Psychodynamic psychotherapy: The evidence is in

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The current issue of *American Psychologist* includes an article by Jonathan Shedler, an associate professor at the University of Colorado, titled 'The efficacy of psychodynamic psychotherapy' (Shedler, 2010). The publication of this article signals a growing recognition within the psychological community that psychodynamic psychotherapy has returned to the mainstream after nearly half a century of hiatus. While the practice of psychodynamic therapy continued through that period, it was increasingly marginalised or excluded in the training of psychologists, being replaced by therapies considered to be evidence-based – initially the behavioural therapies and subsequently the cognitive therapies.

The problem for psychodynamic psychotherapy was not so much that it had been shown to be ineffective but rather that it had not been shown to be effective. Its proponents usually had little interest in research and relied instead on reputation. Once that reputation was challenged, they had little with which to counter the increasingly impressive evidence of the effectiveness of behavioural and cognitive therapies (CBT). However, during this period of retreat, investigations of the effectiveness of psychodynamic therapy were initiated by sympathetic researchers in the UK, Europe and the US. It has taken until relatively recently for this body of research to yield enough information to warrant clear conclusions about the empirical status of psychodynamic therapy. Shedler (2010) has done this and has created a narrative that will be widely read, because it appears in the leading journal for practising psychologists in the US. The American Psychological Association has recently issued a press release regarding the importance of this new evidence for the effectiveness of psychodynamic psychotherapy (see www.apa.org/news/press/releases/2010/01/psychodynamic-therapy.aspx).

What does the evidence show?

Shedler reviews meta-analytic studies of research into the effectiveness of psychodynamic psychotherapy, which show effect sizes[1] at least as great as those reported for CBT, and argues that there may be enduring benefits that exceed those of other therapies. For example, he cites a recent Cochrane Library review which included 23 randomised controlled trials and yielded an effect size of .97 for psychodynamic psychotherapy for general symptom improvements, which increased to an effect size of 1.51 when patients were assessed at long-term follow-up (Abbas, Hancock, et al. 2006, cited in Shedler, 2010). He provides further examples of treatment effects for psychodynamic psychotherapy of patients with a range of disorders, including personality disorders, with an effect size of 1.46 at long-term follow-up (Leichsenring & Leibing, 2003, cited in Shedler, 2010). These results lend support to Shedler's argument that the benefits of psychodynamic psychotherapy not only endure but increase over time. He posits that this may be due to the process instigated by psychodynamic psychotherapy, which he contrasts with that of other non-psychodynamic therapies where the effects have been shown to decay over time.

Shedler goes so far as to claim that psychodynamic psychotherapy substantially outperforms medication in treatment of depression. This will be appealing to psychologists but, for reasons outlined below, we do not find it to be persuasive. Finally Shedler suggests that the therapy processes characteristic of psychodynamic psychotherapy may result in internal changes in clients (going well beyond symptom relief) that may not be achieved through other therapies.

In addition to the rigorous presentation of data in relation to the effectiveness of psychodynamic therapy for a range of conditions and populations, Shedler discusses the data on the treatment of personality disorders, particularly borderline personality disorder. He challenges the dominance of dialectical behaviour therapy by citing the evidence for the effectiveness of psychodynamic approaches in the management of such patients. He argues that psychodynamic approaches address underlying psychological mechanisms, which in turn mediate symptom change by i) enhancing reflective functioning, and ii) addressing the attachment function. The benefits of this approach, based upon a five-year follow-up, are shown to be enduring.

As we see it, Shedler's argument that psychodynamic therapies can and should be considered to be evidence-based and empirically supported is compelling. Shedler acknowledges that the evidence base is not as substantial as that of CBT, but the findings are consistent and robust, and the numbers are more than adequate to justify his conclusion. We think this is well established, both in his paper and in related studies (e.g., Leichsenring & Rabung, 2008). He acknowledges that the evidence suggesting that psychodynamic therapy produces more enduring and more fundamental changes than other therapies is less compelling.

[1] The difference in treatment and control groups expressed in standard deviation (SD) units, where an effect size of 1.0 means that the average treated patient is one SD healthier on the normal distribution than the average untreated patient.

Over-reach?

There are several weaknesses in Shedler's arguments and conclusions that require consideration. First, his argument that psychodynamic psychotherapy can be clearly distinguished from other therapies by reference to the seven features listed in the boxed information is at the very least open to debate. For example, identifying recurring themes and patterns could be equally said to be characteristic of CBT, and focus on interpersonal relations is central to Interpersonal Therapy (IPT). The lack of reference to transference or unconscious conflict is noteworthy. One consequence of defining a therapy by a set of very broad characteristics is that many people with little or no training in psychodynamic therapy might well read the description and conclude: 'That sounds like me; I must be a psychodynamic therapist'.

Second, the comparison of effect sizes for medication and psychotherapy is quite misleading. Whereas the small effect size reported for anti-depressant medication is relative to double blind placebo control, the effect size reported for psychotherapy is relative to waitlist, no treatment, or treatment as usual. Placebo is an effective treatment for depression, and psychotherapy effects include the placebo effect (which probably amounts to at least two thirds of the treatment effect). Research that has compared efficacy of anti-depressant medication and psychotherapy for depression has typically found very similar effect sizes, and the suggestion that psychotherapy is clearly more effective than medication is simply wrong.

Third, when Shedler suggests that psychodynamic therapy has more enduring effects than therapies such as CBT, he is overlooking the possibility that the enduring effect is simply an artefact of treatment duration. In other words it is possible that there is a linear relationship between treatment duration and duration of treatment (after-)effect and that the only reason psychodynamic therapy has a longer treatment effect is because it is typically more prolonged than other therapies.

Finally, Shedler omits any discussion of relative cost effectiveness. In particular he fails to discuss dose differences between different psychotherapies; even brief psychodynamically-oriented treatments are substantially longer than a typical course of CBT. While Shedler suggests that psychodynamic therapy may lead to longer-lasting and more fundamental intrapsychic change, the empirical support for this is relatively weak. Until we are in possession of stronger evidence regarding this, the suspicion must remain that in many circumstances, psychodynamic interventions for the treatment of less complex disorders are relatively less cost-effective than the alternatives.

Description of psychodynamic psychotherapy (Shedler, 2010)

Goal

Extend beyond symptom remission, using self reflection, self exploration and self discovery to foster the positive presence of psychological capacities and resources such as:

- Developing the capacity for more fulfilling relationships
- Making more effective use of one's talents and abilities
- Maintaining a realistically based sense of self esteem
- Tolerating a wider range of affect
- Having more satisfying sexual experiences
- Understanding self and others in more nuanced and sophisticated ways
- Facing life's challenges with greater freedom and flexibility.

Distinctive features

1. Focus on affect and expression of emotion
2. Exploration of attempts to avoid distressing thoughts and feelings
3. Identification of recurring themes and patterns
4. Discussion of past experience (developmental focus)
5. Focus on interpersonal relations
6. Focus on the therapy relationship
7. Exploration of fantasy life

Implications

So what are the implications for the profession of the current state of knowledge, as exemplified in this important publication? First, we think that it is time for those universities that have not already done so to move beyond the convenient but intellectually dishonest position that CBT is the only evidence-based psychotherapy. Undergraduate students should be taught the principles and evidence base for psychodynamic therapy, postgraduate psychology students should have opportunities for training in psychodynamic psychotherapy, and such training should be supplied by psychologists with genuine interest and expertise in the area.

Second, we think that the APS should encourage the Government to revisit the specified psychological treatments for Medicare rebate. At present there are two specified treatments for which rebates are provided to generalist psychologists: CBT and IPT. Psychodynamic therapy probably has a more substantial claim to an evidence base than IPT, but it may be that specifying treatments by name is inherently unsatisfactory, and it would be better to specify that practice should be evidence-based and to provide guidelines as to what this means.

Third, we need to refine our understanding of when psychodynamic therapy is the indicated treatment. We think it may be most clearly indicated as a secondary treatment when a brief focal treatment such as CBT has not yielded the expected outcomes (which may be the case for up to one third of all cases). It may also be indicated where problems are clearly complex and involve fundamental rather than transient disturbance of intrapersonal or interpersonal functioning. ■

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References

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