Angelo, 2005). A second quasi-experimental study (Korner, Gerull, Meares, & Stevenson, 2006) replicated these findings.

Mentalization Based Therapy. Bateman and Fonagy (2004, 2006) developed Mentalization Based Therapy (MBT) that integrates philosophy (theory of mind) and elements of psychoanalytic traditions (ego psychology, Kleinian theory, and attachment theory). They posit that the mechanism of change in all effective treatments for BPD involves the capacity for mentalization—the capacity to think about mental states in oneself and in others in terms of wishes, desires, and intentions. Men-

talizing involves both (1) implicit or *unconscious* mental processes that are activated along with the attachment system in interpersonal situations and (2) coherent integrated representations of mental states of self and others that influence thinking, emotional states, and behavior. The concept of mentalization has been operationalized in the Reflective Function (RF) scale (Fonagy, Steele, Steele, & Holder, 1997).

In an RCT (Bateman & Fonagy, 1999), the effectiveness of 18 months of an MBT day hospitalization program was compared with routine general psychiatric care for patients with BPD. Patients randomly assigned to the day hospital program showed statistically significant improvement in depressive symptoms and better social and interpersonal functioning, and significant decreases in suicidal and parasuicidal behavior and number of inpatient days. Patients were reassessed every three months for up to 18 months post-discharge (Bateman & Fonagy, 2001). Short-term follow-up results indicated that patients who completed the MBT not only maintained their substantial gains, but also showed continued steady and significant improvement on most measures, suggesting that BPD patients can continue to demonstrate gains in functioning long after treatment has ended. At 18-month post-discharge follow-up, 59.1% of patients treated with MBT were below the BPD diagnostic threshold, compared to only 12.5% of those treated in routine general psychiatric care. In a second follow-up, eight years post randomization and five years post the end of treatment, even more impressive findings were obtained: those treated with MBT showed not only statistical superiority in reduced suicidality, service utilization, medication use, and increases in global and vocational functioning, but an impressive level of clinical change (only 13% met criteria for BPD compared to 87% of those in the TAU group; Bateman & Fonagy, 2008). A recent RCT found MBT to be as effective as supportive psychotherapy in most of the outcome measures, but slightly more effective in improvement of global functioning (Jørgensen et al., 2013).

In summary, findings on the long-term significance of MBT are particularly important given the entrenched and chronic nature of BPD. Follow-up studies of CBT treatments for BPD have typically examined relatively short time frames (between 6 and 18 months), leaving the long-term efficacy of these treatments unclear. Additionally, outcomes for these studies have generally been mixed.

Transference Focused Psychotherapy (TFP). TFP is a modification of psychodynamic therapy based on object relations theory to address the needs of patients with BPD. TFP aims to reduce the patient's use of primitive defenses that deny the patient access to important parts of his emotional experience and to increase the patient's coherent sense of

self as a means to reduce suicidality and self-injurious behaviors, and to facilitate better behavioral control, increased affect regulation, more gratifying relationships, and the ability to pursue life goals (Clarkin, Yeomans, & Kernberg, 2006; Kernberg, Yeomans, Clarkin, & Levy, 2008). Using *clarifications*, *confrontations*, and *interpretations*, the therapist helps the patient integrate cognitions and affects that were previously split off and disorganized. The tactful *interpretation* of the dominant themes that the patient experiences in the here and now of the *transference* shed light on the reasons that internal representations of self and other remain fragmented and thus facilitate the development of a coherent sense of self and others.

There is accumulating evidence for the effectiveness and efficacy of TFP. An initial study (Clarkin et al., 2001) with a pre-post design showed that patients with BPD who were treated with TFP had marked reductions in the severity of parasuicidal behaviors, fewer emergency room visits, hospitalizations, days hospitalized, and reliable increases in global functioning. The effect sizes were large and equal to those demonstrated by other BPD treatments (Bateman & Fonagy, 1999; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991). The one-year drop-out rate was 19.1%, and no patient committed suicide. These results compared well with other treatments for BPD.

A second quasi-experimental study (Levy, Clarkin, Foelsch, & Kernberg, 2007) provided further support for the effectiveness of TFP in treating BPD. Twenty-six women diagnosed with BPD and treated with TFP were compared to 17 patients in a TAU group. There were no significant pre-treatment differences between the treatment group and the comparison group in terms of demographic or diagnostic variables, severity of BPD symptomatology, baseline emergency room visits, hospitalizations, days hospitalized, or global functioning scores. The one-year drop-out rate was 19%. Patients treated with TFP, compared to those treated with TAU, showed significant decreases in suicide attempts, hospitalizations, and number of days hospitalized, as well as reliable increases in global functioning. All of the within-subjects and between-subject effect sizes for the TFP-treated participants indicated favorable change. The within-subject effect sizes ranged from 0.73 to 3.06 for the TFP-treated participants, with an average effect size of 1.19—well above what is considered a “large” effect (Cohen, 1988).

In an RCT (Clarkin et al., 2007; Levy et al., 2006), 90 clinically referred patients were randomized to one of the three treatments: TFP, DBT, and a psychodynamic supportive psychotherapy (SPT; Appelbaum, 2005). Results of individual growth-curve analysis indicated that both the TFP and DBT-treated groups, but not the SPT group, showed signifi-

cant decrease in suicidality. Both TFP and supportive treatment were associated with improvement in anger and with improvement in facets of impulsivity. Only the TFP-treated group demonstrated significant improvements in irritability, verbal assault, and direct assault.

In an earlier report on this sample, Levy and colleagues (Levy et al., 2006) examined changes in attachment organization and reflective function as putative mechanisms of change, using the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1985) and the Reflective Function coding scale (RF; Fonagy, Steele, Steele, & Target, 1997). After 12 months of treatment there was a significant increase in the number of patients classified as secure with respect to attachment state of mind for TFP, but not the other two treatments. Significant changes in narrative coherence and RF were found as a function of treatment, with TFP showing increases in both constructs during the course of treatment. These findings are important as they show that TFP is not only an efficacious treatment for BPD, but works in a theoretically predicted way and thus has implications for conceptualizing the mechanism by which patients with BPD may change. The fact that patients in TFP did better on these putative mechanisms (e.g., reflective function) than those in DBT and SPT is initial evidence that this form of psychodynamic therapy is associated not only with symptom change but also with underlying psychological processes that mediate the patient's adjustment to the world. This is significant in the context of the literature showing that many treatments do not show specific effects on specific, theory-driven mechanisms (Ablon & Jones, 1998; Ablon, Levy, & Katzenstein, 2006; Castonguay, Goldfried, Wisner, Raue, & Hayes, 1996; DeRubeis et al., 1990; DeRubeis & Feeley, 1990; Ilardi & Craighead, 1994; Jones & Pulos, 1993; Shaw et al., 1999; Trepka, Rees, Shapiro, Hardy, & Barkham, 2004).

TFP was also examined as a control condition in a study in Amsterdam by Arntz and colleagues (Giesen-Bloo et al., 2006). The authors compared TFP with Schema Focused Therapy (SFT; Young, 1994), an integrative approach based on cognitive-behavioral or skills-based techniques along with object relations and gestalt approaches. Their study is unique in examining two active treatments over three years, however it lacked a control (Grenyer, 2007). While patients benefited from both treatments, SFT appeared more efficacious. However, a number of serious limitations including failure in the randomization process (Levy, Meehan, & Yeomans, 2012) and non-adherent therapists (Yeomans, 2006) argue against this conclusion. Additionally, a later independent study (Doering et al., 2010) also found TFP to be efficacious, and a recent meta-analysis of treatments for BPD failed to find any differences in treatment effects between specific treatments (Levy et al., 2012).

Mixed and Other Personality Disorders

Other studies have examined psychodynamic psychotherapy for personality disorders (Abbass, Sheldon, Gyra, & Kalpin, 2006; Winston, Laiken, Pollack, Samstag, McCullough, & Muran, 1994; Winston, Pollack, McCullough, Flegenheimer, Kestenbaum, & Trujullo, 1991). Winston and colleagues compared a short-term psychodynamic psychotherapy based on the work of Malan (1976) and Davanloo (1992) and a short-term psychodynamic psychotherapy called Brief Adaptive Psychotherapy (BAP) with a waitlist control in a group of patients predominately diagnosed with cluster C personality disorders. Both STPP treatments address defensive behavior and elicit affect in interpersonal contexts, although the BAP treatment is less confrontational. The authors found that both treatment groups showed significant change on the global severity index of the SCL-90 (approximately 1 standard deviation) and some changes on the social adjustment scale. At 18 months, post-treatment follow-up indicated the maintenance of treatment gains (Winston et al., 1994). Abbass et al. (2006) examined STPP for outpatients with a range of personality disorders. The authors found significant improvement in interpersonal problems, significantly more hours worked, and better employment outcomes relative to controls.

In another study using an RCT-design to examine outpatients with cluster C personality disorders (avoidant, dependent, obsessive-compulsive; Svartberg, Stiles, & Seltzer, 2004), the authors examined a 40-week STPP compared with cognitive therapy (CT) and found no statistically significant difference between the short-term psychotherapy group and CT groups on any measure for any time period. At two-year follow-up, 54% of the short-term dynamic psychotherapy patients and 42% of the CT patients had recovered symptomatically.

Depression

Although the data base is not as large for psychodynamic treatments of depression as it is for CBT, there is enough data to suggest that PDT is equally effective, and thus should be available to patients, and that further research is warranted on psychodynamic approaches. This conclusion is based on three sets of findings reviewed below: (1) meta-analytic studies; (2) RCTs; and (3) process-outcome studies.

Before turning to studies on depression, it is important to call attention to the emerging literature indicating a high rate of treatment failure

or treatment resistance in depressed patients, and a growing interest in management of what is commonly referred to as “treatment resistant depression.” Treatment resistance is of particular relevance to this review, as one of the reasons for resistance seems to be comorbidity. In the large STAR*D study of depression, 78% of the sample had comorbidity or other problems like suicidality that would have excluded subjects from RCTs, but that made them similar to the majority of patients that clinicians see. STAR*D found that the comorbid group was more intolerant of antidepressant medications, had lower rates of treatment response (39% versus 52%), and lower rates of remission from depressive symptoms (25% versus 34%) when compared with patients who did not have comorbidity (Wisniewski et al., 2009). There is also evidence that personality disorders in particular adversely affect the outcome of major depressive disorders, cause persistent functional impairment, extensive treatment utilization, and are associated with a significant suicide risk (Bender et al., 2006; Skodol et al., 2005). Personality disorders, especially BPD “robustly predicted the persistence” of major depressive disorder (Skodol et al., 2011), leading Skodol and his colleagues to suggest that assessment and treatment of personality disorders is essential in patients with major depressive disorder. Given the apparent association of comorbidity, especially personality disorder comorbidity, with treatment resistance in depression (and other disorders), research into the treatment of complex comorbid patients is indicated.

Meta-Analytic Studies on Therapy for Depression. The psychotherapy treatment of depression is probably the most studied of any psychological disorder. In the last three decades alone, there have been 40 meta-analytic reviews of the outcomes for patients with depression alone (Cuijpers & Dekker, 2005; Lambert, 2013). A number of meta-analyses have focused specifically on the psychodynamic treatment of depressive disorders (Crits-Christoph, 1992). There are several meta-analytic studies that examine the efficacy of psychodynamic psychotherapy as compared with other active treatments, mostly CBT (Churchill, Hunot, Corney, Knapp, McGuire, Tylee et al., 2002; Crits-Christoph, 1992; Driessen et al., 2010; Gloaguen, Cottraux, Cucheret, & Blackburn, 1998; Leichenring, 2001; Svartberg & Stiles, 1991). Each of these meta-analyses suggests good evidence for the efficacy of psychodynamic psychotherapy and CBT (Crits-Christoph, 1992; Leichenring, 2001). A number of these studies compared effect sizes in PDT with that of CBT (Churchill et al., 2002; Gloaguen et al., 1998; Svartberg & Stiles, 1991). In the Churchill et al. review, the authors found no significant differences between groups post-treatment with regard to symptoms, symptom reduction, or dropout. Further, there were no differences between groups

at 3 months and 1-year follow-up. For the Gloaguen and colleague's meta-analysis, Wampold and colleagues (Wampold, Minami, Baskin, & Callen Tierney, 2002) showed that there were no demonstrable differences between PDT and CBT in studies in which CBT was compared with bona-fide PDT (i.e., PDT defined as a clearly articulated model of treatment). Leichsenring (2001) found no significant differences between CBT and PDT modalities in terms of depressive symptoms, general psychiatric symptoms, or social functioning. The most recent meta-analysis by Driessen et al. (2010) found short-term psychodynamic psychotherapy (STPP) to be a viable option for the treatment of depression. STPP was more effective than nonspecific TAU, and during follow-up as effective as other specific psychotherapeutic treatments, mostly CBT.

Effect sizes for psychodynamic psychotherapy are quite 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. As a point of comparison, the effect sizes for antidepressant medications range between .24 for citalopram (Celexa) and .31 for escitalopram (Lexapro; Turner, Matthews, Linardatos, Tell, & Rosenthal, 2008), and effect sizes for medications decrease when antidepressants are compared to active placebos (e.g., non-inert placebo that mimics the side effects of an antidepressant drug but do not have antidepressant components).

Randomized Controlled Trials on Therapy for Depression. Initially, brief dynamic therapy was used as a comparison from which to assess the validity of other treatments (Hersen, Himmelhoch, Thase, & Bellack, 1984). In these studies, PDT was not a bona fide treatment, meaning it was not a clearly defined therapy but rather a "grab bag" term as little attention was paid to a clearly articulated model of treatment, the appropriateness of the therapists, or the fidelity of the treatment. More recent studies have paid better attention to these issues and tend to show that psychodynamic treatment is as effective as other modalities (Barber, Barrett, Gallop, Rynn, & Rickels, 2012a; Barkham, Shapiro, Hardy, & Rees, 1999; Cooper, Murray, Wilson, & Romaniuk, 2003; Driessen et al., 2013; Gallagher-Thompson & Steffen, 1994; Shapiro et al., 1994; Shapiro, Rees, Barkham, & Hardy, 1995). For example, Gallagher-Thompson and Steffen (1994) found in an RCT that 20 sessions of brief psychodynamic psychotherapy were as effective as 20 sessions of CBT in reducing depression in caregivers of elderly family members. Shapiro et al. (1994, 1995) randomized patients to 8 or 16 weeks of psychodynamic-interpersonal psychotherapy or CBT. They found that both treatments were equally effective for the 8-week and 16-week conditions,

and that there were no group differences at one-year follow-up. In both therapy conditions, severe depressions responded better to 16 weeks of intervention, speaking to the length of treatment issue that we will discuss later in the article. Thus, similar effect sizes were found when PDT was compared with CBT and these effects were comparable to those reported in other studies of CBT and IPT. Two recent RCTs add to the evidence. In a randomized-controlled study in a sample of patients with low socioeconomic status, high psychiatric comorbidity, and a long illness duration, STPP was as effective as psychotropic medication with SSRI/SNRIs (Barber et al., 2012). In the largest RCT for depression to date, 341 patients were randomized to either 16 sessions of manualized STPP or 16 sessions of manualized CBT accompanied with optional antidepressant medication for severe cases. Results indicated that both treatments are equally effective in symptom reduction (Driessen et al., 2013). What is particularly important about this study is that with the large sample size, it was sufficiently powered to test for equivalence on a number of measures, which was found. This led Thase (2013) in his editorial in the *American Journal of Psychiatry* to declare that “. . . psychodynamic psychotherapy is indeed an effective treatment option for outpatients with major depressive disorder” (p. 954).

Process-Outcome Studies. A different approach to studying psychotherapy outcome focuses on the relationship between specific aspects of therapy process—the techniques that are observed in the course of the session—and treatment outcome. There are a number of process studies that suggest the value of a psychodynamic approach for depression. Jones and Pulus (1993) found that although patients in both CBT and PDT improved, improvement in both therapies was dependent on the use of psychodynamic techniques embedded in the sessions in each treatment. Indirect evidence for the importance of psychodynamic process also comes from the findings of Castonguay, Goldfried, Wisner, Raue, and Hayes (1996). In examining mechanisms of change in CBT for depression, they found that focusing on distorted cognitions was inversely related to successful treatment outcome. However, a focus on feelings about the self, while elaborating and integrating emotional experience to develop an in-depth self-understanding, predicted positive treatment outcome. These findings suggest that cognitive behavioral therapists use psychodynamic strategies at times, and that these are associated with positive treatment outcome for patients of both psychodynamic and cognitive-behavioral therapists.

Anxiety Disorders

The effectiveness of CBT for the treatment of anxiety disorders is well established (Hofmann & Smits, 2008). In fact, during the 1980s and 1990s there were many RCTs examining CBT for a range of anxiety disorders. By the later 1990s and early 2000s the literature in support of the effectiveness of CBT was large enough to raise doubts about the value or ethics of non-exposure based/CBT methods for treating a range of anxiety disorders (Eagle, 2005). On the other hand, the outcome for CBT was far from complete. Many patients relapsed and sought out continued psychotherapy (Westen & Morriison, 2001). Additionally, the notion of CBT as a superior treatment was for the most part not based on direct comparisons with bona fide treatments (e.g., PDT) but rather comparisons to placebos and waitlist controls. Despite mounting pressure from the academic community and insurance companies to limit treatment for anxiety exclusively to CBT treatments, some clinical researchers persisted with humanistic/existential and psychodynamic approaches, resulting in several RCTs of PDT in the treatment of anxiety disorders (Alström et al., 1984a, 1984b; Beutel et al., 2013; Bögels, Wijts, Oort, & Sallaerts, 2014; Bressi, Porcellana, Marinaccio, Nocito, & Magri, 2010; Brom, Kleber, & Defares, 1989; Crits-Christoph, Wilson, & Hollon, 2005; Durham et al., 1994; Leichsenring et al., 2013; Milrod et al., 2007; Pierloot & Vinck, 1978; Wiborg & Dahl, 1996). Overall, the evidence is positive for the effectiveness of PDT for a range of anxiety disorders as indicated from findings from a recent meta-analysis including 14 RCTs with 1073 patients (Keefe et al., 2014). The within-group effect size for PDT was large ($g = 1.06$). Psychodynamic treatment was always superior to waitlist control or minimal care interventions in five RCTs. PDT was equally effective when compared with other active treatments, with all but three comparison treatments being CBT or BT spectrum treatments. For example, two smaller RCTs compared psychodynamic psychotherapy with CBT (Bögels et al., 2014; Durham et al., 1994); one found the treatments equally effective (Bögels et al., 2014) and the other found that PDT provided significant improvement but to a lesser degree than CBT (Durham et al., 1994). However, in the latter study, in contrast to the CBT treatment, PDT was not manualized, there was no specific training of therapists, and there were neither adherence checks nor treatment fidelity monitoring for the dynamic therapists.

A particularly important RCT was conducted by Milrod and colleagues (2007) who manualized a psychodynamic treatment for panic

based on theory and case reports that focused on symptom reduction through exploring *unconscious* determinants, such as unacknowledged anger and conflicts regarding autonomy and dependence. Panic Focused Psychodynamic Psychotherapy (PFPP) is aimed at helping patients understand the underlying emotional meaning of their panic allowing patients to acknowledge previously unacceptable feelings and ideas that have led to panic. This contrasts with CBT, which relies on exposure to panic triggers (i.e., bodily sensations such as breathlessness, tightness in the chest, heart palpitations), and a highly structured set of exercises aimed at easing attacks. In an RCT, Milrod and colleagues compared PFPP over 12 weeks to Applied Relaxation Therapy (ART), a standard and structured relaxation-focused approach that has often been used in trials aimed at assessing the effectiveness of other treatment approaches. Results showed not only efficacy for PDT but found similar effect sizes to those seen in studies of CBT, and a lower dropout rate than typical in CBT. The 26 patients in the PFPP group had a greater reduction in their symptoms compared to the 23 patients in the ART group, with 73% of PFPP patients meeting criteria for “response,” compared to just 39% of those in the ART cohort. Even more important, moderator analyses (Milrod, Leon, Barber et al., 2007) revealed that PFPP was particularly useful for panic patients who had a comorbid personality disorder. This is important given that a host of reviews suggest that anxiety patients with comorbid personality disorders do not benefit as much in standard CBT as those without the comorbidity (Brooks, Baltazar, & Munjack, 1989; Massion, Dyck, Shea, Phillops, Warshaw, & Keller, 2002; Noyes et al., 1990; Pollack, Otto, Rosenbaum, & Sacks, 1992; Reich & Green, 1991; Yonkers, Dyck, Warshaw, & Keller, 2000; see review by Mennin & Heimberg, 2000). If replicated, these results would make Panic Focused Psychodynamic Psychotherapy the treatment of choice for patients with panic disorder and personality disorder.

A second RCT for panic disorder (Beutel et al., 2013) compared PFPP with CBT and found no differences in remission rates or difference in symptom change scores between PFPP and CBT when taking patient baseline level of emotional processing into account. Taken together, PFPP has proved its effectiveness in two independent RCTs, both against a fair TAU group as well as against a strong CBT comparator.

For generalized anxiety disorder, Leichsenring and colleagues (2009; Salzer, Winkelbach, Leweke, Leibing, & Leichsenring, 2011) found no differences between STPP and CBT with regard to expert-rated symptom reduction in a small RCT. Regarding social phobia, a large multicenter RCT comparing STPP with CBT found both treatments to be equally effective with regard to response rates and more effective than

a waitlist control group (Leichsenring et al., 2013). In the short term, the CBT group had higher remission rates, but these differences disappeared in the two-year follow-up assessment (Leichsenring, 2013). Finally, one RCT found that psychodynamic treatment combined with pharmacotherapy was more effective in preventing relapse for panic disorder than pharmacotherapy alone (Bressi et al., 2010).

Somatic Symptoms

There are a growing number of studies showing evidence for the effectiveness of PDT in treating psychosomatic symptoms. In one RCT, 16 sessions of STPP added to the medical treatment as usual (TAU) were more effective than the medical treatment alone in patients with functional dyspepsia (Faramazi et al., 2013). Another RCT on women with breast cancer and comorbid depression found psychodynamic group psychotherapy to be more effective with regard to depression, quality of life, and other variables than TAU (Beutel et al., 2013). While some studies failed to find a superiority of PDT over specialized enhanced primary care (see for example Scheidt et al., 2013), two recent meta-analyses on the impact of STPP on somatic symptoms (Abbass, Kisely, & Kroenke, 2009) and general psychotherapeutic approaches on severe somatoform disorder (Koelen et al., 2014) present compelling evidence on the effectiveness of psychotherapeutic interventions in this difficult to treat patient group. Koelen and colleagues found a slight superiority of psychodynamic over CBT approaches on the improvement of patient functioning, though not on symptom change. Especially relevant for GPs are findings that additional, psychodynamically informed group therapy reduced symptom distress and GP visits in an RCT with difficult to treat patients with medically unexplained symptoms (Schaefer et al., 2013).

Eating Disorders

Several randomized control trials have examined psychodynamic treatment for eating disorders (Bachar, Latzer, Kreidler, & Berry, 1999; Crisp et al., 1991; Dare, Eisler, Russell, Treasure, & Dodge, 2001; Fairburn, Kirk, O'Connor, & Cooper, 1986; Garner et al., 1993; Gowers, Norton, Halek, & Crisp, 1994; Hall & Crisp, 1987; Russell, Szumkler, Dare, & Eisler, 1987). The general finding was that for anorexia nervosa, psychodynamic treatment is as effective as other treatments, including

behavioral and strategic family therapy (Crisp et al., 1991; Dare et al., 2001; Gowers et al., 1994; Hall & Crisp, 1987; Russell et al., 1987). Gowers et al. found significant improvements in weight and body mass index as compared to a TAU control condition. Dare and colleagues found that both psychodynamic psychotherapy and family therapy were significantly superior to routine treatment in terms of weight gain. With regard to bulimia nervosa, Fairburn et al. (1986) and Garner et al. (1993) found that psychodynamic and CBT treatments resulted in comparable improvements in bulimic episodes and self-induced vomiting although CBT was superior on other measures of general psychopathology. At follow-up both were equally effective and superior to pure behavior therapy (Fairburn et al., 1995) suggesting that both CBT and psychodynamic treatment are preferred choices over behavior therapy. On the other hand, a very recent study on the treatment of bulimia nervosa compared a non-directive psychodynamic therapy with a shorter but highly specific CBT intervention. Both led to significant symptom improvement, but the CBT intervention was more effective (Poulsen et al., 2014). More research is needed on the effectiveness of PDT in bulimia.

In the Anorexia Nervosa Treatment of Outpatients (ANTOP; Zipfel et al., 2014) trial, the largest study to date on the treatment of anorexia nervosa, 242 women were randomized to either 40 hours of focal STPP, enhanced CBT, or optimized treatment as usual by experienced community therapists. All three treatments were effective with regard to weight gain. However, there were more dropouts in the treatment by community TAU experts than in both manualized intervention groups. While STPP was equally effective as CBT at the end point of treatment, only psychodynamic therapy was more effective than TAU by community experts at 12-months follow-up.

Marital Therapy

In a controlled outcome study, Snyder, Wills, and Grady-Fletcher (1991) followed up 59 couples four years after receiving either behavioral or insight-oriented marital therapy. There were no group differences between the two treatment conditions at either termination or six-month follow-up. However, at four-year follow-up couples who received the insight-oriented therapy were more likely to be happily married (79% vs. 50%), whereas the couples who received the behavioral therapy were more likely to be divorced (38% vs. 3%).

Schizophrenia

There is clear evidence for the limited efficacy of CBT in the treatment of schizophrenia. In this context, a recent review conducted by the rigorous standards of the Cochrane Collaboration found other “active” psychological interventions equally effective (Jones, Hacker, Cormac, Meaden, & Irving, 2012). Furthermore, results from new trials on alternate approaches yield promising results, allowing patients to have a wider variety of treatment options. For example, in a controlled study, a manual-based supportive psychodynamic psychotherapy showed large effects in general as well as in specific treatment domains in patients with a first episode of psychosis after two years of treatment (Rosenbaum et al., 2012). In addition, it was more effective in the improvement of overall symptoms and functioning than TAU, with small to medium effects. These results are in line with an earlier study by Rosenbaum and colleagues (2006), where one weekly session of supportive psychodynamic psychotherapy was more effective than TAU, and as effective as a time-intensive, multimodal treatment after one year.

SUMMARY OF EMPIRICAL FINDINGS WITH PSYCHODYNAMIC PSYCHOTHERAPY

In summary, psychodynamic psychotherapy appears to be as effective as other treatments: effect sizes from meta-analyses suggest that it is equally, and sometimes even more effective than other psychotherapy, as effective as CBT, and often more effective than antidepressants. Although controversial, there are also a number of reasons to suggest the value of longer-term psychodynamic treatments for depression and anxiety. First, the long-term outcome and relapse rates from studies of depression strongly suggest the need for more intensive treatment. Despite reasonable short-term efficacy, the long-term efficacy of short-term versions of CBT, IPT, and PDT, as well as for medication treatment is poor. Second, there is an established literature showing that short-term treatments tend to ameliorate demoralization and symptoms but do not lead to more established rehabilitative changes in personality and functioning (Howard, Lueger, Maling, & Martinovich, 1993). These two sets of findings taken together suggest the need for longer and more intensive interventions. Third, there are findings from meta-anal-

yses, particularly of within-group effects that have found large effects for longer-term treatments (de Maat, de Jonghe, Schoevers, & Dekker, 2009; Leichsenring & Rabung, 2008, 2011). Finally, there are a number of quasi-experimental as well as experimental studies (i.e., RCTs) that have found superiority for longer-term PDT as compared to short-term (Knekt et al., 2008; Knekt, Lindfors, Laaksonen et al., 2011; Knekt, Lindfors, Renlund et al., 2011). Across individual studies, both experimental studies such as RCTs and more naturalistic studies, as well as multiple meta-analyses, and across a number of disorders, the findings are quite consistent in suggesting the value of psychodynamic psychotherapy in reducing the burden of mental illness. Empirical support for the usefulness of PDT exists for the treatment of depression, anxiety disorders, eating disorders, personality disorders, substance abuse, somatic symptoms, and marital discord. Emerging evidence also points toward the effectiveness of PDT for schizophrenia.

COMMON MISCONCEPTIONS ABOUT PSYCHOTHERAPY AND MEDICATION

There are a variety of commonly held misconceptions among clinicians as well as patients with regard to psychotherapy outcome as compared with medication management. Medications are often prescribed as a first-line intervention for the treatment of depressive and anxiety disorders (Otto, Smits, & Resee, 2005). However, the evidence that these disorders often respond more reliably to psychotherapeutic intervention (often with fewer untoward effects) is frequently neglected.

Results of both individual RCTs and meta-analytic reviews suggest that for a range of disorders such as borderline personality disorder, depressive disorders, and many anxiety disorders, psychotherapy should be the first line and/or primary treatment (DeRubeis, Siegle, & Hollon, 2008; Fournier et al., 2010; Hollon et al., 2005; Wexler & Cicchetti, 1992). For borderline personality disorders, medications can be an important augmentation, by taking the edge off certain symptoms, although their use can also result in iatrogenic problems (Frankenburg & Zanarini, 2006, 2011). For depression, medications may be indicated when depression is severe and includes neurovegetative signs or there is a worsening clinical picture. Some have noted that in these cases medications can help the patient be more available for psychotherapy (Roose & Johannet, 1998)—while this might be true, especially in the case of neurovegetative signs, such an understanding is very different from medications serving as the only treatment provided, as is increasingly the case.

Similar findings exist for anxiety disorders (Otto, McHugh, & Katak, 2010) where the combination of medications and psychotherapy do not yield greater improvements relative to either treatment alone. While medications might be useful for brief periods to help control anxiety, it is important to note that their use often undermines the effectiveness of psychotherapy, particularly CBT and BT approaches that rely on exposure and new learning or extinction (Hart, Panayi, Harris, & Westbrook, 2014; Otto, McHugh, & Katak, 2010).

With regard to the treatment of depression, Wexler and Cicchetti (1992) published a meta-analysis examining treatment success rates, treatment failure rates, and treatment dropout rates. Findings indicated that although psychotherapy and medications were both effective, psychotherapy produced a higher success rate (47%) than medication (29%) and that the combination of the two did not provide any additional benefit over that of psychotherapy alone (47%); however, adding psychotherapy to medication did provide some benefit over medication alone (47% for the combined psychotherapy and medication). Moreover, the use of medication, either alone or in combination with psychotherapy resulted in increased risk of dropout from treatment and other negative side effects. Thus they concluded with the very reasonable recommendation that the first-line treatment for depression should be a course of individual psychotherapy rather than exposing patients to unnecessary costs and side effects associated with combined treatment or medication alone. Only if there is no improvement in four months of treatment, or if there is a worsening of symptoms, should medication be introduced. Shortly after this publication, a letter to the editor chastised Wexler and Cicchetti's conclusion that psychotherapy be considered the initial treatment of choice by noting that it was difficult to imagine insurance companies adhering to their recommendation. Wexler and Cicchetti responded that if that was true it would be a shame because they would be ignoring the data. Since that meta-analysis, there have been many additional studies and meta-analyses examining psychotherapy, medication, and their combined effects in the treatment for depression (Huhn et al., 2014). The general effect sizes from meta-analyses for psychotherapy tend to be considerably larger than the effect sizes found in meta-analyses examining medication (effect size estimates = 0.31 for medications vs. effect size estimates ranging from .85 to 1.48 for psychotherapy; see Shedler, 2010); however, the few studies that directly compare psychotherapy and medication tend not to reveal consistent differences between the two treatments. In contrast to the findings of Wexler and Cicchetti, a few meta-analytic studies do find the combination of psychotherapy and medication to be superior to either alone with regard to outcome (Cuijpers et al., 2014). However,

psychotherapy consistently has lower rates of dropout and obviously fewer medication-rated side effects and the introduction of medication raises dropout for psychotherapy, although when in combination with psychotherapy, medication dropout is reduced. Further, much of this effect for antidepressants is only with those patients who exhibit neurovegetative signs; for those patients who do not exhibit neurovegetative signs, the effect size for antidepressant treatment is often around zero.

While the data are unclear whether or not augmenting psychotherapy with medications is useful or contraindicated, there is strong evidence that the addition of psychotherapy is a useful augment in the medication treatment of a range of disorders including ADHD, bipolar disorder (Miklowitz, 2008), and even schizophrenia (Brus, Novakovic, & Friedberg, 2012; Dixon et al., 2010; Gottdiener, 2006), and moreover, having good psychotherapeutic skill aids in the prescribing of medications and increases its effects (Blatt, Sanislow, Zuroff, & Pilkonis, 1996).

CONCLUSION

The under-provision and declining utilization of psychotherapy in the U.S. is not warranted in light of the strong evidence base for psychotherapy as evidenced in our broad review focused on psychodynamic psychotherapy as an exemplar. This situation represents a significant problem for the implementation of the Affordable Care Act. We would suggest that to the degree that decreasing reimbursement for psychotherapy relative to medication fuels declining utilization, the shift away from psychotherapeutic treatment relative to medication is "penny wise and pound foolish." This may be especially pronounced in relation to the costs incurred, by both patients and society at large, in the management of complex mental disorders.

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