Evidence for Psychodynamic Therapy in Specific Mental Disorders

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Criteria of Evidence-based Medicine

- Evidence-based Medicine Working Group (Sacket, 1989; Cook et al., 1995; Guyatt et al., 1995)

- Canadian Task Force on the Periodic Health Examination (1979, 2004)

- Cochrane Collaboration (Clark & Oxman, 2003)
Psychotherapy Research

- American Psychological Association
  (APA, Chambless & Hollon, 1998)

- Roth & Fonagy (2005)

- Nathan & Gorman (2015)
Criteria for Efficacy

- Randomized Controlled Trials (RCTs): "Gold Standard"
- Random assignment to treatment conditions
- Comparison with a control condition
- Use of treatment manuals
- Specific mental disorder (e.g. Social Phobia or PTSD)
- Critical discussion of RCTs
Strengths and Limitations of RCTs
(Efficacy Studies)

- controlled experimental conditions
- internal validity usually high
- external validity may be limited
  (not sufficiently representative of clin. practice)
- effectiveness studies; conditions of clinical practice
Review on the Efficacy of Psychodynamic Therapy

- Using the criteria of EBM/APA
- Randomized Controlled Trials (RCTs)
- Treatment Manuals
- Treatment of a specific mental disorder
Method

- Computerized Search (MEDLINE, PsycINFO)
- Key words: psychodynamic, psychoanalytic, (psycho-) therapy, empirical study
- Textbooks, Journal Articles
- Period: 1960 – September 2017
Results

- Screen a large number of journal articles
- “Digging for Gold“
- RCTs fulfilling the inclusion criteria
Depressive Disorders (MDD)

- RCTs: STPP vs. Cognitive-Behavioral Therapy (CBT)
  - STPP = CBT
    - Thompson et al. (1987; Gallagher-Thompson et al., 1990)
    - Gallagher et al. (1994)
    - Shapiro et al. (1994; 1995)
    - Barkham et al. (1996)
    - Driessen et al (2013): STPP: N=177 CBT: N=164 Remission: 24% vs. 21%
Depressive Disorders

- Meta-Analyses

  Leichsenring (2001): STPP=CBT

  Cuipers et al (2009): STPP=CBT=IPT

  Driessen et al (2015): STPP (individual) = other psychotherapies (individual)
Anxiety Disorders

- Milrod et al. (2007): Panic Disorder
  - STPP > CBT (Applied Relaxation, Öst)

- Milrod et al. (2015): Panic Disorder
  - STPP = CBT (response rates)
Anxiety Disorders

- Crits-Christoph et al. (2005): GAD
  - STPP > Supportive Therapy (remission rates)

  - STPP = CBT; STPP < CBT
Anxiety Disorders

- Knijnik et al. (2004): Social Phobia
  - STPP > Placebo

- Bögels et al. (2015): Social Phobia
  - STPP = CBT

Large-scale multicenter RCT in social phobia: SOPHO-NET *

  - N=494 patients with Social Phobia
  - STPP vs CBT vs Waiting list
  - N= 207 vs. 209 vs 79

* funded by BMBF (German Federal Ministry of Research and Education)
Large-scale multicenter RCT in social phobia: SOPHO-NET

CBT vs STPP

- CBT = STPP (response rates): 60% vs 52%
- CBT > STPP (remission rates): 36% vs 26%

- all differences were small (h ≤ 0.23) and below a priori set margin of 15%
Large-scale multicenter RCT in social phobia: SOPHO-NET

- Follow-up: 6, 12, 24 months
- Treatment effects were stable, tending to increase
- CBT = STPP
Meta-Analysis in Anxiety Disorders

Keefe, McCarthy, Dinger, Zilcha-Mano, Barber (2014)

- STPP > Controls (WL, Supportive Therapie): $g=0.64$

- STPP = other therapies
  - Post: $g = 0.02$
  - $\leq 1$-YFU: $g = -0.11$
  - $> 1$ Y FU: $g = -0.26$
Somatoform Disorders

- Guthrie al. (1991): irritable bowl syndrome
  - STPP > TAU
- Creed et al. (2003): irritable bowl syndrome
  - STPP > TAU
- Hamilton et al. (2000): chron. functional dyspepsia
  - STPP > Supportive Therapie
- Monsen & Monsen (2000): somatof. pain disorder
  - STPP > control (no treatment or TAU)
- Sattel et al (2011): somatoform disorders
  - STPP > TAU (enhanced medical care)
Somatoform Disorders

Meta-Analysis (Abbass, Kisley, Kroenke, 2009)

- Somatic Disorders
- STPP > Controls
- effects stable in follow-up
- improvements in physical and psychological symptoms, social functioning
Personality Disorders
Cluster C

- RCTs
  - Winston et al. (1994): Cluster C Personality Disorders
    - STPP > Waiting List
  - Svartberg et al. (2004): Cluster C Personality Disorders
    - STPP = CBT
  - Muran et al. (2005): Cluster C Personality Disorders
    - STPP = CBT= brief relational therapy
  - Abbass et al. (2008): Personality Disorders
    - STPP > minimal contact
Borderline Personality Disorder

- Bateman & Fonagy (1999; 2001)
  - LTPP (MBT) > TAU

- Bateman & Fonagy (2009)
  - LTPP (MBT) > Structured Clinical Management.

- Clarkin et al (2007)
  - LTPP (TFP) ≥ DBT, Supportive Therapy

- Doering et al (2010)
  - LTPP (TFP) > TAU (experienced community therapists)

  - LTPP > TAU
Borderline Personality Disorders

**Meta-Analysis** (Cristea et al., 2017)

- PDT > Controls (TAU, other therapies): $g=0.41$
- DBT > Controls (TAU, other therapies): $g=0.35$
- CBT = Controls (TAU, other therapies): $g=0.24$ n.s.
Eating Disorders

- **Bulimia Nervosa**
  - Fairburn et al. (1986, 1995)
    - STPP = CBT (bulimic episodes, vomiting)
  - Garner et al. (1993)
    - STPP = CBT (bulimic episodes, vomiting)
  - Poulsen et al. (2014): LTPP < CBT
  - Bachar et al. (1999)
    - STPP > Cognitive Therapy
    - STPP > Control (nutritional counseling)
Eating Disorders

- **Anorexia Nervosa**
  - Gowers et al. (1994)
    - STPP > TAU
  - Dare et al. (2001)
    - STPP > TAU

- **Binge Eating (Tasca et al. 2006)**
  - STPP = CBT > Waiting list (e.g. days binged)
Anorexia Nervosa

Zipfel, Herzog et al (Lancet, 2013)

- LTPP vs E-CBT vs O-TAU (Primary Outcome: BMI)
- N = 80 : 80 : 82
- Sessions: LTPP: 39.9, E-CBT: 44.8, O-TAU: 50.8
- LTPP = E-CBT = O-TAU
Zipfel, Herzog et al (Lancet, 2013)

12 MFU: recovery (PSE 1 or 2 and BMI > 18.5):

- LTPP: 35%
- E-CBT: 19%
- O-TAU: 13%

LTPP > O-TAU
E-CBT = O-TAU
LTPP vs E-CBT: n.s.
PTSD

- STPP = CBT = Hypnotherapy (Brom et al., 1989)
- STPP > Waiting list (Steinert et al., 2016, 2017)
Further Evidence

- Alcohol misuse: STPP = CBT (Sandahl et al., 1989)

- Opiat Addiction:
  - STPP = CBT > Drug Counseling (Woody et al., 1990)
  - STPP > Drug Counseling (Woody et al. 1995)
Short- vs. long-term Psychotherapy
Short- vs. Long-Term Psychotherapy: Dose–effectiveness relationships

- Acute mental problems: 20 sessions are sufficient to achieve remission in 70% of patients (Kopta et al., 1994)

- Chronic mental disorders: 50 sessions required for remission of 70% of patients (Kopta et al., 1994)

- Personality Disorders: 50 sessions are nor sufficient for remission of 50% of patients  (Kopta et al., 1994)
Improving Access to Psychological Therapies: (IAPT)

- low intensity CBT (< 8 sessions, in person or via telephone, assisted by computerized learning modules)
- 53% of remitters relapsed within 1 year (Ali et al., 2017)
- the majority (79%) relapsed within the first 6 months post-therapy (Ali et al., 2017)
Short- vs. Long-Term Psychotherapy: Dose–effectiveness relationships

There is a time for everything …
Meta-Analysis: LTPP*

- LTPP (at least 50 sessions or 1 year)
- Complex Mental Disorders: chronic, multimorbid, personality disorders
- overall outcome, target problems, general symptoms, personality functioning, and social functioning
- Large effect sizes for LTPP
- stable in FU; increased significantly during FU
- LTPP > shorter forms of treatment (8 studies)

Meta-Analysis of LTPP*: an update

- LTPP (at least 50 sessions or 1 year)
- Complex Mental Disorders
- 10 controlled studies
- LTPP > shorter forms of treatment

Between-group effect sizes

<table>
<thead>
<tr>
<th>Category</th>
<th>Effect Size</th>
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<tbody>
<tr>
<td>Overall</td>
<td>0.54</td>
</tr>
<tr>
<td>Target problems</td>
<td>0.49</td>
</tr>
<tr>
<td>General psychiatric problems</td>
<td>0.44</td>
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<tr>
<td>Personality functioning</td>
<td>0.68</td>
</tr>
<tr>
<td>Social functioning</td>
<td>0.62</td>
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</tbody>
</table>

LTPP: Another update 2013


- Results were corroborated

Long-term Psychodynamic Therapy

- Results support those reported by Olavi Lindfors and Felicitas Rost
Reviews
Short-term psychodynamic psychotherapies for common mental disorders (Review)


THE COCHRANE COLLABORATION®

This is a reprint of a Cochrane review, prepared and maintained by The Cochrane Collaboration and published in The Cochrane Library 2014, Issue 7

http://www.thecochranelibrary.com

WILEY
Cochrane Report (2014)
Abbass, Kisley, Town, Leichsenring, Driessen, deMaat,
Gerber, Dekker, Rabung, Rusalovska, Crowe

- STPP vs. Controls
- Common mental disorders (dep, anx, personality etc.)
- Depressive symptoms
- anxiety symptoms
- somatic symptoms
- general psychiatric symptoms
Cochrane Report (2014)
Abbass, Kisley, Town, Leichsenring, Driessen, deMaat, Gerber, Dekker, Rabung, Rusalovska, Crowe

STPP > Controls

- short-term ≤ 3-MFU
- medium-term 3-6-MFU
- long-term: effect sizes tended to increase (n.s.)
Reviews

Meta-Analysis
(Steinert et al., 2017): Am J P

- Is PDT as efficacious as treatments established in efficacy?
- Controlled for researcher allegiance
- Logic of equivalence testing
- margin (g=0.25)
- two-one-sided tests (TOST)
Meta-Analysis
(Steinert et al., 2017): Am J P

- Across disorders (e.g. depressive, anxiety, personality disorders)
- PDT as efficacious as established treatments
- PDT as efficacious as CBT
Evidence for efficacy of psychodynamic therapy in:

- Depressive Disorders
- Anxiety Disorders (GAD, Social Phobia, Panic Disorder)
- PTSD
- Somatoform Disorders
- Eating Disorders (Anorexia, Bulimia, Binge Eating)
- Personality Disorders (Cluster C; BPD)
- Substance-related Disorders
Several approaches exist: e.g. CBT, PDT, IPT …

Is there a Gold Standard for Psychotherapy?
Is CBT the gold standard for Psychotherapy?
(Leichsenring & Steinert, 2017, JAMA)

- Leichsenring & Steinert (2017, JAMA), we reviewed
- study quality
- efficacy (response rates)
- evidence for superiority
- meta-analyses or reviews by independent researchers
Is CBT the gold standard for Psychotherapy? (Leichsenring & Steinert, 2017, JAMA)

- Study Quality is limited: 17% (24/144) of high quality (Cuijpers et al., 2016)
- Weak empirical tests: in 80% of 121 studies in anx dis test against waiting list (Depresson: 44%) Cuijpers et al 2016
Is CBT the gold standard for Psychotherapy?  
(Leichsenring & Steinert, 2017, JAMA)

- Mechanisms of change were not corroborated (e.g. negative triad, Kazdin, 2007)

- Limited efficacy: CBT is not a panacea (e.g. response: 50% in anxiety or depress dis) : Cuijpers et al, 2014, Craske & Stein 2017

- No clear evidence of superiority, e.g. in depr. or anx. disorders (Cuijpers et al, 2014; Tolin et al, Keefe et al)
Is CBT the gold standard for Psychotherapy? (Leichsenring & Steinert, 2017, JAMA)

- no form of psychotherapy can presently claim to be the gold standard
- neither CBT, PDT, IPT or any other form
- monocultures not successful (e.g. only CBT)
- different approaches may be helpful to different patients
German Health Care System
German Health Care System

- PDT was shown to significantly reduce the days in hospital (Dührssen & Jorswieck 1965)
- PDT significantly reduced costs
- 1967 insurance companies decided to reimburse PDT
- 1987: CBT was included
- Cost reduction was corroborated (Margraf et al, 2009)
German Health Care System

- Psychodynamic therapy and CBT: „Richtlinientherapien“, i.e. reimbursed by the insurance companies
- CBT and PDT are equally frequently applied.
- CBT: 24 - 80 sessions
- PDT: 24 - 100 sessions
- Psychoanalytic therapy: 80-300 sessions
- Mean: about 50 sessions (CBT, PDT, Psa)
Thank you for your attention!