

## Psychoanalytic psychotherapy: what's the evidence?

*Psychoanalytic psychotherapy has a strong and expanding evidence base. There now exists a large number of outcome studies which have alternately examined the efficacy of short-term and long-term psychoanalytic psychotherapy and the efficacy of psychoanalytic psychotherapy for specific conditions. Of particular note is the consistent finding from this research of significantly increased long-term follow up effect sizes: patients continue to make considerable gains long after treatment has ended. There is also evidence that non-psychoanalytic forms of therapy may be effective because of the inclusion of psychoanalytic techniques and process. Psychoanalytic and psychodynamic psychotherapy are essentially interchangeable terms and for the purposes of brevity this paper uses the term psychoanalytic.*

### Summary

- There are now a significant number of well-designed studies which demonstrate the efficacy of psychoanalytic psychotherapy. The research is objectively strong.
- Psychoanalytic psychotherapy yields impressive effect sizes, with effect sizes typically increasing at long-term follow up, suggesting that patients who receive psychoanalytic psychotherapy experience continuing psychological benefits long after therapy has ended.
- Longer-term psychoanalytic psychotherapy (one year's treatment or more) is more effective than shorter forms of therapy for the treatment of complex mental disorders.
- Psychoanalytic psychotherapy has particularly promising findings in relation to helping people with personality disorder. Mentalization-based therapy (a form of psychoanalytic psychotherapy) has been shown to yield the most positive results for personality pathology.
- A growing body of evidence suggests that psychoanalytic psychotherapy is effective for many common mental disorders, including depressive disorders, anxiety disorders, eating disorders, post-traumatic stress disorder and substance-related disorder.
- There is also a growing body of evidence which suggests that non-psychoanalytic therapies benefit from the inclusion of psychoanalytic processes and techniques.
- Given the growing evidence base, it is time commissioners and health policy makers turned their attention to psychoanalytic psychotherapy. It could help a great many people with unmet mental health needs in the country.

### Introduction

Psychoanalytic psychotherapy has endured a storm of criticism in recent years. Detractors have pointed out that it lacks scientific credibility and health care policy makers now often

assume that its evidence base is weak and patchy. Concurrent with this prevailing opinion has been the rise of other forms of ‘talking treatment’, some of which, in particular cognitive behavioural therapy (CBT), have undergone thousands of studies that show their effectiveness. Faced with the choice of commissioning a therapy such as CBT, which appears to promise a fast cure and has a good evidence base, or of commissioning a therapy such as psychoanalytic psychotherapy, which offers a longer course of treatment and appears to have a weak evidence base, is it any wonder which choice commissioners have all too often made?

The psychoanalytic community also needs to accept some responsibility for this state of affairs. Until relatively recently, the community at large was slow, and even at times averse, to conducting research. Research methods such as manualisation of treatments or randomisation of patients seemed removed from clinical reality, and there was sometimes a sense of anxiety of having to question beliefs about theory and technique collectively built up from individual clinical experience and clinical lore. Moreover, much of the research that was conducted historically lacked methodological rigour.

Nevertheless, the reader should note the deliberate reference to history. This is because, gradually, and increasingly at a faster pace, the psychoanalytic community has come to appreciate the value of research. As this paper will detail, there are now a significant number of respectable, well-designed studies which demonstrate the efficacy of psychoanalytic psychotherapy. The culture towards research is changing.

This paper presents the lay reader with some of the key findings from the research. In this continuing climate of austerity and vastly cut back mental health services, the reader may be particularly interested to note that the research suggests psychoanalytic therapy has a significant positive long-term effect on patients. Although, as with any form of treatment, there is still scope for further research, objectively the evidence is strong. The time has now come when commissioners and health care policy makers should turn their attention to psychoanalytic psychotherapy.

### **The defining elements of psychoanalytic psychotherapy**

Psychoanalytic psychotherapy refers to a range of therapeutic treatments derived from psychoanalytic ideas and methods and a critical appreciation of the effect of childhood experiences on adult personality development. Patients are typically seen by therapists once or twice a week, sit in a chair facing the therapist, and might be seen for months as opposed to years as is typical in psychoanalysis.

Psychoanalytic psychotherapy utilises various techniques derived from psychoanalysis, including:

*Free association*: therapy sessions deliberately have no formal structure, instead encouraging the patient to talk about anything that is on their mind, or ‘free associating’. The therapist tries to uncover unconscious themes underlying the patient’s discourse, paying particular attention to points such as patient resistance to talking about certain

subjects, and verbally intervenes in a range of ways – from offering empathy to more exploratory or challenging interventions, such as interpretations.

*Interpretations:* the therapist offers these in order to help the patient gain insight into repetitive conflicts prolonging their problems (Gabbard, 2004) and to aid the patient in understanding their unconscious themes.

*Use of the countertransference:* the therapist also carefully notes their own feelings, or ‘countertransference’ towards the patient and the patient’s discourse. These can offer insight into how the patient relates to people.

After analysing many hundreds of hours of transcripts and recordings of therapy sessions, Blagys and Hilsenroth (2000) identified seven core processes and techniques which distinguish manualised psychoanalytic psychotherapy from other therapies:

- 1) *Explaining emotions:* patients are encouraged to explore their emotions in depth. The therapist helps the patient to identify how they feel, putting contradictory and troubling feelings into words. It is believed that emotional insight, in contrast to intellectual insight, can lead to profound change.
- 2) *Exploring efforts to avoid distressing thoughts and feelings:* people do things to avoid thoughts and feelings which trouble them in a variety of ways – from the subtle – focusing on facts rather than how they feel about something – to the more obvious – such as going quiet in a session. The therapist will encourage the patient to explore what is distressing them.
- 3) *Identifying reoccurring patterns:* the therapist will try to identify and explore recurring patterns in patients’ thoughts, feelings, relationships and life. Patients may be extremely aware or they may be distressingly unaware of such patterns.
- 4) *Discussing past experience:* psychoanalytic psychotherapists recognise that the past, particularly early attachment experiences, influences the development of the adult personality and functioning. Therapists explore a patient’s past in order to gain further insight into a patient’s present psychology.
- 5) *Focus on relationships:* psychoanalytic psychotherapists recognise that psychological difficulties are largely rooted in problems in how the patient relates to others and therapists will try to explore a patient’s past and present relationships.
- 6) *Considering the relationship between the patient and therapist:* the therapist will examine this relationship (sometimes referred to as ‘transference’) because patients tend to interact with their therapist in the same way they will interact with other people.
- 7) *Exploring fantasy life:* psychoanalytic psychotherapy encourages patients to talk freely about whatever is on their minds. Patients will discuss many thoughts, such as

desires, dreams and fantasies. These thoughts are a potential treasure chest of information into the patient.

Above all, the aim of psychoanalytic psychotherapy is to go *beyond* remission of symptoms and to instil psychological strengths in a patient, giving patients the ability to better face

### Research Terms

*Control Group:* group in an experiment that receives no treatment or a different treatment to the experimental group. Allows researchers to compare to the experimental group.

*Effect size:* a way of quantifying how effective an intervention is, measuring the size of the difference between an experimental group and a control group. An effect size of 0.8 represents a large effect size, 0.5 a medium effect size and 0.2 a small effect size.

*Efficacy:* how far an intervention is able to cause its intended effect during clinical trials.

*Long-term follow up:* where patients who underwent an intervention are revisited after an interval of time to measure the treatment effect size after this time interval.

*Meta-analysis:* statistically comparing results from independent studies with related hypotheses, to reach conclusions about the efficacy of 1 or more treatments.

*Randomized controlled trial:* a type of scientific experiment whereby patients are randomly allocated to receive one or other of the different treatments being studied, after which any differences detected between patients should be because of the treatments under comparison, and not due to any other factor.

difficulties and challenges and the capacity to live a fuller and richer life in the present.

### The evidence:

#### 1) For psychoanalytic psychotherapy in general

The past two decades have seen a rise in the number of high-quality randomised controlled trials (RCTs) of psychoanalytic psychotherapy. Shedler (2010) highlights various meta-analyses, which aggregate results from these RCTS and demonstrate that psychoanalytic psychotherapies yield impressive effect sizes. Among these, there is, for example, a meta-analysis published by the Cochrane Library, which examined 23 RCTs of a total of 1,431 patients (Abbass, Hancock, Henderson et al, 2006). The RCTs compared patients with a range of common mental disorders who received short-term psychoanalytic psychotherapy with controls who received minimal treatment and non-treatment interventions, yielding an overall effect size of 0.97 for general symptom improvement. This effect size increased to 1.51 when the patients were assessed 9 months after treatment. The meta-analysis also reported an effect size of 0.81 for change in somatic symptoms, increasing to 2.21 at long-term follow up; an effect size of 1.08 for change in anxiety ratings, increasing to 1.35 at follow up; and an effect size of 0.59 for change in depressive symptoms, which increased to 0.98 at follow-up. This trend to larger effect sizes at follow up suggests that patients who received psychoanalytic psychotherapy experience continuing psychological benefits long after therapy has ended.

A meta-analysis reported in the journal *Archives of General Psychiatry* (Leichsenring, Rabung and Leibusch, 2004) examined 17 RCTs of short-term psychoanalytic psychotherapy and reported an effect size of 1.17 compared with control interventions. The pre-treatment to post-treatment effect size was 1.39, increasing to 1.57 at long-term follow up (an average 13 months after treatment).

Two further meta-analyses, published in the *Journal of the American Medical Association*

### **The significance of long-term follow up effect sizes**

A consistent finding from the research is that patients who undergo psychoanalytic psychotherapy appear to be making considerable psychological gains long after treatment has ended. An increasing number of meta-analyses (such as Abbass et al, 2009; de Maat et al, 2009; Leichsenring and Rabung, 2008; Leichsenring et al, 2004) suggest that this is the case, with larger effect sizes found at follow-up than at the end of treatment.

By contrast, the benefits of other therapies tend to decay over time (de Maat, Dekker, Schoevers et al, 2006; Hollon et al, 2005; Westen, Novotny, and Thompson-Brenner, 2004; excepting manualized treatments for specific anxiety conditions – see Westen et al, 2004).

(Leichsenring and Rabung, 2008; de Maat et al, 2009) examined the efficacy of longer-term psychoanalytic psychotherapy (one year's treatment or more). Leichsenring and Rabung compared longer-term psychoanalytic therapy with shorter forms of therapy for the treatment of complex mental disorders (defined as multiple or chronic mental disorders, or personality disorders) and found it to be much more effective than shorter forms of therapy. An overall effect size of 1.8 was found, with a pre-treatment to post-treatment overall effect size of 1.03, which increased to 1.25 at long-term follow up. De Maat et al examined the effectiveness of long-term psychoanalytic psychotherapy for patients with a range of DSM (Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association) diagnoses. For patients with mixed/moderate pathology, the pre-treatment to post-treatment effect size was 0.78 for general symptom improvement, increasing to 0.94 at long-term follow up, at an average of 3.2 years after treatment. For patients with severe personality pathology, the pre-treatment to post-treatment effect was 0.94, increasing to 1.02 at long-term follow up, at an average of 5.2 years after follow up.

## **2) For psychoanalytic psychotherapy and specific disorders**

A common criticism thrown at studies of psychoanalytic psychotherapy is that they focus on a range of patient symptoms and conditions rather than on specific diagnostic categories, and that consequently their findings have limited real world clinical utility (for example, Westen et al, 2004). At the same time, the reader should be aware that there is widespread concern about the clinical utility of diagnostic categories (such as in the *Diagnostic and Statistical Manual of Mental Disorders 5<sup>th</sup> edition*, DSM-5, American Psychiatric Association, 2013). Specifically, the concern is that such categories do not accurately define patient groups, given that psychiatric comorbidity is common and that diagnosable complaints are often embedded in personality syndromes (Blatt and Zuroff, 2005; Westen, Gabbard and Blavgov, 2006). A number of studies have focused on psychiatric comorbidity, with some

(such as that of Abbass, Town and Driessen, 2011) recommending psychoanalytic psychotherapy be considered as a first line treatment. Nonetheless, there are an increasing number of studies focusing on specific diagnoses (such as Bateman and Fonagy, 2008; Clarkin et al, 2007; Culpers, van Straten; Andersson et al, 2008; Leichsenring, 2001, 2005; Milrod et al, 2007).

Findings in relation to personality disorders are perhaps the most promising (such as Winston, 1994; Hellerstein et al, 1998; Town et al, 2011). A meta-analysis examining the efficacy of both psychoanalytic psychotherapy and CBT for personality disorder published in the American Journal of Psychiatry (Leichsenring and Leibling, 2003) showed pre- to post-treatment effect sizes of 1.46 for psychoanalytic psychotherapy and 1.0 for CBT. A study by Bateman and Fonagy (2008) showed that mentalization-based therapy (MBT – a psychoanalytic psychotherapy adapted for personality disorder) leads to enduring benefits five years after completion. At five-year follow up, 87% of patients who received ‘treatment as usual’ still met diagnostic criteria for borderline personality disorder, compared to 13% of patients who had received psychoanalytic therapy. There is as yet, no other treatment which yields such positive results for personality pathology.

There is also a slowly growing body of evidence which suggests that psychoanalytic psychotherapy is an effective treatment for major depressive disorder (e.g. Driessen et al, 2013) and for somatic disorders and medically unexplained symptoms (Abbas et al, 2008; 2009).

Most recently, Leichsenring and Klein (2014) reviewed the evidence for psychoanalytic therapy for specific mental disorders in adults, meta-analysing 47 RCTs published between January 1970 and September 2013 that looked at the efficacy of psychoanalytic psychotherapy for specific mental disorders using treatment manuals and valid measures for diagnosis and outcome. The meta-analysis showed that psychoanalytic therapy is efficacious for many common (and diagnosable) mental disorders, including depressive disorders, anxiety disorders, personality disorders, eating disorders, post-traumatic stress disorder and substance-related disorder.

### **Psychoanalytic techniques and process in other therapies**

There are also an increasing number of studies which suggest that non-psychoanalytic therapies benefit from the inclusion of psychoanalytic elements. As Elkin et al (1989) pointed out, it is not unusual for therapists to incorporate processes and techniques not associated with their treatment manual into practice and for therapists providing the same treatment to interact with patients in a variety of ways. Studies examining transcripts or recordings of therapy sessions suggest that psychoanalytic techniques and processes are commonly used by non-psychoanalytic therapists (Goldfried and Wolfe, 1996; Kazdin, 2007, 2008). Furthermore, the active ‘agents of change’ of some therapies may not be those presumed by the theory or model behind the therapy. Kazdin (2007) for example, notes that the agents of change in cognitive therapy do not seem to be the cognitions as presumed by the theory.

Shedler (2010) highlights a number of studies which suggest that psychoanalytic processes and techniques are used by non-psychoanalytic therapists and lead to successful outcome in non-analytic therapies (such as Diener, Hilsenroth and Weinberger, 2007; Hoglend et al, 2008; Vocisano et al, 2004). Among these, ones associated with the Psychotherapy Process Q-Sort (PQS) might be of most interest (Jones, 2000). The PQS includes 100 variables which assess the therapy process based on matters such as the behaviour and actions of the therapist. A study by Ablon and Jones (1998) for example, asked experts in CBT and psychoanalytic therapy to use the PQS to describe ideally conducted treatments. Following feedback from these experts, prototypes of ideally constructed CBT and psychoanalytic psychotherapy were made. The CBT prototype focused on highly structured treatment, with the therapist introducing topics and discussing patient treatment goals. The psychoanalytic prototype focused on unstructured, open-ended dialogue, with the therapist identifying recurring themes in the patient's experience and drawing attention to feelings regarded by the patient as unacceptable. Ablon and Jones examined three archival treatment records (one for cognitive therapy, two for brief psychodynamic therapy), focusing on therapist adherence to each therapy prototype without regard to the treatment model the therapists thought they were applying. Therapist adherence to the psychoanalytic prototype predicted successful outcome in both psychoanalytic and cognitive therapy, whereas therapist adherence to the CBT prototype bore little or no relation to outcome in either type of therapy. These findings echo those of Jones and Pulos (1993) who found that psychoanalytic interventions predicted successful outcome for both psychoanalytic and cognitive therapy. Other studies have reported positive relations between CBT technique and outcome (such as Strunk, DeRubeis, Chiu et al, 2007) but findings suggest that the more effective therapists utilise psychoanalytic process and techniques.

## **Conclusions**

One can now state with confidence that the evidence base for psychoanalytic psychotherapy is strong and credible and that psychoanalytic psychotherapy is efficacious in the treatment of a wide range of mental health conditions and disorders. A historical antipathy to research in the psychoanalytic community is increasingly giving way to active and willing involvement in research. Moreover, after a spate of poor trials (with for example, too small patient samples), studies are now becoming much tighter and more methodologically rigorous. In this way, research in psychoanalytic psychotherapy is beginning to catch up with the large number of methodologically sound RCTs conducted on other forms of therapy such as CBT.

There is also a real incentive for commissioners and health policy makers to turn to psychoanalytic psychotherapy. As the public policy landscape points out (for example, the British Psychoanalytic Council and UK Council for Psychotherapy, 2015; Mind, 2013, 2014) many people who would benefit from psychoanalytic psychotherapy are currently unable to access appropriate treatments on the NHS. It is therefore of acute concern that an increasing number of NHS services providing psychoanalytic forms of treatment are being

decommissioned (British Psychoanalytic Council and UK Council for Psychotherapy, 2013, 2015).

It should also be noted definitively that psychoanalytic psychotherapy does have scientific support. Sweeping assertions that psychoanalytic work lacks any scientific credibility can no longer stand up to scrutiny (such as Barlow and Durand, 2005). Perpetuating such assertions also does a disservice to patients. Further, psychoanalytic psychotherapy shows significantly strong effect sizes at long-term follow up. The evidence makes it clear that patients receive lasting benefits, which go well beyond the remission of symptoms.

Above all, in the often fractious and sometimes competing world of psychological therapies, it is time for all researchers to collaborate more, to think again about what is really in the best long-term interests of patients. Patients deserve the most appropriate treatments and it is the job of researchers to lay aside any therapeutic allegiances they may have and work solely in the interests of those experiencing mental distress.

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