# The Efficacy of Psychodynamic Psychotherapy

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*Psychodynamic psychotherapy is an evidence-based, empirically supported treatment. Empirical evidence for the efficacy of psychodynamic psychotherapy is as strong as that for other therapies that have been actively promoted as "empirically supported." Additionally, patients who receive psychodynamic therapy maintain therapeutic gains and appear to continue to improve after treatment ends. Finally, non-psychodynamic therapies may be effective in part because the more skilled practitioners utilize techniques that have long been central to psychodynamic theory and practice. The perception that other therapies have greater empirical support than psychodynamic psychotherapy may reflect a triumph of public relations, not scientific evidence.*

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

The actual scientific evidence tells a different story, one that many in the field have not heard. The empirical evidence shows that psychodynamic psychotherapy is effective. It is as effective as other therapies that have been actively promoted as "empirically supported" and it may be more effective in the long run (with "the long run" coming as soon as 6 to 9 months post-treatment).

The discrepancy between perceptions and evidence may be due to biases in the dissemination of research findings. One source of bias is a lingering disgust in the mental

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health professions with psychoanalytic arrogance and authority. In decades past, American psychoanalysis was dominated by a hierarchical medical establishment which denied training to non-MDs and adopted a dismissive stance toward academic psychology and research. This did not win friends in academic circles. When empirical findings emerged that supported non-psychodynamic treatments, many academicians greeted them jubilantly and were eager to discuss and disseminate them. When empirical evidence supported psychodynamic treatments, many were content to ignore it.

Relatively few in the professional community have the interest, temperament, background, or time to systematically review original research sources, let alone the "fine print" of those sources. We generally depend on professional academics to review and synthesize complex research literatures (Chambless & Ollendick, 2001) and we are unavoidably influenced by the prevailing attitudes of colleagues and teachers (who may have formed their own attitudes the same way). If the information we receive is selective or filtered, the "buzz" in the professional community about what "research shows" can diverge far indeed from what research shows.

This article brings together findings from several empirical literatures that bear on the efficacy of psychodynamic treatment. It will first discuss 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 indicating that non-psychodynamic therapies may be effective in part because the more skilled practitioners utilize interventions that have long been central to psychodynamic theory and practice.

Any article-length work of this scope must necessarily paint with broad strokes. This article will survey research findings from an eagle's eye view, relying on summary statistics that pool findings across many studies. Because there is no such thing as a methodologically "perfect" study, conclusions of individual studies are always open to challenge (perhaps the findings would have been different had the study used a different research design, controlled for another variable, utilized different outcome measures, etc.). When multiple independent studies converge on the same conclusion, we have greater confidence in that conclusion.

The information presented here may cause cognitive dissonance in some quarters, especially among professionals who have been led to believe that psychodynamic treatments lack scientific support. Among academic researchers, the most common strategy for reducing such dissonance is to question ever more micro-level details of study methodology. In this way, the discourse quickly becomes about methodology rather than about the original psychological questions. Investigators who may be tempted to reduce dissonance in this way might consider whether their concerns, if valid, would lead to a different understanding of the forest or merely of trees and leaves. If the latter, they are tangential to the main thesis of this article and are unlikely to advance understanding of how to practice effective psychotherapy.

### *Distinctive Features of Psychodynamic Psychotherapy*

There is a certain amount of disinformation in the field about what *contemporary* psychodynamic psychotherapy is about. Undergraduate textbooks tend to equate psychoanalytic and psychodynamic psychotherapies with some of the more outlandish and inaccessible theoretical speculations made by Sigmund Freud roughly a century ago, rarely presenting mainstream psychodynamic concepts as they are understood and practiced today. These presentations leave students with highly distorted views of psychodynamic theory and practice (for discussion of how clinical psychoanalysis is represented and misrepresented in undergraduate curricula, see Bornstein, 1988, 1995; Hansel, 2005; Redmund & Schulman, in press).

It is also important to recognize that the terms *psychodynamic* and *psychoanalytic* refer to many diverse theories and therapies, not one therapy.[1] There may be greater diversity of techniques and viewpoints within psychoanalysis than within other schools of psychotherapy, if only because the psychoanalytic tradition is the oldest of the therapy traditions, and psychoanalytic clinicians and theorists have been challenging, revising, refining, reworking, replacing, and developing new treatment models for the better part of a century. Attempts to equate psychoanalysis with any one theory or belief system are

[1] The term *psychodynamic* was coined after World War II at a conference on medical education and used as a synonym for *psychoanalytic* (R. Wallerstein, personal communication; Whitehorn et al., 1953). It evolved to refer to treatments based on psychoanalytic concepts and methods which did not necessarily take place five days per week or involve lying on a couch. In this article, I use the terms interchangeably.

simplistic and fundamentally inaccurate. Nevertheless, there are common elements shared by most psychodynamic approaches.

Blagys & Hilsenroth (2000) conducted a computer search of the *PsycLit* database to identify empirical studies which compared the process and technique of manualized psychodynamic psychotherapy with that of manualized cognitive behavioral therapy. The following are the seven *distinctive* features of psychodynamic technique that were identified through this systematic review of the empirical literature (note that these features concern process and technique only, not underlying principles that inform these techniques; for a discussion of concepts and principles, see Gabbard, 2004; Shedler, 2005).

*1. Focus on affect and expression of emotion.* Psychodynamic psychotherapy encourages the 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; Blagys & Hilsenroth, 2002; Burum & Goldfried, 2007). There is also a recognition that *intellectual* insight is not the same as emotional insight which resonates at a deep level and leads to psychological 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 to overcome those difficulties).

*2. Exploration of attempts to avoid aspects of experience.* People do a great many things, knowingly and unknowingly, to avoid aspects of experience that are painful or threatening. This avoidance (in theoretical terms, defense and resistance) may take coarse forms, such as missing sessions, arriving late, or evading topics. 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 an experience rather than on what is psychologically meaningful, minimizing or discounting thoughts or feelings, attending to facts or 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 encourage exploration of avoidances.

*3. Identification of 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 them and understand their meaning and current function.

*4. Discussion of past experience.* Related to the identification of recurring themes and patterns is the recognition that past experience, including early experiences of attachment figures, profoundly affects our relation to, and experience of, the present (in the words of William Wordsworth, the child is father to the man). 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 the topic of discussion often centers on interpersonal themes. 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. Conversely, psychological and psychiatric problems that have their origins elsewhere can adversely impact relationships, which may in turn compound those problems (e.g., a person with a biologically based depression may withdraw from others and deprive herself of interpersonal support when it is needed most; the resulting social isolation further fuels the depression, creating a vicious cycle).

*6. Focus on the therapeutic 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 regard others with distrust and suspicion may view the therapist with suspicion; a person who fears disapproval, rejection, or abandonment may fear such disapproval from 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, dreams, and fantasies.* In contrast to other therapies where there may be a predetermined agenda for sessions, psychodynamic psychotherapy encourages patients to speak openly and 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 meaning, satisfaction, and enjoyment in life.

The last sentence hints at a larger goal that is implicit in all of the others, which is that the objectives 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, such as the capacity to have richer and more rewarding relationships, to make more effective use of one's talents and abilities, to find greater meaning in one's activities, to have a satisfying sex life, to maintain a realistically based sense of self esteem, to tolerate a wide range of affect, to understand self and others in nuanced and sophisticated ways, to be more emotionally alive, and to live life with greater freedom

and flexibility. These ends are accomplished through a process of self reflection, self exploration, and self discovery which 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: Psychoanalytic Psychotherapy for the Rest of Us* (Shedler, 2005; freely available for download at http://psychsystems.net/shedler.html). *Schopenhauer's Porcupines* (Luepnitz, 2002) provides a series of engaging case studies that offer a rare window into the therapy room and provide a "feel" for psychodynamic work. *Psychodynamic Psychotherapy: A Practitioner's Guide* (McWilliams, 2004) offers guidance for beginning (and not so beginning) psychotherapists. *Long-Term Psychodynamic Psychotherapy: A Basic Text* (Gabbard, 2004) provides a systematic overview of theory and technique. These works, especially read in sequence, provide an excellent introduction to contemporary psychodynamic psychotherapy.

***How Effective is Psychotherapy in General?***

The question of whether psychotherapy is effective has been settled to the satisfaction of all but the most intransigent critics. In psychology and in medicine more generally, meta-analysis is the method of choice for summarizing and synthesizing the findings of many independent studies (Lipsey & Wilson, 2001; Rosenthal, 1991; Rosenthal & DiMatteo, 2001). Meta-analysis makes the results of different studies comparable by converting the findings into a common metric. This allows findings to be aggregated or pooled across studies to reveal consistent patterns. A widely used metric is *effect size*, which is simply the difference between treatment and control groups, expressed in standard deviation units. An effect size of 1.0 would mean that the average treated patient is one standard deviation healthier on the normal distribution or bell curve than the average untreated patient (e.g., someone worse off than 84% of the population would end up at the population mean as a result of treatment). An effect size of .8 is considered a large effect in psychological and medical research. An effect size of .5 is a considered a moderate effect, and an effect size of .2 is considered a small effect.

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 (Smith, Glass, & Miller, 1980). Subsequent meta-analyses have similarly supported the efficacy of psychotherapy. The influential review by Lipsey & Wilson (1993) 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. (1990) 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 Lambert & Ogles, 2004).

To provide some points of reference, it is instructive to consider effect sizes for antidepressant medication. 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 (Turner et al., 2008).[2] These are relatively small effects. A meta-analysis reported in the prestigious *Cochrane Library* (Moncrieff, Wessely, & Hardy, 2004) found an effect size of .17 for tricyclic antidepressants compared to active placebo control (an active placebo mimics the side effects of an antidepressant drug but is not itself an antidepressant). The review concluded that "tricyclic antidepressants are only slightly better than active placebos."[3]

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[2] The measure of effect size in this study was Hedges' *g* (Hedges, 1982) rather than Cohen's *d* (Cohen, 1988) 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" (R. Rosenthal, personal communication to Marc Diener).

[3] Although antidepressant trials are intended to be double-blind, the blind may be easily penetrated because the side effects of antidepressant medications are physically discernable and widely known. Participants and their doctors can therefore figure out whether they are receiving medication or placebo, and the 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.

## Table 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, & Miller (1980) | various therapies & disorders | .85 | 475 studies |
| Lipsey & Wilson (1993) | various therapies & disorders | .75[a] | 18 meta-analyses |
| Robinson et al. (1990) | various therapies, for depression | .73 | 37 studies |
| **CBT and related therapies** | | | |
| Lipsey & Wilson (1993) | CBT & behavior therapy, various disorders | .62[b] | 23 meta-analyses |
| Haby et al. (2006) | CBT for depression, panic, & generalized anxiety | .68 | 33 studies |
| Öst (2008) | Dialectical Behavior Therapy, primarily for borderline personality disorder | .58 | 13 Studies |
| **Antidepressant medication** | | | |
| Turner et al., 2008 | FDA-registered studies of antidepressants approved between 1987 and 2004 | .31 | 74 studies |
| Moncrieff et al. (2004) | tricyclic antidepressants versus "active placebo" | .17 | 9 studies |
| **Psychodynamic psychotherapy** | | | |
| Abbass et al. (2006) | various disorders, general symptom improvement | .97 | 12 studies |
| Leichsenring et al. (2004) | various disorders, change in target problems | 1.17 | 7 studies |
| Leichsenring & Leibing (2003) | Personality disorders, general symptom improvement | 1.32 | 2 studies |
| Leichsenring & Leibing (2003) | personality disorders, pretreatment to post-treatment | 1.46[c] | 15 studies |
| Anderson & Lambert (1995) | various disorders & outcomes | .85 | 9 Studies |

[a] median effect size across 18 meta-analyses (from Lipsey & Wilson, 1993, Table 1.1)
[b] median effect size across 23 meta-analyses (from Lipsey & Wilson, 1993, Table 1.2)
[c] pretreatment to post-treatment (within group) comparison

***How Effective is Psychodynamic Psychotherapy?***

Having established some points of reference, we can consider empirical evidence for the efficacy of psychodynamic psychotherapy. The most recent and methodologically stringent meta-analysis of psychodynamic psychotherapy, published by the *Cochrane Library*, included 23 randomized controlled trials of 1,431 patients (Abbass, Hancock, et al., 2006). The studies compared patients who received short term (<40 hours total) psychodynamic psychotherapy with controls (wait list, minimal treatment, or "treatment as usual"), yielding an overall effect size of .97 for general symptom improvement. This 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 separately 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 long-term follow up; and an effect size of .59 for change in depressive symptoms, which increased to .98 at long term follow up.[4] 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 second recent meta-analysis, reported in *Archives of General Psychiatry*, included 17 randomized controlled trials of short term (average of 21 sessions) psychodynamic psychotherapy (Leichsenring, Rabung, & Leibing, 2004). For change in target problems, the effect size was 1.17 for psychodynamic psychotherapy compared to controls (wait list or "treatment as usual"). 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 after treatment end. 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. At follow up… they were better off than 95% of the patients." (Note that effect sizes based on pre

[4] As noted earlier, this article surveys the landscape from an eagle's eye perspective. 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 (Abbass, Hancock, et al., 2006).

and post comparisons of the same individuals are not comparable to effect sizes based on between group comparisons, i.e., treatment group versus controls.)

The third recent meta-analysis, reported in the *American Journal of Psychiatry*, examined the efficacy of both psychodynamic psychotherapy (14 studies) and CBT (11 studies) in the treatment of patients with personality disorders (Leichsenring & Leibing, 2003). The study reported pretreatment 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, and the pretreatment to post-treatment effect size was 1.46. The findings again indicate that the benefits of psychodynamic treatment endure over time. For CBT (mean length of treatment was 16 weeks), the mean follow-up period was 13 weeks, and the pretreatment to post-treatment effect size was 1.0. The authors concluded that both psychodynamic psychotherapy and CBT demonstrated effectiveness for patients with personality disorders.

These meta-analyses represent the most recent and methodologically rigorous evaluations of psychodynamic psychotherapy. Especially noteworthy is the repeated finding that the benefits of psychodynamic psychotherapy increase with time. The findings echo those of a much earlier meta-analysis (Anderson & Lambert, 1995) which reported an overall effect size of .85 for psychodynamic psychotherapy compared to waitlist controls.[5] This effect size did not differ from that reported for other active treatments such as CBT, but the study did find a statistically significant advantage (which the authors termed an "incubation effect") for psychodynamic psychotherapy over other therapies when follow-up assessments were conducted 6 months or more post-treatment. In sharp contrast, a recent review suggests that the benefits of other (non-psychodynamic) empirically supported therapies decay over time (Westen, Novotny, & Thompson-Brenner, 2004).

Table 1 summarizes the meta-analytic findings described above and adds additional findings to provide further points of reference. Except as noted, effect sizes reported in the table are based on comparisons of treatment and control groups and reflect

[5] This value was obtained after the authors excluded two outlier studies in which patients were treated for bronchitis and ulcers, not psychological conditions.

initial response to treatment (not long term outcomes). Findings from different meta-analytic studies may or may not be directly comparable, depending on study inclusion and exclusion criteria, characteristics of patient samples, and other factors, although there is precedent for such comparisons (e.g., Lipsey & Wilson, 1993; Meyer, Finn, Eyde, et al., 2001).

Studies supporting the efficacy of psychodynamic psychotherapy span a wide range of conditions and populations. Randomized controlled trials document the efficacy of psychodynamic psychotherapy for depression, anxiety, panic, PTSD, somatoform disorders, eating disorders, substance related disorders, and various personality disorders (Leichsenring, 2005). Two newer studies, published after the above meta-analyses were completed, demonstrated efficacy of psychoanalytic psychotherapy for panic disorder (Milrod et al., 2007) and borderline personality disorder (Clarkin et al., 2007). The latter study is especially noteworthy, in that it not only demonstrated treatment benefits that equaled or exceeded those of another evidence based treatment, dialectical behavior therapy (DBT; Linehan, 1993), but also showed changes in underlying psychological mechanisms (intrapsychic processes) believed to mediate symptomatic change (Levy et al., 2006). These intrapsychic changes occurred in patients who received psychodynamic psychotherapy but not in patients who received DBT.

Such intrapsychic changes may account for the long-term benefits of psychodynamic treatment in patients with borderline personality disorder. A newly released study showed enduring benefits of psychodynamic psychotherapy *eight years* after treatment initiation (and five years after treatment completion). At eight 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 (Bateman & Fonagy, in 2008). No other treatment for personality pathology has shown such enduring benefits.

### *A Rose by Another Name: Psychodynamic Process in Other Therapies*

There is a story, possibly apocryphal, about a behavior therapist who participated in a study in which former patients were contacted to find out how they viewed therapy in retrospect. One patient, the story goes, reported that his therapy had been extremely

successful. Asked what had been helpful, he reported that his therapist (let us call him Dr. A) had been compassionate and had really listened and understood him. Through his discussions with Dr. A, he had come to see himself differently. When questioned further, the patient added that he did homework assignments and kept graphs to humor Dr. A., because Dr. A was such a nice man and those things seemed important to him.

A committed behavior therapist might argue (as, the story goes, did Dr. A) that the patient was mistaken and that the treatment benefits were really due to the behavioral interventions. However, most investigators would be willing to entertain the hypothesis that the patient's own perceptions were at least somewhat valid (for a non-apocryphal and more scholarly discussion, see Sloane et al., 1977). The moral of the story is that the "active ingredients" of therapy are not necessarily those presumed by the theory or treatment model.[6] This is not a merely hypothetical observation. Indeed, the available evidence indicates that the mechanisms of change in cognitive therapy (CT) are *not* those presumed by the theory. Based on a review of the literature on mediators and mechanisms of change, Kazdin (2007) 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 considerable differences in the way therapists practice, even therapists ostensibly providing the same form of 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, stray from prescribed interventions, implement interventions differently, and introduce processes not specified by the treatment manuals (e.g., Elkin, Shea, Watkins, et al., 1989). In some cases, investigators have had difficulty

[6] The anecdote is not meant to disparage behavior therapy, only to illustrate the importance of looking beyond theoretical assumptions and therapy brand names. As a psychoanalytic therapist, I had a strikingly similar experience. A depressed patient became suicidal and had to be hospitalized for an extended period. During his hospital stay, I telephoned the treating physician to check on the patient's status. The patient was discharged, resumed therapy, and began to make progress in therapy that he had not made prior to hospitalization. I attributed the positive changes to my incisive interpretations about the patient's conflicts and defenses. Months later, the patient described his turning point very differently: "When you telephoned the hospital, I realized that you cared about me. I thought that if you could care about me, then maybe I could begin to care about myself." The patient's words caused me cognitive dissonance for some time.

determining from verbatim session transcripts which manualized treatment was being provided (Ablon & Jones, 2002). Despite the best efforts of researchers (for scientific reasons) and managed healthcare companies (for business reasons), therapists have yet to be made interchangeable (Norcross, 2002).

For these reasons, studies of therapy "brand names" can be misleading. Studies that look beyond brand names by examining session videotapes or transcripts may be more informative (Goldfried & Wolfe, 1996; Kazdin, 2007, 2008). One method of studying therapy sessions makes use of the *Psychotherapy Process Q-Sort* (PQS; Jones, 2000), which consists of 100 variables that assess therapist technique and other aspects of therapy process based on specific actions, behaviors, and statements during the sessions. In a series of painstaking 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 (Ablon & Jones, 1998; Jones & Pulos, 1993).

In one study, the investigators asked panels of internationally renowned experts in psychoanalytic and cognitive-behavioral therapy to use the PQS to describe "ideally" conducted treatments (Ablon & Jones, 1998). Based on the expert ratings, the investigators constructed prototypes of ideally conducted psychodynamic and cognitive-behavioral therapy. The two prototypes differed considerably.

Among the items rated highly in the psychodynamic prototype were the following: "Patient's dreams or fantasies are discussed;" "Therapist identifies a recurrent theme in Patient's experience or conduct;" Patient's feelings or perceptions are linked to situations or behavior of the past;" "Therapist draws attention to feelings regarded by Patient as unacceptable (e.g., anger, envy, or excitement);" "Therapist points out Patient's use of defensive maneuvers, e.g. undoing, denial;" "Therapist interprets warded-off or unconscious wishes, feelings or ideas;" "The therapy relationship is a focus of discussion;" and "Therapist draws connections between the therapeutic relationship and other relationships."

Among the items rated most highly in the CBT prototype were the following: "Patient's treatment goals are discussed;" "Therapist explains rationale behind technique or approach to treatment;" "Discussion centers on cognitive themes, i.e. about ideas or

belief systems;" "Therapist actively exerts control over the interaction (e.g. structuring, introducing new topics);" "Dialogue has a specific focus;" "There is discussion of specific activities or tasks for the Patient to attempt outside of session;" and "Therapist behaves in a teacher-like (didactic) manner."[7]

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 (Ablon & Jones, 1998). 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 paralleled 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 (Jones & Pulos, 1993).

An independent team of investigators using different research methods also found that psychodynamic process predicted successful outcome in cognitive therapy (Castonguay, Goldfried, Wiser, Raue, Hayes, 1996). The study assessed outcomes in cognitive therapy conducted according to Beck's treatment model (Beck et al., 1979) and the findings had been reported as evidence for the efficacy of cognitive therapy for depression (Hollon et al, 1992).[8]

Investigators coded 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 concepts *working alliance* and *therapeutic alliance* are now widely recognized across treatment modalities; many do not know that these concepts come from psychoanalysis and have played a central role in psychoanalytic theory and practice for at least four decades; Greenson, 1967; Zetzel, 1956). The second variable assessed therapist implementation of the cognitive treatment model (i.e., correcting distorted cognitions which are believed to cause depressive affect). The third variable, which the

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[7] See the original source for more complete descriptions of the two therapy prototypes (Ablon & Jones, 1998).

[8] The study is one of the archival studies analyzed by Jones and his associates (Ablon & Jones, 1988; Jones & Pulos, 1993).

investigators termed *experiencing* (EXP), reflected patients' "emotional involvement" and "ability to focus on and accept their affective reactions." The measure has seven points or stages: "The gradual change from lower to higher stages represents an increase in clarity and immediacy of private events (e.g., feelings about the self). It also reflects a greater elaboration and integration of emotions" (Castonguay et al., 1996, p. 499).

Although the investigators' orientation was cognitive-behavioral and not psychodynamic, their description of the EXP variable beautifully captures the essence of psychodynamic process. I quote from the original article: "At the lower stages of EXP, 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" (Castonguay et al., 1996, 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 consciously accessible. The construct measured by the EXP scale hearkens back to the earliest days of psychoanalysis and its central goal of making the unconscious conscious (Freud, 1917).

In this study of manualized cognitive therapy for depression, the following findings emerged: 1) Working alliance predicted patient improvement on all outcome measures. 2) Psychoanalytic process (EXP) predicted patient improvement on all outcome measures. 3) Therapist adherence to the cognitive treatment model (i.e., focusing on distorted cognitions) predicted *poorer* outcome.

The results should not be interpreted as indicating that cognitive techniques are destructive to patients, and other studies have found positive relations between CBT technique and outcome (Feeley, DeRubeis, & Gelfand, 1999, Strunk et al., 2007; Tang & DeRubeis, 1999). Qualitative analysis of the verbatim session transcripts suggests 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. (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* strongly suggest that the more skillful therapists facilitated therapeutic processes that have long been central to psychodynamic theory and practice.

Other empirical studies have also demonstrated links between psychodynamic processes and successful treatment outcome, whether or not the investigators explicitly identified the processes as "psychodynamic" (e.g., Barber, Crits-Christoph, & Luborsky, 1996; Diener, Hilsenroth, & Weinberger, 2007; Gaston et al., 1998; Hayes & Strauss, 1998; Hilsenroth et al., 2003; Høglend et al., in press; Norcross, 2002; Pos et al, 2003).

**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 (1936) and subsequently Luborsky, Singer, & Luborsky (1975) reached the same conclusion as 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 those rare instances where research does find significant differences between active treatments, the findings virtually always favor the preferred treatment of the researchers (Luborsky, Diguer, Seligman, et al., 1999).

Subsequent research has done little to alter the Dodo bird verdict (Lambert & Ogles, 2004). For example, studies that have directly compared CBT with short-term psychodynamic psychotherapy for depression have failed to demonstrate greater efficacy for CBT over psychodynamic psychotherapy, or vice versa (Leichsenring, 2001). The authors of the review 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 (Task Force, 1995; Chambless, Baker, Baucom, et al., 1998). Some of the studies compared psychodynamic treatments of only 8 sessions duration, which most practitioners would consider inadequate, with 16-session

CBT treatments. Even in those studies, outcomes were equivalent (Barkham, Rees, Shapiro, et al., 1996; Shapiro, Barkham, Rees, et al., 1994).

There are many reasons why outcome studies may fail to show differences between treatments, even if profound differences really exist. Others have discussed the limitations and unexamined assumptions of current research methods (Goldfried & Wolfe, 1996; Norcross, Beutler, & Levant, 2005; Westen, Novotny, & Thompson-Brenner, 2004). Here I focus on one salient limitation: the mismatch between what psychodynamic psychotherapy aims to accomplish and what outcome studies measure.

As noted earlier, the goals of psychodynamic psychotherapy include, but extend well 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 psychotherapy outcome research (e.g., the Beck Depression Inventory [Beck et al., 1961] or Hamilton Depression Rating Scale [Hamilton, 1960]) do not assess such inner capacities and resources (Blatt & Auerbach, 2003; Kazdin, 2008). Possibly, the Dodo bird verdict reflects a failure of researchers, psychodynamic and non-psychodynamic alike, to adequately assess the range of phenomena that can change in psychotherapy.

The Shedler-Westen Assessment Procedure (SWAP; Shedler & Westen, 2007; Westen & Shedler, 1999a, 1999b) 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 used by clinicians of any theoretical orientation and has demonstrated high reliability and validity relative to a wide range of criterion measures (Shedler & Westen, 2007; Westen & Shedler, 2007). The SWAP includes an empirically derived *Healthy Functioning Index* comprised of the items listed in Table 2, which serves to define and operationalize mental health *as consensually understood by clinical practitioners across theoretical orientations* (Westen & Shedler, 1999a, 1999b) It may be the case that many forms of brief therapy are equally effective in alleviating acute psychiatric symptoms, at least in the short run. It seems doubtful, however, that all therapies are equally effective in 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, can be previewed at www.SWAPassessment.org.)

## Table 2: Defining 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. |

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 two years of psychodynamic psychotherapy (Lingiardi, Shedler, & Gazzillo, 2006). 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 sooth 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. Her score on the SWAP High Functioning Index increased by approximately two standard deviations over the course of treatment.

A second study used the SWAP to compare 26 patients beginning psychoanalytic treatment with 26 patients completing psychoanalytic treatment (Cogan & Porcerelli, 2005). 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). 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 psychoanalytic treatment, the mean score on the SWAP High 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 the kind of 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 (Norcross, 2005).

**Discussion**

One intent of this paper was to provide an overview of some basic principles of psychodynamic psychotherapy for readers who have not had the opportunity to be 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 empirical support. The available evidence indicates that psychodynamic psychotherapy is at least as effective as many other treatments that have been actively promoted to the field as "empirically supported" and "evidence based." The evidence also indicates that the benefits of psychodynamic treatment are lasting and not just transitory, and they appear to extend beyond symptom remission. For many people, psychodynamic psychotherapy may foster inner resources and capacities that allow richer, freer, and more rewarding lives.

In writing this article, it was impossible not to be struck by a number of ironies. One is that academicians who dismiss or denigrate psychodynamic approaches—sometimes in vehement tones—often do so in the name of science. Some in the field advocate a science of psychology grounded specifically in the experimental method. Yet the same experimental method yields findings that support psychodynamic concepts (Westen, 1998) and treatments. In light of the accumulation of empirical findings, blanket assertions that psychodynamic approaches lack scientific support (e.g., Barlow & Durand, 2005; Crews, 1996; Kihlstrom, 1999) are no longer defensible. Presentations that equate psychoanalysis with dated concepts that last held currency in the

psychoanalytic community in the early 20th century are similarly indefensible; they are at best uninformed and at worst disingenuous.

Another irony is that relatively few clinical practitioners, including psychodynamic practitioners, are aware of the research described in this article. 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 anti-psychoanalytic biases may have impeded dissemination of this research in academic circles, distrust of academic research methods may have impeded dissemination in psychoanalytic circles (Bornstein, 2001). Such attitudes are changing, but they cannot change quickly enough.

Writing this article has also made me acutely aware of the science-practice schism that has plagued the field for decades. A goal of this article was to help bridge the science-practice schism by discussing research findings in ways that clinical practitioners might find relevant and meaningful, and discussing psychodynamic clinical concepts in ways that researchers might find empirically compelling. In fact, reviewing the psychotherapy outcome literature has persuaded me that the science-practice schism is as wide as ever, and the prospects for bridging it dim (Shedler, 2006).

Many investigators take for granted that clinical practitioners are the intended consumers of clinical research, but many of the psychotherapy outcome studies and meta-analyses reviewed for this article are clearly *not* written for practitioners. On the contrary, they are densely complex and technical in ways that make them all but impenetrable, not only to the average educated and well-informed clinician, but even to most psychological and psychiatric researchers. They appear to be 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 many hours of painstaking and laborious study, and more than a few telephone calls and emails to colleagues who conduct and publish outcome research. I do not know how the average clinical practitioner could navigate the thicket of arcane statistical methods and inconsistent findings across multiple outcome variables of uncertain clinical relevance. Perhaps there is something in the editorial review process

that pushes authors ever further in the direction of the arcane. Whatever the cause, something must change if the findings of psychotherapy research are to be relevant to clinical practitioners and have an impact on the real-world practice of psychotherapy.

Another irony concerns the randomized controlled trial (RCT) as a method of investigation. I have relied heavily on RCT research to demonstrate the efficacy of psychodynamic psychotherapy because the most ardent proponents of "empirically supported therapies" consider RCTs the "gold standard" of scientific evidence. In fact, RCT methodology may be ill suited to the study of psychotherapy (for critiques, see, e.g., Garfield, 1996; Goldfried & Wolfe, 1996; Norcross, Beutler, & Levant, 2005; Persons, 1991; Persons & Silberschatz, 1998; Seligman, 1995; Westen, Novotny, & Thompson-Brenner, 2004). But even if we accept the controversial evidential standards advocated by the "empirically supported therapy" movement (Chambless & Ollendick, 2001), psychodynamic psychotherapy is *still* empirically supported.

Researching this article has served only to increase my doubts about RCT methodology. Like most psychodynamic clinicians, I believe that good psychotherapy addresses underlying psychological processes (e.g., personality processes) that give rise to symptoms (McWilliams, 1994, 1999; PDM Task Force, 2006). The *patient* is the focus of my clinical attention, not just the patient's psychiatric diagnosis. In contrast, RCT methodology is deliberately designed to eliminate the patient as a variable that could influence the course and outcome of treatment. It regards psychological differences between patients as mere error variance or statistical "noise." Likewise, it regards differences between *clinicians* as error variance or noise.

In fact, patient variables are crucial determinants of treatment response, and interventions that are helpful to certain kinds of people are unhelpful (or even harmful) to others, even others who share the same diagnosis (Blatt & Zuroff, 2005). Therapist characteristics are also crucial determinants of psychotherapy outcome and are as well validated as manualized therapies (Norcross, 2002). Although RCTs provide strong support for psychodynamic psychotherapy, I am troubled that they relegate to irrelevance what is of greatest relevance to most clinical practitioners—the human beings who come together to create therapy relationships. The ideal of the RCT seems to be a disembodied

set of techniques applied to disembodied symptoms. For most clinical practitioners, this is simply not what psychotherapy is about.

Psychodynamic psychotherapy is intensely interpersonal. What makes a therapy psychodynamic is not a particular technique, but an emphasis on exploring those aspects of self that we do not fully know, especially as they are manifested and potentially influenced in the therapy relationship. As long as there are patients (and therapists) who seek to better know themselves and to allow themselves to be deeply known, there will be psychodynamic psychotherapy, whether it is known by that name or another.

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