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SYSTEMATIC RESEARCH SUPPORTING PSYCHOANALYTIC AND PSYCHODYNAMIC TREATMENTS

Research for the efficacy of psychoanalytic and psychoanalytically oriented therapies is accumulating. There has been a long-standing belief held by the public and many mental health professionals that psychoanalytically based therapies do not have empirical support, or do not have nearly as much empirical support as cognitive-behavioral therapies and medications have. This issue will contribute to eradicating that perception. It will provide psychoanalytic practitioners with a plethora of evidence that argues for the efficacy of their way of working and it provides nonpsychoanalytic practitioners such data to consider.

From 1913 to 1960 psychology was dominated by behaviorism. During the 1960s psychology witnessed a "cognitive" revolution (Gardner, 1988). In most departments of psychology in U.S. universities, scholars with psychoanalytic leanings were not hired. Research on outcomes in psychotherapy was thus conducted largely by those with cognitive and behavioral orientations. As the movement toward evidence-based medicine grew, researchers were pressed to demonstrate that psychotherapy was also helpful in treating many disorders, not only pharmacotherapy. When a task force in psychology went to establish a list of empirically validated therapies, research had already been conducted by psychologists examining the short-term therapies that cognitive-behaviorists advocated.

The list of empirically validated therapies, originally composed in 1995 by a task force of the Clinical Psychology Division of the American

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Psychological Association, was derived only from data of randomized control trials (RCTs), of people with specific disorders given manualized treatments. The researchers must also have had a control group and provided evidence conducted in more than one study by one team of researchers. The original list included 18 treatments and no psychodynamic treatments, because no RCTs on psychodynamic treatments had been conducted at that time.[1] One of these, the National Register of Evidence-Based Programs and Practices for mental health and substance abuse has 284 interventions but none that are psychodynamic.

As the demand for such empirically based treatments increased, researchers interested in psychoanalysis, psychodynamic therapies, and humanistic-experiential therapies began to collect data to demonstrate that therapies besides cognitive-behavioral ones were also supported by empirical evidence. As of 2005, the clinical psychology list could include research other than RCTs. Yet of the 77 therapies now present, only 4 are for clearly psychodynamic therapies: mentalization-based treatment for borderline personality disorder, psychoanalytic treatment for panic disorder, short-term psychodynamic treatment for depression, and transference-focused treatment for borderline personality disorder. Four others are for interpersonal psychotherapy, and although derived from ideas by the psychoanalyst Harry Stack Sullivan, they are not specifically psychodynamic. Researchers such as Norcross (2002, 2011) responded to the idea that we were treating disorders instead of people, publishing *Psychotherapy Relationships That Work: Evidence-based Responsiveness*. Yet this research, probably because it is not specifically psychodynamic, is not well known to many psychoanalysts.

There are some advocates of empirically supported treatments (ESTs) who have suggested that clinicians be trained primarily in these methods and consider other forms of treatment "less essential and outdated" (Calhoun, Moras, Pilkonis & Rehm, 1998, p. 151). There are many problems with this perspective. A major problem with the EST studies is that those selected for the trials usually have a single Axis I disorder, such as major depression, and anyone with other problems (e.g., alcohol abuse, a personality disorder) or serious problems (suicidality) is excluded. Dialectical behavior therapy is one of the two therapies with empirical support for

[1] Another link alone provides over 30 federal, state, professional, and university websites that enumerate these interventions: http://ucoll.fdu.edu/apa/lnksinter.html

borderline personality disorder. Although after a year, patients showed a decline in behavioral problems (parasuicidal gestures), little change occurred in feelings of emptiness (Scheel, 2001). Westen, Novotny, and Thompson-Brenner (2004) concluded that one- to two-thirds of patients were excluded from the research. For example, in a study of CBT for depression, after screening, only 76 patients were found suitable for inclusion (Thase et al., 1992). Of those included, 36% showed a full recovery and 42% a partial recovery. At a one-year follow-up, 38% remained improved. This represented 29 of the original "more than 130" (p. 1047), or about 22%. In Westen and Morrison's (2001) meta-analysis of empirically supported studies of generalized anxiety disorders and depression, the exclusion rate was approximately two-thirds. Westen and Morrison concluded that "With the exception of CBT for panic, the majority of patients receiving treatments for all the disorders we reviewed did not recover" (p. 650).

Another problem with the "evidence" for the CBT therapies is that the control groups, some supposedly receiving treatment as usual, often received something that was not treatment (Wampold et al., 2011). Wampold et al. reported that in some cases, treatment as usual consisted of the primary care physician making a referral. Still, there is often a public perception that only CBT works:

> Mental-health care has come a long way since the remedy of choice was trepanation—drilling holes into the skull to release "evil spirits." Over the last 30 years, treatments like cognitive-behavioral therapy, dialectical behavior therapy and family-based treatment have been shown effective for ailments ranging from anxiety and depression to post-traumatic stress disorder and eating disorders. The trouble is, surprisingly few patients actually get these kinds of evidence-based treatments once they land on the couch—especially not cognitive behavioral therapy. (Brown, 2013)

The public perception likely comes in part from the impact of the journals in which psychodynamic research and CBT research have been published. Weiss (2009), in the *Handbook of Evidence-Based Psychodynamic Psychotherapy*, commented that psychodynamic psychotherapy is published for a "psychodynamic island ... with little communication with the outside world" (p. 391). He noted that the top three journals, in terms of psychodynamic psychotherapy publications, *Psychotherapy Research*, *Psychotherapy*, and the *American Journal of Psychotherapy,*

have an impact factor at or below a value of 1. *The Archives of General Psychiatry*, on the other hand, has an impact factor of 13.9, indicating a far greater citation flow to other journals. Searching in the *Archives of General Psychiatry* (now *JAMA Psychiatry*) for "cognitive behavior therapy" and "cognitive behavioral therapy" in the titles yielded 20 articles, whereas "psychodynamic therapy" yielded only 2. The articles from the *Archives* are cited in publications in journals that are in turn cited themselves. Although this special section won't help deal with the isolation of psychoanalysts, at least more of those who practice psychodynamic therapy will learn about the evidence that supports the effectiveness of many of the interventions they are likely making.

Although CBT was considered the best treatment for disorders such as depression and anxiety in many European countries, the situation is changing in Sweden and the Netherlands. Although CBT was recommended first in the guidelines of the Swedish National Board of Health and Welfare, these recommendations will now be revised. Sweden spent 2 billion kroners disseminating CBT and offering it to those suffering from depression and anxiety, only to find that those treated with it were more likely to become disabled (i.e., on long term sick leave), as reported in *Socionomen*, the official journal for Swedish social workers (cf. Miller, 2012). Something similar is occurring in the Netherlands. Although CBT and Interpersonal Psychotherapy were the only treatments listed in that country's 2004 guidelines of evidence-based treatments for depression, psychodynamic therapy is now being added (see Dekker et al., this issue).

In this special section of *Contemporary Psychoanalysis,* researchers present arguments and evidence for the efficacy of psychodynamic and psychoanalytic treatments, and they present data describing the ways in which change takes place. In the first article, Sandell argues for a double vision—one that examines individual differences in single case studies and also regularities that are found in the treatments of groups of patients. He first explores the two major arguments leveled against systematic research in psychoanalysis: (1) the idea that the processes are not observable, and (2) the idea that the persons of the analyst and the analysand are unique and cannot be investigated by group studies. In regard to uniqueness, he questions the usefulness of case studies if one believes they are truly unique. It would then seem they are too specific to generalize. On the other hand, group data may be too heterogeneous to predict anything certain about a case. He argues for an approach in

which one looks at the averages for subgroups to find the regularities that emerge when one notices how individuals resemble others in a subgroup, but not the whole group.

Zilcha-Mano and Barber then explode two myths: (1) that dynamic therapy is not an evidence-based practice and (2) that it is not effective at alleviating symptoms. In regard to Myth 1, they cite studies demonstrating efficacy for both short-term and long-term (average of 150 sessions) treatments, with improvement after the end of treatments, and large effect sizes, especially at long-term follow-up. They report meta-analyses of randomized control trials for depression, personality disorders, and almost all anxiety disorders, showing that dynamic therapy was equal to CBT or superior to control groups at termination and follow-up. In regard to Myth 2, they cite studies demonstrating that many symptoms are alleviated—depression, panic, agoraphobia, generalized anxiety disorder, traumatic and somatic symptoms, cocaine abuse, and borderline, avoidant, and obsessive-compulsive personality disorders. They then examine what makes dynamic therapy successful, citing two major factors—the alliance and specific techniques. They also report findings concerning dynamic therapy's insufficiencies. (For example, with cocaine-dependent patients, abstinence first works better than understanding the reasons for drug use.) The frequent use of interpretations has been shown to be problematic—the competency of the delivery is what is important. A number of techniques have been shown to be helpful, such as supporting the patient's wish to achieve his or her goals, pointing out similarities in past and present relationships, and relating symptoms to components of the relationship problems. This issue of what leads to change and what leads to a lack of change is taken up in later articles by Hersoug et al., Diamond et al., Safran et al., and Kächele and Schachter.

First, however, more evidence is presented for the efficacy of dynamic treatments in papers by Leichsenring et al. and Dekker et al. Leichsenring et al. focus on randomized control trials. They present many studies showing the efficacy of dynamic treatments for people with depression; anxiety; somatoform, personality, eating and substance-related disorders; complicated grief; and PTSD. They comment on the need for more studies of long-term psychotherapies. Dekker et al. focus on short psychodynamic supportive psychotherapy (SPSP), developed as a treatment for depressed outpatients in the early 1990s by De Jonghe (2005). Reviewing a series of comparative studies, they note that adding

SPSP to antidepressants was more effective than antidepressants by themselves, and that adding medication to SPSP did not have as large an effect. No differences were found between CBT and SPSP.

Hersoug et al., in an expansion of their extensive work on the experimental study of transference, found that transference work was beneficial with patients with a low quality of relationship with other people, especially women, but not helpful with patients with a good alliance and a high quality of relationships with others. This result seems perplexing in light of other research findings. Further research will be needed to determine precisely what was meant by "transference work." For example, in comparison of data from psychoanalysts from the White Institute and Norwegian analysts, we (Curtis, Knaan-Kostman, Mannix, & Field, 2004) found that the Norwegian analysts engaged in interventions that were more traditionally "Freudian," although these Norwegian analysts were of an interpersonal bent. Does transference work mean something like an interpretation such as, "You feel this way toward me, as you did toward your father." If so, this might well irritate a high-functioning person. If the transference work, on the other hand, were a comment such as, "So you felt as if I were frowning when you came into the room. . . . Tell me about that and how you were feeling," a sort of intervention traditionally used by interpersonal analysts, the result that the transference work is not helpful might be more surprising. If, however, it turns out that in general patients with both a high quality of relationships with others and a good alliance do not benefit as significantly from transference work as from other sorts of interventions, psychoanalysts may wish to revise their theories of change (cf. Curtis, 2009, 2012), based on thinking seriously about other mechanisms of change. Systematic research can specify and clarify such issues, as will likely be done by this prolific group in the future.

In the next article, Diamond et al. examined how attachment style and reflective functioning changed in patients fitting diagnostic criteria for both narcissistic and borderline personality disorder simultaneously and those meeting criteria for borderline personality disorder alone during transference focused psychotherapy. For both groups, those with an insecure/disorganized attachment state of mind shifted to an organized, although insecure style, and reflective functioning improved. The research indicated, however, that some of the narcissistic ways of coping appeared to help patients become less disorganized.

Safran et al. examined how their brief relational therapy, derived from aspects of relational psychoanalysis, helped therapists and patients resolve ruptures in their relationships. Brief relational therapy included formal mindfulness training exercise and alliance-focused training. Supporting ideas drawn from interpersonal psychoanalysis, the value of addressing the patient's negative feelings about the therapist was demonstrated. High reflective functioning on the part of the therapist predicted better rupture resolution. Although the patients of therapists with better reflective functioning did not show better interpersonal functioning or fewer symptoms at the termination of their 30 sessions of therapy, they did show these changes at a six-month follow-up.

And finally, Kächele and Schacter address an often-avoided issue: When does psychodynamic treatment fail to help? Attrition rates are high and similar in both psychotherapy and psychoanalysis, 32–67% and 27–60%, respectively, in various studies for various time periods. Only about 50% of psychoanalyses end in mutually agreed upon terminations, although the rate is much higher when psychoanalysts themselves are patients. They address some of the possible causes: incorrect diagnoses, unfavorable external conditions, constitutional factors, transference and countertransference issues, and therapist factors such as training, skill, and personality.

More case studies and systematic research would help determine the factors leading to more helpful and less helpful treatments. To deal with the problem that the most common number of sessions in psychotherapy is only one, therapists might learn what questions are important to ask in a first session, such as "What might keep you from coming back?" Lambert (2010) also found that session rating forms reduced drop-out among patients who were at risk of treatment failure.

Some psychoanalysts are reluctant to acknowledge that starting with a psychoanalytic approach may not be best for all patients with all sorts of problems. The research reported by Zilcha-Mano and Barber, which showed that abstinence was a better way to begin therapy with substance abusers than only exploring causes, is an example in which patients might be better served by a behavioral approach. Even in chess, where the pieces are always lined up the same, there are different openings. But psychoanalysis and psychotherapy may be more akin to a game of cards, where each person is dealt a different hand with which to begin.

Psychoanalysts often complain that they do not learn anything from systematic research. Perhaps we are on the verge of having more

interaction between clinicians and researchers, in which case researchers may be able to answer more useful questions. I think psychoanalysts will learn at least a few new things from these articles about what works, when it works, and with whom it works. And, at the very least, they will have a wealth of studies with which to respond to anyone who criticizes psychodynamic approaches as not working.

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