Psychodynamic therapy: a well-defined concept with increasing evidence

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The efficacy of psychodynamic therapy (PDT) is well established[1 2] and has been acknowledged by independent review committees.[3 4] Stefan Hofmann, however, again questioned the empirical status of PDT.[4] When confronted with evidence refuting his claims,[4] Hofmann ignored the data and repeated his critique in this journal.[5] We again address Hofmann's claims.

DEFINITION OF PDT

Hofmann criticised PDT as a 'poorly defined concept', claiming that all therapies including cognitive–behavioural therapy (CBT) would meet its definition.[5] However, there is evidence that PDT and CBT can be significantly differentiated by blind raters (eg, references # 26, 27, 40, 42, 46, 64, 67, 70, 81 in Leichsenring *et al*[1])—also showing adequate treatment integrity in contrast to Hofmann's claims.[5] Thus, PDT is defined well enough to reliably discriminate PDT from CBT.[6]

Including a large variety of behavioural and cognitive approaches, CBT is an umbrella concept too—at least as wide as PDT. Hofmann has never criticised CBT for being 'poorly defined'. It appears he is applying double standards when judging PDT versus CBT.

QUALITY OF RESEARCH ON PDT

Hofmann argues that randomised controlled trials (RCTs) of PDT suffer from almost any conceivable methodological flaw,[5] again ignoring the evidence refuting his claims[4]:

- As shown by independent researchers including proponents of CBT and PDT, the quality of PDT and CBT studies does not differ significantly.[7 8] Most of the RCTs listed in the criticised review[1] were included in this comparison.[7 8]
- Even if there are flaws, there is no evidence that study quality favours PDT. Study quality may just be associated, for example, with unsystematic error in overall effect estimates. Meta-analyses failed to find significant relationships between methodological quality and outcome for PDT,[8] but did so for CBT.[7]
- If study quality questions PDT, this would equally apply to RCTs of CBT showing comparable study quality. Hofmann has never criticised these RCTs, although the vast majority of CBT RCTs on depression were recently shown to have a high risk of bias and to be underpowered.[9] Instead, Hofmann highlighted 269 CBT meta-analyses,[5] which, however, show considerable overlap, thus not providing independent information.
- In contrast to Thoma *et al*,[7 8] Hofmann[5] failed to include proponents of both PDT and CBT (adversarial collaboration).

SYSTEMATIC REVIEW

Hofmann's claim that 'Treatments…were combined in the meta-analysis'[5] is simply not true, since we presented a systematic review, not a meta-analysis.[1] This is worthy of note since possible shortcomings of individual studies would not affect the review as a whole.

MECHANISMS OF CHANGE

Hofmann misconstrues the purpose of RCTs which focus on outcome, not on process.[5] Furthermore, there is a consensus that mechanisms of change of psychotherapy are far from being clear.[10 11] This is true for CBT as well,[11] so Hofmann's claim that this is a unique limit of PDT is gratuitous, all the more so as there is evidence that gains in self-understanding are related to outcome in PDT.[10]

CONCLUSIONS

The information listed above was demonstrably available to Hofmann.[4] From his recent comment, we question why he chose to ignore it. It appears that his article misuses research as a political means to devalue PDT and to idealise CBT.

Owing to Hofmann's negative publicly expressed opinions about PDT[4 5 12] and the way he conducted this critique, we respectfully ask again that if he writes about PDT, he should involve psychodynamic researchers in the process in order to facilitate a balanced dialogue.[4] We again would welcome the collaboration with CBT researchers.[4]

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REFERENCES

1. **Leichsenring F**, Luyten P, Hilsenroth MJ, *et al*. Psychodynamic therapy meets evidence-based medicine: a systematic review using updated criteria. *Lancet Psychiatry* 2015;**2**:648–60.
2. **Abbass AA**, Kisely SR, Town JM, *et al*. Short-term psychodynamic psychotherapies for common mental disorders. *Cochrane Database Syst Rev* 2014;**7**:CD004687.
3. Scientific Advisory Board on Psychotherapy. http://www.wbpsychotherapie.de (accessed 10 April 2016).
4. Comment on: Psychodynamic therapy meets evidence-based medicine: a systematic review using updated criteria. http://www.ncbi.nlm.nih.gov/pubmed/26303562 (accessed 10 April 2016).
5. **Hofmann SG.** Psychodynamic therapy: a poorly defined concept with questionable evidence. *Evid Based Ment Health* 2016;**19**:63.
6. **Blagys MD**, Hilsenroth MJ. Distinctive features of short-term psychodynamic-interpersonal psychotherapy: a review of the comparative psychotherapy process literature. *Clin Psychol* 2000;**7**:167–88.
7. **Thoma NC**, McKay D, Gerber AJ, *et al*. A quality-based review of randomized controlled trials of cognitive-behavioral therapy for depression: an assessment and metaregression. *Am J Psychiatry* 2012;**169**:22–30.
8. **Gerber AJ**, Kocsis JH, Milrod BL, *et al*. A quality-based review of randomized controlled trials of psychodynamic psychotherapy. *Am J Psychiatry* 2011;**168**:19–28.
9. **Cuijpers P.** Are all psychotherapies equally effective in the treatment of adult depression? The lack of statistical power of comparative outcome studies. *Evid Based Ment Health* 2016;**19**:39–42.
10. **Crits-Christoph P**, Connolly Gibbons MB, Crits-Christoph K, *et al*. Psychotherapy process outcome research. In: Lambert MJ, ed. Bergin and Garfield's handbook of psychotherapy and behavior change. 6th edn. New York: Wiley, 2013:298–340.
11. **Kazdin AE.** Understanding how and why psychotherapy leads to change. *Psychother Res* 2009;**19**:418–28.
12. **Hofmann SG**, Sawyer AT, Witt AA, *et al*. The effect of mindfulness-based therapy on anxiety and depression: a meta-analytic review. *J Consult Clin Psychol* 2010;**78**:169–83.

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Notes