Chapter 2
The Efficacy of Psychodynamic Psychotherapy *

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There is a belief in some quarters that psychodynamic concepts and treatments lack empirical support, or that scientific evidence shows that other forms of treatment are more effective. The belief appears to have taken on a life of its own. Academicians repeat it to one another, as do healthcare administrators, as do healthcare policy makers. With each repetition, its apparent credibility grows. At some point, there seems little need to question or revisit it because "everyone" knows it to be so.

The scientific evidence tells a different story: considerable research supports the efficacy and effectiveness of psychodynamic psychotherapy. The discrepancy between perceptions and evidence may be due, in part, to biases in the dissemination of research findings. One potential source of bias is a lingering distaste in the mental health professions for past psychoanalytic arrogance and authority. In decades past, American psychoanalysis was dominated by a hierarchical medical establishment that denied training to non-MDs and adopted a dismissive stance toward research. This did not win friends in academic circles. When empirical findings emerged that supported nonpsychodynamic treatments, many academicians greeted them enthusiastically and were eager to discuss and disseminate them. When empirical evidence supported psychodynamic concepts and treatments, it was often overlooked.

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This chapter brings together findings from several empirical literatures that bear on the efficacy of psychodynamic treatment. It will first outline the distinctive features of psychodynamic psychotherapy. It will next review empirical evidence for the efficacy of psychodynamic treatment, including evidence that patients who receive psychodynamic psychotherapy not only maintain therapeutic gains but continue to improve over time. Finally, it will consider evidence that nonpsychodynamic therapies may be effective in part because the more skilled practitioners utilize interventions that have long been central to psychodynamic theory and practice.

Distinctive Features of Psychodynamic Technique

Psychodynamic or *psychoanalytic psychotherapy*[1] refers to a range of treatments based on psychoanalytic concepts and methods that involve less frequent meetings and may be considerably briefer than *psychoanalysis* proper. Session frequency is typically once or twice per week, and the treatment may be either time limited or open ended. The essence of psychodynamic psychotherapy is exploring those aspects of self that are not fully known, especially as they are manifested and potentially influenced in the therapy relationship.

Undergraduate textbooks too often equate psychoanalytic or psychodynamic therapies with some of the more outlandish and inaccessible speculations made by Sigmund Freud roughly a century ago [1], rarely presenting mainstream psychodynamic concepts as understood and practiced today. Such presentations, along with caricatured depictions in the popular media, have contributed to widespread misunderstanding of psychodynamic treatment; for discussion of how clinical psychoanalysis is represented and misrepresented in undergraduate curricula, see [2–5]. To help dispel possible myths and facilitate greater understanding of psychodynamic practice, this section reviews core features of contemporary psychodynamic technique.

Blagys and Hilsenroth [6] conducted a search of the *PsycLit* database to identify empirical studies that compared the process and technique of manualized psychodynamic psychotherapy with that of manualized cognitive behavioral therapy. Seven features reliably distinguished psychodynamic therapy from other therapies, *as determined by empirical examination of actual session recordings and transcripts;* note that the features listed in the following text concern process and technique only, not underlying principles that inform these techniques; for a discussion of concepts and principles, see [7–9]:

1. *Focus on affect and expression of emotion*. Psychodynamic psychotherapy encourages exploration and discussion of the full range of a patient's emotions. The therapist helps the patient describe and put words to feelings, including contradictory feelings, feelings that are troubling or threatening, and feelings that the patient may not initially be able to recognize or acknowledge (this stands in contrast to a cognitive focus, where the greater emphasis is on thoughts and beliefs; [10, 11]). There is also a recognition that *intellectual* insight is not the same as emotional insight which resonates at a deep level and leads to change; this is one reason why many intelligent and psychologically minded people can explain the reasons for their difficulties, yet their understanding does not help them overcome those difficulties.

2. *Exploring attempts to avoid distressing thoughts and feelings.* People do a great many things, knowingly and unknowingly, to avoid aspects of experience that are troubling. This avoidance (in theoretical terms, defense and resistance) may take coarse forms, such as missing sessions, arriving late, or being evasive. It may take subtle forms that are difficult to recognize in ordinary social discourse, such as subtle shifts of topic when certain ideas arise, focusing on incidental aspects of

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[1] I use the terms *psychodynamic* and *psychoanalytic* interchangeably.

an experience rather than on what is psychologically meaningful, attending to facts and events to the exclusion of affect, focusing on external circumstances rather than one's own role in shaping events, and so on. Psychodynamic psychotherapists actively focus on and explore avoidances.

3. *Identifying recurring themes and patterns*. Psychodynamic psychotherapists work to identify and explore recurring themes and patterns in patients' thoughts, feelings, self-concept, relationships, and life experiences. In some cases, a patient may be acutely aware of recurring patterns that are painful or self-defeating but feel unable to escape them (e.g., a man who repeatedly finds himself drawn to romantic partners who are emotionally unavailable; a woman who regularly sabotages herself when success is at hand). In other cases, the patient may be unaware of the patterns until the therapist helps him or her recognize and understand them.

4. *Discussion of past experience (developmental focus).* Related to identifying of recurring themes and patterns is the recognition that past experience, especially early experiences of attachment figures, affects our relation to, and experience of, the present. Psychodynamic psychotherapists explore early experiences, the relation between past and present, and the ways in which the past tends to "live on" in the present. The focus is not on the past for its own sake, but rather on how the past sheds light on *current* psychological difficulties. The goal is to help patients free themselves from the bonds of past experience in order to live more fully in the present.

5. *Focus on interpersonal relations.* Psychodynamic psychotherapy places heavy emphasis on patients' relationships and interpersonal experience (in theoretical terms, object relations and attachment). Both adaptive and nonadaptive aspects of personality and self-concept are forged in the context of attachment relationships, and psychological difficulties often arise when problematic interpersonal patterns interfere with a person's ability to meet emotional needs.

6. *Focus on the therapy relationship*. The relationship between therapist and patient is itself an important interpersonal relationship, one that can become deeply meaningful and emotionally charged. To the extent that there are repetitive themes in a person's relationships and manner of interacting, these themes tend to emerge in some form in the therapy relationship. For example, a person prone to distrust others may view the therapist with suspicion; a person who fears disapproval, rejection, or abandonment may fear rejection by the therapist, whether knowingly or unknowingly; a person who struggles with anger and hostility may struggle with anger toward the therapist; and so on (these are relatively crude examples; the repetition of interpersonal themes in the therapy relationship is often more complex and subtle than these examples suggest). The recurrence of interpersonal themes in the therapy relationship (in theoretical terms, transference and countertransference) provides a unique opportunity to explore and rework them in vivo. The goal is greater flexibility in interpersonal relationships and an enhanced capacity to meet interpersonal needs.

7. *Exploration of wishes and fantasies.* In contrast to other therapies where the therapist may actively structure sessions or follow a predetermined agenda, psychodynamic psychotherapy encourages patients to speak freely about whatever is on their minds. When patients do this (and most patients require considerable help from the therapist before they can truly speak freely), their thoughts naturally range over many areas of mental life, including desires, fears, fantasies, dreams, and daydreams (which in many cases the patient has not previously attempted to put into words). All of this material is a rich source of information about how the person views self and others, interprets and makes sense of experience, avoids aspects of experience, or interferes with a potential capacity to find greater enjoyment and meaning in life.

The last sentence hints at a larger goal that is implicit in all of the others: The goals of psychodynamic psychotherapy include, but extend beyond, symptom remission. Successful treatment should not only relieve symptoms (i.e., get *rid* of something) but also foster the positive presence of psychological capacities and resources. Depending on the person and the circumstances, these might include the capacity to have more fulfilling relationships, make more effective use of one's talents and abilities, maintain a realistically based sense of self esteem, tolerate a wider range of affect, have

more satisfying sexual experiences, understand self and others in more nuanced and sophisticated ways, and face life's challenges with greater freedom and flexibility. Such ends are pursued through a process of self reflection, self exploration, and self discovery that takes place in the context of a safe and deeply authentic relationship between therapist and patient. (For a jargon-free introduction to contemporary psychodynamic thought, see *That was Then, This is Now: An Introduction to Contemporary Psychodynamic Therapy* ([7]; freely available for download at http://psychsystems. net/shedler.html [12]).

How Effective Is Psychotherapy in General?

In psychology and in medicine more generally, meta-analysis is a widely accepted method for summarizing and synthesizing the findings of independent studies [13–15]. Meta-analysis makes the results of different studies comparable by converting findings into a common metric, allowing findings to be aggregated or pooled across studies. A widely used metric is *effect size*, which is the difference between treatment and control groups, expressed in standard deviation units.[2] An effect size of 1.0 means that the average treated patient is one standard deviation healthier on the normal distribution or bell curve than the average untreated patient. An effect size of .8 is considered a large effect in psychological and medical research, an effect size of .5 is considered a moderate effect, and an effect size of .2 is considered a small effect [17].

The first major meta-analysis of psychotherapy outcome studies included 475 studies and yielded an overall effect size (various diagnoses and treatments) of .85 for patients who received psychotherapy compared to untreated controls [18]. Subsequent meta-analyses have similarly supported the efficacy of psychotherapy. The influential review by Lipsey and Wilson [19] tabulated results for 18 meta-analyses concerned with general psychotherapy outcomes, which had a median effect size of .75. It also tabulated results for 23 meta-analyses concerned with outcomes in cognitive behavioral therapy (CBT) and behavior modification, which had a median effect size of .62. A meta-analysis by Robinson et al. [20] summarized the findings of 37 psychotherapy studies concerned specifically with outcomes in the treatment of depression, which had an overall effect size of .73. These are relatively large effects. (For a review of psychotherapy efficacy and effectiveness research, see [21]).

To provide some points of reference, it is instructive to consider effect sizes for antidepressant medications. An analysis of FDA databases (published and unpublished studies) reported in the *New England Journal of Medicine* found effect sizes of .26 for fluoxetine (Prozac), .26 for sertraline (Zoloft), .24 for citalopram (Celexa), .31 for escitalopram (Lexapro), and .30 for duloxetine (Cymbalta). The overall mean effect size for antidepressant medications approved by the FDA between 1987 and 2004 was .31 [22].[3] A meta-analysis reported in the prestigious *Cochrane Library* [24] found an effect size of .17 for tricyclic antidepressants compared to active placebo (an active placebo mimics the side effects of an antidepressant drug but is not itself an antidepressant).[4]

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[2] This score, known as the *standardized mean difference*, is used to summarize the findings of randomized control trials. More broadly, the concept *effect size* may refer to any measure that expresses the magnitude of a research finding [16].

[3] The measure of effect size in this study was Hedges' *g* [23] rather than Cohen's *d* [17] which is more commonly reported. The two measures are based on slightly different computational formulas, but in this case, the choice of formula would have made no difference: "Because of the large sample size (over 12,000), there is no change in going from *g* to *d*; both values are .31 to two decimal places" (Rosenthal R, Personal communication to Marc Diener).

[4] Although antidepressant trials are intended to be double-blind, the blind is easily penetrated because the adverse effects of antidepressant medications are physically discernable and widely known. Study participants and their doctors can therefore figure out whether they are receiving medication or placebo, and effects attributed to medication may be inflated by expectancy and demand effects. Use of "active" placebos better protects the blind, and the resulting effect sizes are approximately half as large as those otherwise reported.

These are relatively small effects. Methodological differences between medication trials and psychotherapy trials are sufficiently great that effect sizes may not be directly comparable, and the findings should not be interpreted as conclusive evidence that psychotherapy is more effective. Effect sizes for antidepressant medications are reported to provide reference points that will be familiar to many readers; for more comprehensive listings of effect size reference points, see, e.g., [19, 25].

How Effective Is Psychodynamic Psychotherapy?

A recent and especially methodologically rigorous meta-analysis of psychodynamic psychotherapy, published by the *Cochrane Library,*[5] included 23 randomized controlled trials of 1,431 patients [26]. The studies compared patients with a range of common mental disorders[6] who received short-term (<40 h) psychodynamic psychotherapy with controls (wait list, minimal treatment, or "treatment as usual"), yielding an overall effect size of .97 for general symptom improvement. The effect size increased to 1.51 when the patients were assessed at long-term follow-up (>9 months post-treatment). In addition to change in general symptoms, the meta-analysis reported an effect size of .81 for change in somatic symptoms, which increased to 2.21 at long-term follow-up; an effect size of 1.08 for change in anxiety ratings, which increased to 1.35 at follow up; and an effect size of .59 for change in depressive symptoms, which increased to .98 at follow up.[7] The consistent trend toward larger effect sizes at follow-up suggests that psychodynamic psychotherapy sets in motion psychological processes that lead to ongoing change, even after therapy has ended.

A meta-analysis reported in *Archives of General Psychiatry* included 17 high quality randomized controlled trials (RCTs) of short-term (average 21 sessions) psychodynamic psychotherapy, reporting an effect size of 1.17 for psychodynamic psychotherapy compared to controls [27]. The pretreatment to post-treatment effect size was 1.39, which increased to 1.57 at long-term follow-up, which was an average of 13 months post-treatment. Translating these effect sizes into percentage terms, the authors noted that patients treated with psychodynamic psychotherapy were "better off with regard to their target problems than 92% of the patients before therapy."

A newly released meta-analysis examined the efficacy of short-term psychodynamic psychotherapy for somatic disorders [28]. It included 23 studies involving 1,870 patients who suffered from a wide range of somatic conditions (e.g., dermatological, neurological, cardiovascular, respiratory, gastrointestinal, musculoskeletal, genitourinary, immunological). The study reported an effect size of .69 for improvement in general psychiatric symptoms and .59 for improvement in somatic symptoms. Among studies that reported data on healthcare utilization, 77.8% reported significant reductions in healthcare utilization due to psychodynamic psychotherapy—a finding with potentially enormous implications for healthcare reform.

A meta-analysis reported in the *American Journal of Psychiatry* examined the efficacy of both psychodynamic psychotherapy (14 studies) and CBT (11 studies) for personality disorders [29]. The meta-analysis reported pretreatment to post-treatment effect sizes using the longest term follow-up available. For psychodynamic psychotherapy (mean length of treatment was 37 weeks), the mean

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[5] More widely known in medicine than in psychology, the Cochrane Library was created to promote evidence-based practice and is considered a leader in methodological rigor for meta-analysis.

[6] These included nonpsychotic symptom and behavior disorders commonly seen in primary care and psychiatric services, e.g., non bipolar depressive disorders, anxiety disorders, and somatoform disorders, often mixed with interpersonal or personality disorders [26].

[7] The meta-analysis computed effect sizes in a variety of ways. The findings reported here are based on the single method that seemed most conceptually and statistically meaningful (in this case, a random effects model, with a single outlier excluded). See the original source for more fine-grained analyses [26].

follow-up period was 1.5 years, and the pretreatment to post-treatment effect size was 1.46. For CBT (mean length of treatment was 16 weeks), the mean follow-up period was 13 weeks, and the effect size was 1.0. The authors concluded that both treatments demonstrated effectiveness. A more recent review of short-term (average 30.7 sessions) psychodynamic psychotherapy for personality disorders included data from seven randomized controlled trials [30]. The study assessed outcome at the longest follow-up period available (an average of 18.9 months post-treatment) and reported an effect size of .91 for general symptom improvement ($N=7$ studies) and .97 for improvement in interpersonal functioning ($N=4$ studies).

Two recent studies examined the efficacy of *long-term* psychodynamic treatment. A meta-analysis reported in the *Journal of the American Medical Association* [31, 32] compared long-term psychodynamic therapy (>1 year or 50 sessions) with shorter term therapies for the treatment of complex mental disorders (defined as multiple or chronic mental disorders, or personality disorders), yielding an effect size of .65 for longer term versus shorter term therapy.[8] The pretreatment to post-treatment effect size was 1.03 for overall outcome, which increased to 1.25 at long-term follow up ($P<.01$), an average of 23 months post-treatment. Effect sizes increased from treatment completion to follow-up for all five outcome domains assessed in the study (overall effectiveness, target problems, psychiatric symptoms, personality functioning, and social functioning). A second meta-analysis, reported in the *Harvard Review of Psychiatry*, examined the effectiveness of long-term psychodynamic psychotherapy (average 150 sessions) for adult outpatients with a range of DSM diagnoses [33]. For patients with mixed/moderate pathology, the pretreatment to post-treatment effect was .78 for general symptom improvement, which increased to .94 at long-term follow-up, an average of 3.2 years post-treatment. For patients with severe personality pathology, the pretreatment to post-treatment effect was .94, which increased to 1.02 at long-term follow-up, an average of 5.2 years post-treatment.

These meta-analyses represent the most recent and methodologically rigorous evaluations of psychodynamic psychotherapy. Especially noteworthy is the recurring finding that the benefits of psychodynamic psychotherapy not only endure but increase with time, a finding that has now emerged in at least five independent meta-analyses [26, 27, 31, 34, 35]. In contrast, the benefits of other (nonpsychodynamic) empirically supported therapies tend to decay over time for the most common disorders (e.g., depression, generalized anxiety; [35–38]).[9]

Table 2.1 summarizes the meta-analytic findings described previously and adds additional findings to provide further points of reference. Except as noted, effect sizes listed in the table are based on comparisons of treatment and control groups and reflect initial response to treatment (not long-term follow-up).

Studies supporting the efficacy of psychodynamic psychotherapy span a range of conditions and populations. Randomized controlled trials support the efficacy of psychodynamic psychotherapy for depression, anxiety, panic, somatoform disorders, eating disorders, substance-related disorders, and personality disorders [39, 40].

Findings concerning personality disorders are particularly intriguing. A recent study of patients with borderline personality disorder [41] not only demonstrated treatment benefits that equaled or exceeded those of another evidence-based treatment, dialectical behavior therapy (DBT; [42]), but also showed changes in underlying psychological mechanisms (intrapsychic processes) believed to mediate symptom change in borderline patients (specifically, changes in reflective function and attachment organization; [43]). These intrapsychic changes occurred in patients who received psychodynamic psychotherapy but not in patients who received DBT.

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[8] The authors had initially reported a higher effect size [31]; the value of .65 reported here is the more conservative value reported in a subsequent publication [32].

[9] The exceptions to this pattern are specific anxiety conditions such as panic disorder and simple phobia, for which short-term, manualized treatments do appear to have lasting benefits [38].

Table 2.1 Illustrative effect sizes from meta-analyses of treatment outcome studies

Treatment type and reference	Description	Effect size	N of studies or meta-analyses
General psychotherapy			
Smith, Glass, and Miller [18]	Various therapies and disorders	.85	475 studies
Lipsey and Wilson [19]	Various therapies and disorders	.75[a]	18 meta-analyses
Robinson et al. [20]	Various therapies, for depression	.73	37 studies
CBT and related therapies			
Lipsey and Wilson [19]	CBT and behavior therapy, various disorders	.62[b]	23 meta-analyses
Haby et al. [102]	CBT for depression, panic, and generalized anxiety	.68	33 studies
Churchill et al. [103]	CBT for depression	1.0	20 studies
Cuijpers et al. [104]	Behavioral activation for depression	.87	16 studies
Öst [105]	Dialectical behavior therapy, primarily for borderline personality disorder	.58	13 Studies
Antidepressant medication			
Turner et al. [22]	FDA-registered studies of antidepressants approved between 1987 and 2004	.31	74 studies
Moncrieff et al. [24]	Tricyclic antidepressants versus active placebo	.17	9 studies
Psychodynamic psychotherapy			
Abbass et al. [26]	Various disorders, general symptom improvement	.97	12 studies
Leichsenring et al. [27]	Various disorders, change in target problems	1.17	7 studies
Anderson and Lambert [34]	Various disorders and outcomes	.85	9 Studies
Abbass, Kisely, and Kroenke [28]	Somatic disorders, change in general psychiatric symptoms	.69	8 studies
Messer and Abbass [30]	Personality disorders, general symptom improvement	.91	7 studies
Leichsenring and Leibing [29]	Personality disorders, pretreatment to post-treatment	1.46[c]	14 studies
Leichsenring and Rabung [31, 32]	Long-term psychodynamic psychotherapy versus shorter-term therapies for complex mental disorders, overall outcome	.65	7 studies
de Maat et al. [33]	Long-term psychoanalytic psychotherapy, pretreatment to post-treatment	.78[c]	10 studies

[a]Median effect size across 18 meta-analyses (from [19], 1993, Table 2.1)
[b]Median effect size across 23 meta-analyses (from [19], 1993, Table 2.2)
[c]Pretreatment to post-treatment (within group) comparison

Such intrapsychic changes may account for long-term treatment benefits. A newly released study showed enduring benefits of psychodynamic psychotherapy 5 *years* after treatment completion (and 8 years after treatment initiation). At 5-year follow-up, 87% of patients who received "treatment as usual" continued to meet diagnostic criteria for borderline personality disorder, compared to 13% of patients who received psychodynamic psychotherapy [44]. No other treatment for personality pathology has shown such enduring benefits.

These last findings must be tempered with the caveat that they rest on two studies and therefore cannot carry as much evidential weight as findings replicated in multiple studies conducted by independent research teams. More generally, it must be acknowledged that there are far more empirical outcome studies of other treatments, notably CBT, than of psychodynamic treatments. The discrepancy in sheer number of studies is traceable, in part, to the indifference to empirical research of earlier generations of psychoanalysts, a failing that continues to haunt the field and that contemporary investigators labor to address.

A second caveat is that many psychodynamic outcome studies have included patients with a range of symptoms and conditions, rather than focusing on specific diagnostic categories (e.g., defined by *Diagnostic and Statistical Manual of Mental Disorders* [45] diagnostic criteria). To what

extent this is a limitation is open to debate. A concern often raised about psychotherapy efficacy studies is that they use highly selected and unrepresentative patient samples and consequently, findings do not generalize to real-world clinical practice (e.g., [38]). Nor is there universal agreement that DSM diagnostic categories define discrete or homogeneous patient groups (given that psychiatric comorbidity is the norm, and diagnosable complaints are often embedded in personality syndromes; [46, 47]). Be that as it may, an increasing number of studies of psychodynamic treatments do focus on specific diagnoses (e.g., [39–41, 44, 48, 49]).

A Rose by Another Name: Psychodynamic Process in Other Therapies

The "active ingredients" of therapy are not necessarily those presumed by the theory or treatment model. For this reason, randomized controlled trials that evaluate a therapy as a "package" do not necessarily provide support for its theoretical premises or for the specific interventions that derive from them. For example, the available evidence indicates that the mechanisms of change in cognitive therapy (CT) are *not* those presumed by the theory. Kazdin [50], reviewing the empirical literature on mediators and mechanisms of change in psychotherapy, concluded: "Perhaps we can state more confidently now than before that whatever may be the basis of changes with CT, it does not seem to be the cognitions as originally proposed" (p. 8).

There are also profound differences in the way therapists practice, even therapists ostensibly providing the same treatment. What takes place in the clinical consulting room reflects the qualities and style of the individual therapist, the individual patient, and the unique patterns of interaction that develop between them. Even in controlled studies designed to compare manualized treatments, therapists interact with patients in different ways, implement interventions differently, and introduce processes not specified by the treatment manuals [51]. In some cases, investigators have had difficulty determining from verbatim session transcripts which manualized treatment was being provided [52].

For these reasons, studies of therapy "brand names" can be highly misleading. Studies that look beyond brand names by examining session videotapes or transcripts may reveal more about what is helpful to patients [50, 53, 54]. Such studies indicate that the active ingredients of other therapies include unacknowledged psychodynamic elements.

One method of studying what actually happens in therapy sessions makes use of the *Psychotherapy Process Q-Sort* (PQS; [55]). The instrument consists of 100 variables that assess therapist technique and other aspects of therapy process based on specific actions, behaviors, and statements during sessions. In a series of studies, blind raters scored the 100 PQS variables from archival, verbatim session transcripts for hundreds of therapy hours from outcome studies of both brief psychodynamic and cognitive behavioral therapy [56, 57].[10]

In one study, the investigators asked panels of internationally recognized experts in psychoanalytic and cognitive behavioral therapy to use the PQS to describe "ideally" conducted treatments [56]. Based on the expert ratings, the investigators constructed prototypes of ideally conducted psychodynamic and cognitive behavioral therapy. The two prototypes differed considerably.

The psychodynamic prototype emphasized unstructured, open-ended dialog (e.g., discussion of fantasies and dreams); identifying recurring themes in the patient's experience; linking patient's feelings and perceptions to past experiences; drawing attention to feelings regarded by the patient as unacceptable (e.g., anger, envy, excitement); pointing out defensive maneuvers; interpreting warded-off or unconscious wishes, feelings, or ideas; focusing on the therapy relationship as a topic of discussion; and drawing connections between the therapy relationship and other relationships.

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[10] The cognitive therapy study was an RCT for depression; the psychodynamic psychotherapy studies were panel studies for mixed disorders and for PTSD, respectively. See the original source for more detailed descriptions [55].

The CBT prototype emphasized dialogue with a more specific focus, with the therapist structuring the interaction and introducing topics; the therapist functioning in a more didactic or teacher-like manner; the therapist offering explicit guidance or advice; discussion of the patient's treatment goals; explanation of the rationale behind the treatment and techniques; focusing on the patient's current life situation; focusing on cognitive themes such as thoughts and belief systems; and discussion of tasks or activities ("homework") for the patient to attempt outside of therapy sessions.[11]

In three sets of archival treatment records (one from a study of cognitive therapy and two from studies of brief psychodynamic psychotherapy), the researchers measured therapists' adherence to each therapy prototype, without regard to the treatment model the therapists *believed* they were applying [56]. *Therapist adherence to the psychodynamic prototype predicted successful outcome in both psychodynamic and cognitive therapy*. Therapist adherence to the CBT prototype showed little or no relation to outcome in either form of therapy. The findings replicated those of an earlier study which employed different methodology and also found that psychodynamic interventions, not CBT interventions, predicted successful outcome in both cognitive and psychodynamic treatments [57].

An independent team of investigators using different research methods also found that psychodynamic methods predicted successful outcome in cognitive therapy [58]. The study assessed outcomes in cognitive therapy conducted according to Beck's treatment model [59], and the findings had been reported as evidence for the efficacy of cognitive therapy for depression [60].[12]

Investigators measured three variables from verbatim transcripts of randomly selected therapy sessions in a sample of 64 outpatients. One variable assessed quality of the working alliance (the concept *working alliance* or *therapeutic alliance* is now widely recognized and often considered a nonspecific or "common" factor in many forms of therapy; many do not realize that the concept comes directly from psychoanalysis and has played a central role in psychoanalytic theory and practice for over four decades; see [61, 62]). The second variable assessed therapist implementation of the cognitive treatment model (i.e., addressing distorted cognitions believed to cause depressive affect). The third variable, labeled *experiencing*, beautifully captures the essence of psychoanalytic process:

"At the lower stages of [*experiencing*], the client talks about events, ideas, or others (Stage 1); refers to self but without expressing emotions (Stage 2); or expresses emotions but only as they relate to external circumstances (Stage 3). At higher stages, the client focuses directly on emotions and thoughts about self (Stage 4), engages in an exploration of his or her inner experience (Stage 5), and *gains awareness of previously implicit feelings and meanings* (Stage 6). The highest stage [7] refers to an ongoing process of in-depth self-understanding" ([58], p. 499; emphasis added).

Especially noteworthy is the phrase *gains awareness of previously implicit feelings and meanings*. The term *implicit* refers, of course, to aspects of mental life that are not initially conscious. The construct measured by the scale hearkens back to the earliest days of psychoanalysis and its central goal of making the unconscious conscious [63].[13]

In this study of manualized cognitive therapy for depression, the following findings emerged: (1) Working alliance predicted patient improvement on all outcome measures. (2) Psychodynamic process ("experiencing") predicted patient improvement on all outcome measures. (3) Therapist adherence to the cognitive treatment model (i.e., focusing on distorted cognitions) predicted *poorer* outcome. A subsequent study using different methodology replicated the finding that interventions aimed at cognitive change predicted poorer outcome [64]. However, discussion of interpersonal relations and exploration of past experiences with early caregivers—both core features of psychodynamic technique—predicted successful outcome.

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[11] See the original source for more complete descriptions of the two therapy prototypes [56].

[12] The study is one of the archival studies analyzed by Jones and his associates [56, 57].

[13] Although the *term* "experiencing" derives from the humanistic therapy tradition, the *phenomenon* assessed by the scale – a trajectory of deepening self-exploration, leading to increased awareness of implicit or unconscious mental life – is the core defining feature of psychoanalysis and psychoanalytic psychotherapy.

These findings should not be interpreted as indicating that cognitive techniques are harmful, and other studies have reported positive relations between CBT technique and outcome [65–67]. Qualitative analysis of the verbatim session transcripts suggested that the poorer outcomes associated with cognitive interventions were due to implementation of the cognitive treatment model in dogmatic, rigidly insensitive ways by certain of the therapists [58]. (No school of therapy appears to have a monopoly on dogmatism or therapeutic insensitivity. Certainly, the history of psychoanalysis is replete with examples of dogmatic excesses.) On the other hand, the findings *do* indicate that the more effective therapists facilitated therapeutic processes that have long been core, centrally defining features of psychoanalytic theory and practice.

Other empirical studies have also demonstrated links between psychodynamic methods and successful outcome, whether or not the investigators explicitly identified the methods as "psychodynamic" (e.g., [68–76]).

The Flight of the Dodo

The heading of this section is an allusion to what has come to be known in the psychotherapy research literature as the dodo bird verdict. After reviewing the psychotherapy outcome literatures of the time, Rosenzweig [77] and subsequently Luborsky, Singer, and Luborsky [78] reached the conclusion of the dodo bird in *Alice in Wonderland*: "Everyone has won and all must have prizes." Outcomes for different therapies were surprisingly equivalent and no form of psychotherapy proved superior to any other. In rare instances where studies find differences between active treatments, the findings virtually always favor the preferred treatment of the investigators (the investigator allegiance effect; [79]).

Subsequent research has done little to alter the Dodo bird verdict [21, 80]. For example, studies that have directly compared CBT with short-term psychodynamic psychotherapy for depression have failed to show greater efficacy for CBT over psychodynamic psychotherapy, or vice versa [48, 49]. Leichsenring [49] noted that both treatments appeared to qualify as empirically supported therapies (ESTs) according to the criteria specified by the American Psychological Association Division 12 Task Force [81, 82]. Some of the studies compared psychodynamic treatments of only eight sessions duration, which most practitioners would consider inadequate, with 16-session CBT treatments. Even in these studies, outcomes were comparable [83, 84].

There are many reasons why outcome studies may fail to show differences between treatments, even if important differences really exist. Others have discussed the limitations and unexamined assumptions of current research methods [38, 53, 85]. Here, I focus on one salient limitation: the mismatch between what psychodynamic psychotherapy aims to accomplish and what outcome studies typically measure.

As noted earlier, the goals of psychodynamic psychotherapy include, but extend beyond, alleviation of acute symptoms. Psychological health is not merely the absence of symptoms; it is the positive presence of inner capacities and resources that allow people to live life with a greater sense of freedom and possibility. Symptom-oriented outcome measures commonly used in outcome studies (e.g., the Beck Depression Inventory [86] or Hamilton Depression Rating Scale [87]) do not attempt to assess such inner capacities [54, 88]. Possibly, the Dodo bird verdict reflects a failure of researchers, psychodynamic and nonpsychodynamic alike, to adequately assess the range of phenomena that can change in psychotherapy.

The *Shedler–Westen Assessment Procedure* (SWAP; [89–91]) represents one method of assessing the kinds of inner capacities and resources that psychotherapy may develop. The SWAP is a clinician-report (not self-report) instrument that assesses a broad range of personality processes, both healthy and pathological. The instrument can be scored by clinicians of any theoretical orientation and

Table 2.2 Definition of mental health items from the Shedler–Westen Assessment Procedure (SWAP-200)

Is able to use his/her talents, abilities, and energy effectively and productively
Enjoys challenges; takes pleasure in accomplishing things
Is capable of sustaining a meaningful love relationship characterized by genuine intimacy and caring
Finds meaning in belonging and contributing to a larger community (e.g., organization, church, neighborhood, etc.)
Is able to find meaning and fulfillment in guiding, mentoring, or nurturing others
Is empathic; is sensitive and responsive to other peoples' needs and feelings
Is able to assert him/herself effectively and appropriately when necessary
Appreciates and responds to humor
Is capable of hearing information that is emotionally threatening (i.e., that challenges cherished beliefs, perceptions, and self-perceptions) and can use and benefit from it
Appears to have come to terms with painful experiences from the past; has found meaning in, and grown from such experiences
Is articulate; can express self well in words
Has an active and satisfying sex life
Appears comfortable and at ease in social situations
Generally finds contentment and happiness in life's activities
Tends to express affect appropriate in quality and intensity to the situation at hand
Has the capacity to recognize alternative viewpoints, even in matters that stir up strong feelings
Has moral and ethical standards and strives to live up to them
Is creative; is able to see things or approach problems in novel ways
Tends to be conscientious and responsible
Tends to be energetic and outgoing
Is psychologically insightful; is able to understand self and others in subtle and sophisticated ways
Is able to find meaning and satisfaction in the pursuit of long-term goals and ambitions
Is able to form close and lasting friendships characterized by mutual support and sharing of experiences

has demonstrated high reliability and validity relative to a wide range of criterion measures [89, 92]. The SWAP includes an empirically derived *Healthy Functioning Index* comprised of the items listed in Table 2.2, which define and operationalize mental health *as consensually understood by clinical practitioners across theoretical orientations* [90, 91]. Many forms of treatment, including medications, may be effective in alleviating acute psychiatric symptoms, at least in the short run. However, not all therapies aim at changing underlying psychological processes such as those assessed by the SWAP. (A working version of the SWAP, which generates and graphs T-scores for a wide range of personality traits and disorders, is available at www.SWAPassessment.org.)

Researchers, including psychodynamically oriented researchers, have yet to conduct compelling outcome studies that assess changes in inner capacities and resources, but two studies raise intriguing possibilities and suggest directions for future research. One is a single case study of a woman diagnosed with borderline personality disorder, who was assessed with the SWAP by independent assessors (not the treating clinician) at the beginning of treatment and again after 2 years of psychodynamic psychotherapy [93]. In addition to meaningful decreases in SWAP scales that measure psychopathology, the patient's SWAP scores showed an increased capacity for empathy and greater sensitivity to others' needs and feelings; increased ability to recognize alternative viewpoints, even when emotions ran high; increased ability to comfort and soothe herself; increased recognition and awareness of the consequences of her actions; increased ability to express herself verbally; more accurate and balanced perceptions of people and situations; a greater capacity to appreciate humor; and, perhaps most importantly, she had come to terms with painful past experiences and had found meaning in them and grown from them. The patient's score on the SWAP *Healthy Functioning Index* increased by approximately two standard deviations over the course of treatment.

A second study used the SWAP to compare 26 patients beginning psychoanalysis with 26 patients completing psychoanalysis [94]. The latter group not only had significantly lower scores for SWAP

items assessing depression, anxiety, guilt, shame, feelings of inadequacy, and fears of rejection, but significantly higher scores for SWAP items assessing inner strengths and capacities (Table 2.2). These included greater satisfaction in pursuing long-term goals, enjoyment of challenges and pleasure in accomplishments, ability to utilize talents and abilities, contentment in life's activities, empathy for others, interpersonal assertiveness and effectiveness, ability to hear and benefit from emotionally threatening information, and resolution of past painful experiences. For the group completing psychoanalysis, the mean score on the SWAP *Healthy Functioning Index* was one standard deviation higher.

Methodological limitations preclude drawing causal conclusions from these studies, but they suggest that psychodynamic psychotherapy may not only alleviate symptoms but also develop inner capacities and resources that allow a richer and more fulfilling life. Measures such as the SWAP could be incorporated in future randomized controlled trials, scored by independent assessors blind to treatment condition, and used to assess such outcomes. Whether or not all forms of therapy aim for such outcomes, or researchers study them, *they are clearly the outcomes desired by many people who seek psychotherapy*. Perhaps, this is why psychotherapists, irrespective of their own theoretical orientations, tend to choose psychodynamic psychotherapy for themselves [95].

Discussion

One intent of this chapter was to provide an overview of some basic principles of psychodynamic psychotherapy for readers who have not been exposed to them, or, at least, who have not heard them presented by a contemporary practitioner who takes them seriously and uses them clinically. Another was to show that psychodynamic treatments have considerable empirically support. The empirical literature on psychodynamic treatments does, however, have significant limitations. First, the number of randomized controlled trials for other forms of psychotherapy, notably CBT, is considerably larger than that for psychodynamic psychotherapy, perhaps by an order of magnitude. Many of these trials, specifically the newer and better designed trials, are superior in methodological rigor (although some of the newest psychodynamic RCTs, e.g., [41], also meet the highest standards of methodological rigor). In too many cases, characteristics of patient samples have been too loosely specified, treatment methods have been inadequately specified and monitored, and control conditions have not been optimal (e.g., using wait-list controls or "treatment as usual" rather than active alternative treatments—a limitation that applies to research on empirically supported therapies more generally). These and other limitations of the psychodynamic research literature must be addressed by future research. The intent of this chapter is not to compare treatments or literatures, but to review the existing empirical evidence supporting psychodynamic treatments and therapy processes, which is often underappreciated.

In writing this chapter, it was impossible not to be struck by a number of ironies. One is that academicians who dismiss psychodynamic approaches, sometimes in vehement tones, often do so in the name of science. Some advocate a science of psychology grounded exclusively in the experimental method. Yet, the same experimental method yields findings that support both psychodynamic concepts (e.g., [96]) and treatments. In light of the accumulation of empirical findings, blanket assertions that psychodynamic approaches lack scientific support (e.g., [97–99]) are no longer defensible. Presentations that equate psychoanalysis with dated concepts that last held currency in the psychoanalytic community in the early twentieth century are similarly misleading; they are at best uninformed and at worst disingenuous.

A second irony is that relatively few clinical practitioners, including psychodynamic practitioners, are familiar with the research reviewed in this chapter. Many psychodynamic clinicians and educators seem ill-prepared to respond to challenges from evidence-oriented colleagues, students,

utilization reviewers, or policy makers, despite the accumulation of high quality empirical evidence supporting psychodynamic concepts and treatments. Just as antipsychoanalytic sentiment may have impeded dissemination of this research in academic circles, distrust of academic research methods may have impeded dissemination in psychoanalytic circles; see [100]. Such attitudes are changing, but they cannot change quickly enough.

Researchers also share responsibility for this state of affairs [7]. Many investigators take for granted that clinical practitioners are the intended consumers of clinical research (e.g., [81]), but many of the psychotherapy outcome studies and meta-analyses reviewed for this chapter are clearly not written for practitioners. On the contrary, they are densely complex and technical, and often seem written primarily for other psychotherapy researchers—a case of one hand writing for the other. As an experienced research methodologist and psychometrician, I must admit that deciphering some of these articles required hours of study and more than a few consultations with colleagues who conduct and publish outcome research. I am unsure how the average knowledgeable clinical practitioner could navigate the thicket of specialized statistical methods, clinically unrepresentative samples, investigator allegiance effects, inconsistent methods of reporting results, and inconsistent findings across multiple outcome variables of uncertain clinical relevance. If clinical practitioners are indeed the intended "consumers" of psychotherapy research, then psychotherapy research needs to be more consumer relevant [101].

With the caveats noted earlier, the available evidence indicates that effect sizes for psychodynamic psychotherapies are as large as those reported for other treatments that have been actively promoted as "empirically supported" and "evidence based." It indicates that the (often unacknowledged) "active ingredients" of other therapies include techniques and processes that have long been core, centrally defining features of psychodynamic treatment. Finally, the evidence indicates that the benefits of psychodynamic treatment are lasting and not just transitory, and appear to extend well beyond symptom remission. For many people, psychodynamic psychotherapy may foster inner resources and capacities that allow richer, freer, and more fulfilling lives.

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