# Efficacy of Experiential Dynamic Therapy for Psychiatric Conditions: A Meta-Analysis of Randomized Controlled Trials

Peter Lilliengren
Stockholm University

Robert Johansson
Linköping University

Karin Lindqvist
The Erica Foundation, Stockholm, Sweden

Jakob Mechler
Northern Stockholm Psychiatry, Stockholm, Sweden

Gerhard Andersson
Linköping University and Karolinska Institutet

Experiential dynamic therapy (EDT) is a subgroup of short-term psychodynamic psychotherapy (STPP) that emphasizes patients' in-session affective processing. To evaluate the efficacy of EDT for psychiatric conditions, we conducted a meta-analysis of randomized controlled trials. Twenty-eight studies published between 1978 and 2014 were included, encompassing 1,782 adult patients with mood, anxiety, personality, or mixed disorders. Across targeted outcome domains, medium-size between-groups effects (Cohen's $d$s ranging from 0.39 to 0.65) favored EDT over inactive controls at posttreatment and in symptom measures at follow-up. We found no differences between EDT and active treatments (e.g., medication, cognitive–behavioral therapy, manualized supportive therapy) at posttreatment, but EDT outperformed supportive therapy at follow-up ($d = 0.75$). In terms of within-group effect sizes, EDT was associated with large improvements in general psychiatric symptoms ($d = 1.11$), depression ($d = 1.33$), and anxiety ($d = 1.09$) and with small to moderate gains in the areas of interpersonal problems ($d = 0.55$) and global functioning ($d = 0.86$). Small but significant effects suggested continued improvement between posttreatment and follow-up. Heterogeneity in pre–post effects was explored in subgroup analyses, which indicated that EDT might be most effective in depressive disorders and that individual EDT had larger effects compared with group treatment. In addition, EDT performed better in higher quality studies. We conclude that EDT is a promising treatment for psychiatric conditions in adults. Further high-quality studies evaluating contemporary versions of EDT in specific psychiatric conditions are warranted.

*Keywords:* experiential, affect focused, short-term psychodynamic psychotherapy, psychiatric disorders, meta-analysis

*Supplemental materials:* http://dx.doi.org/10.1037/pst0000024.supp

There is growing empirical support for the efficacy of short-term psychodynamic psychotherapy (STPP) in common psychiatric conditions among adults. For example, meta-analytic reviews suggest that STPP outperforms inactive controls (e.g., wait list, treatment as usual) in the treatment of depression (Driessen et al., 2010), anxiety disorders (Keefe, McCarthy, Dinger, Zilcha-Mano, & Barber, 2014), personality disorders (Town, Abbass, & Hardy, 2011) and somatic disorders (Abbass, Kisely, & Kroenke, 2009). In a recent Cochrane Library review update, Abbass et al. (2014) concluded that STPP "may be effective for a very broad range of common mental disorders . . ., with evidence of modest to large treatment effect sizes that increase in long-term follow-up" (p. 16). However, STPP represents a family of treatment models that, although they share several key features, have different emphases in theory and technique. Thus, the growing evidence-base for STPP may not be generalizable to all subgroups of STPP.

One such subgroup is experiential dynamic therapy (EDT), which encompasses STPP models that place a strong emphasis on helping patients directly experience and express previously warded-off affects (Osimo & Stein, 2012). EDT includes Malan's brief psychotherapy (Malan, 1963, 1976, 1979); Davanloo's intensive short-term dynamic psychotherapy (ISTDP; Davanloo, 1990,

2000, 2005); and more recently developed models derived from the work of Malan and Davanloo, such as Fosha's accelerated experiential–dynamic psychotherapy (Fosha, 2000), Osimo's experiential short-term dynamic psychotherapy (Osimo, 2003), and McCullough's affect phobia therapy (McCullough et al., 2003). Contemporary EDT models integrate basic notions from affective neuroscience and attachment theory (Fosha, Siegel, & Solomon, 2009) within a psychodynamic conflict theory framework (Abbass, 2015; Fosha, 2000; Osimo & Stein, 2012). Some versions also incorporate ideas from learning theory (McCullough, 1999). A fundamental underlying assumption of all EDTs is that psychiatric conditions such as depression, anxiety, and personality disorders are byproducts of an individual's attempts to regulate strong emotions, typically associated with adverse experiences in key attachment relationships during childhood (Anda et al., 2006; Schore, 2001, 2002). When the attachment system and associated affects are triggered again in later relationships, the individual may resort to maladaptive coping mechanisms (i.e., *defenses* and *resistance*, in psychodynamic terms), leading to relational difficulties and/or symptom formation.

The main treatment principles underlying EDT can be summarized using the *triangle of conflict* and the *triangle of persons* (see Figure 1). These two schemes were originally combined by Malan (1979) to represent "the basic principles of dynamic psychotherapy" (p. 90). The triangle of conflict illustrates how defenses and anxieties block the experience of true feelings, and the triangle of persons refers to how these patterns began with past persons, are maintained with current persons, and may be enacted with a therapist. Although EDTs may differ somewhat in their use of specific techniques and interventions, all use these two triangles as basic schemes for understanding the psychodynamics of each patient and for formulating a treatment focus in the initial phase of treatment (Osimo & Stein, 2012).

In addition, in line with Malan's (1979) statement that "the aim of every moment of every session is to put the patient in touch with as much of his true feelings as he can bear" (p. 74), the triangle of conflict is used as a guide for the moment-to-moment assessment of patient needs and the corresponding choices of interventions directly in sessions. Thus, EDT therapists continually strive to (a) help patients become aware and let go of maladaptive defenses that generate and/or perpetuate their symptoms and presenting complaints; (b) track anxiety and regulate it when it is too high; and (c) help patients access, viscerally process, and integrate previously avoided affects. The triangle of persons is also used actively to track recurring relational patterns, but interpretation of such patterns is typically not used until a patient has gained access to the underlying affects involved in maintaining problematic patterns (Davanloo, 1990, 2000, 2005; Malan, 1986a, 1986b).

In this regard, the basic technique in EDT may be contrasted with STPP models that focus more on patients' interpersonal dynamics, such as psychodynamic interpersonal therapy (Hobson, 1985), supportive–expressive therapy (Luborsky, 1984; Luborsky & Crits-Christoph, 1998), time-limited dynamic psychotherapy (Strupp & Binder, 1984), and brief relational therapy (Safran & Muran, 2000). Although sharing many features and goals with EDT, these models place more emphasis on therapists' skillful use of interpretation and/or metacommunication (Kiesler, 1988) to help patients gain insight into recurring maladaptive relational patterns. Although such interventions may sometimes be used in EDT, they are typically restrained in favor of interventions that facilitate the direct experience of underlying affects in the here and now (Davanloo, 1990, 2000, 2005; Malan, 1986a, 1986b).

In line with the fundamental assumptions underlying the EDT technique, there is increasing evidence indicating that patients' in-session affective processing is related to outcome in psychodynamic psychotherapies (Diener & Hilsenroth, 2009; Diener, Hilsenroth, & Weinberger, 2007; Hilsenroth, Ackerman, Blagys, Baity, & Mooney, 2003; Kramer, Pascual-Leone, Despland, & de Roten, 2015; McCullough & Magill, 2009; Salvadori, 2010; Whelton, 2004). For example, in a meta-analysis of 10 process–outcome studies, Diener et al. found that the more therapists facilitated affective experience/expression, the more patients improved ($r = .30$). Recent studies also suggest that reaching a particular state of high emotional arousal coupled with low anxiety and few active defenses in the treatment process, termed an *unlocking of the unconscious* by Davanloo (1990), may be particularly important for facilitating changes in more resistant and fragile patients (Johansson, Town, & Abbass, 2014; Town, Abbass, & Bernier, 2013). Also in line with basic EDT principles, therapists' skillful work with clarification and confrontation of defenses has been found to lead patients to higher levels of affect experiencing in sessions (McCullough & Magill, 2009; Town, Hardy, McCullough, & Stride, 2012) and to affect the therapeutic alliance positively (Despland, de Roten, Despars, Stigler, & Perry, 2001; Gerosthatos, de Roten, Berney, Despland, & Ambresin, 2014).

Thus, EDT may be considered a specific subgroup of STPP that is based on a set of key assumptions regarding the etiology and maintenance of psychiatric symptoms and distinct treatment principles. As the overall evidence base for STPP continues to grow, there is an increasing need to evaluate the efficacy of specific subgroups of STPP. Such evaluation may assist in the identification of the most effective psychodynamic treatment principles, which could guide clinical practice and training and inform the development of future STPP protocols (Leichsenring & Salzer, 2014; Leichsenring & Schauenburg, 2014) and novel therapeutic applications (Johansson, Frederick, & Andersson, 2013). However, the efficacy of EDT has not been fully evaluated previously. In their recent Cochrane Library review update of STPP, Abbass et al.'s (2014) post hoc analysis suggested that STPP models based on the work of Malan and/or Davanloo are efficacious in reducing



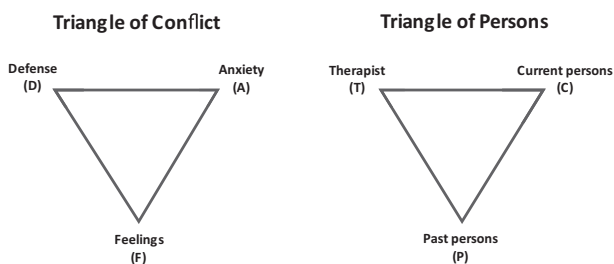*Figure 1.* The two triangles illustrate how defenses and anxieties block the experience and expression of true feelings and how such patterns began with past persons, are maintained with current persons, and may be enacted with a therapist. The triangles represent "the basic principles of dynamic psychotherapy" (Malan, 1979, p. 90) that underlies both patient assessment and therapist intervention in experiential dynamic therapy.

psychiatric symptoms. Nevertheless, the analysis included only 11 studies, and the review focused exclusively on comparisons with inactive treatment controls. In addition, two of the included studies concerned patients with a primary somatic diagnosis, which may limit conclusions regarding psychiatric conditions specifically. To evaluate EDT more comprehensively, the aim of the present study was therefore to conduct a meta-analysis of all randomized controlled trials (RCTs) of EDT for psychiatric conditions in adults. We aimed to perform separate analyses of EDT in comparison with inactive and active treatment controls and to evaluate within-group effects of EDT. Further, possible moderators, impact of study quality, dropout rates, and publication bias were explored. This overview elucidates the current evidence base for EDT and may offer some guidance for clinical practice and future research in this area.

## Method

### Selection of Studies

Our search for relevant studies started with extraction of all RCTs included in (or excluded form) previously published meta-analyses and reviews of psychodynamic psychotherapy. Specifically, we examined the following sources in detail (including any supplemental materials available): Abbass, Hancock, Henderson, and Kisely (2006); Abbass et al. (2009); Abbass, Town, and Driessen (2012); Anderson and Lambert (1995); Barber, Muran, McCarthy, and Keefe (2013); Gerber et al. (2011); Slavin-Mulford, and Hilsenroth (2012), and Svartberg and Stiles (1991). To find any previously missed or more recently published studies (up until December 31, 2014), we also performed electronic searches on PubMed/MEDLINE and PsycINFO. The following search terms were used for titles and abstracts: (*psychodyn** OR *psychoanaly** OR *dynamic ther**) AND (*random** OR *trial*). We made no restrictions regarding date of publication, publication type, or original language. Lastly, because the file-drawer effect can be a problem in meta-analyses, we also consulted two experts with extensive experience in conducting both RCTs and meta-analyses of psychodynamic psychotherapy for their knowledge of any unpublished or additional studies meeting our main inclusion criterion.

The main inclusion criterion was that the treatment under study was directly based on or derived from the work of Malan and/or Davanloo. To determine if this criterion was met, we screened all of the collected RCTs for any reference to Malan or Davanloo (or any of their known successors, as detailed earlier) in descriptions of interventions. If a description was unclear in this regard, we consulted any treatment manuals, books, or other articles referenced. In the case of one study (Reneses et al., 2013), we also contacted the authors to confirm that the treatment approach was derived from Davanloo. Because this was a first evaluation of EDT, we decided to retain studies in which other STPP models were mentioned together with a reference to Malan and/or Davanloo and explore the possible impact of mixed or unclear treatment descriptions in the subgroup analyses (detailed later).

Studies that met the main inclusion criterion were then read in detail to assess whether (a) measures of psychiatric symptoms, global functioning, and/or interpersonal difficulties were used and (b) enough data to calculate effect sizes were reported. To maxi-

mize the number of primary studies for this evaluation, we included studies of different treatment formats (i.e., individual therapy, group therapy, and guided self-help) as long as the treatment was explicitly derived from the work of Malan and/or Davanloo, and we made no restrictions regarding particular study characteristics as long as a study had a randomized controlled design. However, because we aimed to evaluate EDT specifically for psychiatric conditions in adults, studies of children/adolescents or patients with a primary somatic diagnosis were excluded. Two researchers (Peter Lilliengren and Robert Johansson) collaboratively assessed the inclusion criteria and coded the studies for moderators (see the Subgroup Analyses section). Any differences in opinion were discussed until consensus was reached.

### Meta-Analytic Procedures

Data from pre-, post-, and follow-up assessments (if reported) were extracted from each primary study. If a study included several follow-up assessments, we used data from the latest follow-up point available. We included all measures related to five outcome domains: general psychiatric symptoms, depression, anxiety, interpersonal problems, and global functioning/quality of life. Measures that were not directly related to any of these domains (such as measures of personality, employment rate, or medication use) were not considered for this review. Both observer-rated and self-report measures were included. If more than one measure targeted the same outcome in a study (e.g., both the Beck Depression Inventory and the Hamilton Depression Scale were used to assess depressed mood), a mean effect size was calculated across measures. For general psychiatric symptoms, we combined all symptom measures available in each study. Combined measures were assumed to be perfectly correlated (i.e., $r = 1$), because this yields the most conservative estimate of the variance of the mean effect when the true correlation is unknown (Borenstein, Hedges, Higgins, & Rothstein, 2009).

Following the definitions used in other reviews (e.g., Abbass et al., 2014; Gerber et al., 2011), we categorized comparison conditions as either *inactive* or *active* treatment controls. Inactive controls include conditions such as wait list, treatment as usual, unstructured support groups, and minimal contact. Although some of these conditions may be expected to have an effect, they were typically described as nonstandardized, low-intensity interventions by the study investigators. One study (Brodaty & Andrews, 1983) used two inactive control conditions, and we decided to use the family practitioner condition (over the no-treatment group) because it also served as a control for nonspecific factors inherent in having a supportive relationship with a doctor. Further, in studies in which medication was distributed equally in both arms, we decided to classify the medication-alone condition as an inactive control, because we expected the combined treatment to include an additional effect of EDT (Cuijpers et al., 2014). Because inactive controls included some interventions with an anticipated effect, we also conducted a post hoc analysis focusing on EDT in comparison with wait-list conditions alone (detailed later).

Active controls were defined as other bona fide psychotherapeutic interventions (Wampold, Minami, Baskin, & Callen Tierney, 2002) as well as specific medication protocols when compared with EDT without medication. We also considered a combination of EDT and medication to be an active control when

compared with EDT without medication. Only active controls of the same duration were considered when several psychotherapeutic treatments were included in the same study (i.e., comparisons with long-term psychodynamic psychotherapy were excluded). For studies that involved comparisons of EDT with both an inactive and an active control group, we calculated the effect sizes and analyzed the results separately for each type of control condition. Thus, each study could only contribute with one effect size per comparison.

Between-groups effect sizes at posttreatment and follow-up were calculated by subtracting the mean score of the comparison condition from the mean score of the EDT condition and dividing the result by the pooled standard deviations of both conditions (i.e., Cohen's *d*). The directions of the effect sizes were adjusted so that positive values indicated an advantage of EDT over the comparison condition; hence, a negative value indicated an advantage for the comparison condition over EDT.

In the case of one study (Brodaty & Andrews, 1983), we noted a substantial pretreatment difference (more than half of the pooled standard deviation) on the Global Severity Index (GSI) of the Symptom Checklist–90, indicating that the control group had substantially lower symptom load at the start of therapy. For this particular study, we therefore decided to impute a test–retest correlation for the GSI (i.e., .94; Edwards, Yarvis, Mueller, Zingale, & Wagman, 1978; Tingey, Lambert, Burlingame, & Hansen, 1996) in the formula for pre–post matched designs (Borenstein et al., 2009). This formula estimates the between-groups effect size from the differences in change scores (i.e., how much change occurred within each treatment) and, thus, may provide a more accurate estimation when there are substantial pretreatment differences (Becker, 1988). The estimated effect was standardized by the pooled posttreatment standard deviation, and the imputed correlation was also used when calculating the variance of this effect. Because this effect was computed differently, we performed a sensitivity analysis to see whether including or excluding this study had any effect on the between-groups estimate for EDT versus inactive control conditions (detailed later).

Because correlations among pre-, post-, and follow-up assessments were not reported in any of the primary studies, we decided to use the formula for independent groups when calculating the within-group effect sizes (Dunlap, Cortina, Vaslow, & Burke, 1996). Hence, within-group effect sizes were calculated by subtracting the posttreatment mean from the pretreatment mean and then dividing by the pooled standard deviation of both assessments. The same calculations were conducted when estimating effects between posttreatment and follow-up. All within-group effect sizes were adjusted so that a positive direction of the effect indicated positive change (i.e., reduction in distress for symptom measures).

Procedures included in the computer program Comprehensive Meta-Analysis (Version 2.2.064; Biostat, Englewood, NJ) were used for calculating study weights and summary effect sizes with respective confidence intervals. The random-effects model was applied because we a priori assumed that the true effects would differ between studies, considering the broad inclusion criteria in terms of study populations, treatment formats, and control conditions. The random-effects model results in wider 95% confidence intervals and, hence, more conservative results. Further, the random-effects model is the preferable model in efficacy research given the improved generalizability to interventions not exactly resembling treatments in the primary studies (Borenstein et al., 2009).

We followed established conventions in the field and considered between-groups effect sizes of ≥0.20 as small, ≥0.50 as medium, and ≥0.80 as large (Cohen, 1992). No such convention is established when it comes to within-group effect sizes. To obtain some guidelines for the interpretation of our results, we examined two recent reviews of long-term psychodynamic psychotherapy (LTPP) in complex disorders (de Maat, de Jonghe, Schoevers, & Dekker, 2009; Leichsenring & Rabung, 2008). Across different measures, these studies reported mean pre–post effects of LTPP ranging from 0.78 to 0.94. On the basis of these estimates for LTPP, we decided to regard within-group effect sizes of ≥0.50 as small, ≥0.75 as medium, and ≥1.00 as large.

To assess heterogeneity we calculated the *Q* statistic. A significant *Q* value indicates that the observed range of effect sizes is significantly larger than what would be expected on the basis of the within-study variances and, consequently, that the null hypothesis of homogeneity is rejected. We also calculated the $I^2$ statistic, which is an estimate of the degree of heterogeneity expressed in percentages: $I^2$ values of 0% indicate no heterogeneity, ≥25% indicate low heterogeneity, ≥50% indicate moderate heterogeneity, and ≥75% indicate substantial heterogeneity (Higgins, Thompson, Deeks, & Altman, 2003). Higher values of $I^2$ suggest a greater potential for explaining the observed heterogeneity by exploring subgroups and/or covariates. We inspected forest plots for potential outliers and performed sensitivity analyses to test the impact of single studies on summary effects sizes and heterogeneity when indicated.

## Subgroup Analyses

Given the broad inclusion criteria, we expected heterogeneity among the effect sizes and, therefore, coded the primary studies for several treatment, patient, and study characteristics for use in exploratory subgroup analyses. Treatment characteristics included which main EDT model was referred to (Malan vs. Davanloo), if the reference was to a specific publication or manual describing the approach or was mixed or unclear (specific/manual vs. mixed/unclear), which format the treatment was delivered in (individual vs. group), and if the therapy was combined with an add-on medication (yes vs. no). Patient characteristics consisted of the primary patient diagnosis targeted in each study (as defined by the investigators), which we grouped in four categories: depressive disorders, anxiety disorders, personality disorders, and mixed disorders. Finally, study characteristics included whether any adherence monitoring was used (yes vs. no/not reported), if outcome assessors were blinded (yes vs. no/not reported), and if a full intent-to-treat (ITT) analysis was used or only completers were included in the analyses (ITT vs. completers).

Because we assumed that the true effects would vary within subgroups, we used the mixed-effects method for subgroup analyses. This approach pools studies within subgroups with the random-effects model but tests for differences between the subgroups with the fixed-effects model. We expected a low number of studies in some of the contrasts and, therefore, pooled the estimate of tau-squared across subgroups, as recommended by Borenstein et al. (2009). To test for subgroup differences, we used the analysis

of variance–based method in which the between-groups $Q$ statistic ($Q_{between}$) is equivalent to the $F$ statistic. Accordingly, a significant $Q_{between}$ indicates that effect sizes differ between targeted subgroups.

## Study Quality

The Randomized Controlled Trial Psychotherapy Research Quality Scale (RCT-PRQS; Kocsis et al., 2010) was used to assess the quality of the included studies. The RCT-PRQS was developed by experienced psychiatric and psychotherapy researchers from various theoretical backgrounds for the purpose of assessing the quality of psychotherapy RCTs. The main scale consists of 24 items corresponding to specific elements of study design, covering domains such as the inclusion and description of subjects, definition and delivery of treatment, treatment assignment, outcome measurement, and data analysis. Each individual item is rated 0 (*poor description, execution, or justification of a design element*), 1 (*brief description or either a good description or an appropriate method/criteria but not both*), or 2 (*well-described; well-executed; and, where necessary, well-justified design element*). Consequently, the total score of the scale ranges from 0 to 48, and the cutoff score indicating adequate study quality has been suggested to be 24 (Gerber et al., 2011). Excellent internal consistency and interrater reliability were reported for a set of 69 psychodynamic treatment trials (Kocsis et al., 2010).

Two graduate-level psychologists and members of the research team rated the included studies independently with RCT-PRQS. The interrater reliability for the total score (intraclass correlation coefficient [ICC]) was excellent, ICC(2, 1) = .86 (Shrout & Fleiss, 1979; Cicchetti, 1994). To examine the calibration of our raters, we also compared their scores with RCT-PRQS ratings reported in two previously published meta-analyses (Barber et al., 2013; Gerber et al., 2011). From these reviews, we were able to extract previous ratings for 15 of the 28 studies included in the present meta-analysis. The result indicated that our raters were in excellent agreement with the assessors of other reviews, ICC(2, 1) = .89.

## Dropout Rates

We also examined whether dropout from EDT differed from dropout in the inactive or active controls. Because dropout is a dichotomous outcome, we calculated the risk ratio ($RR$), which is the ratio of the probabilities of dropping out in two compared conditions. A risk ratio of 1.00 suggests that there is equal risk in both conditions, and we computed the ratios so that an $RR < 1.00$ indicated a lower risk of dropout in EDT compared with the control condition. Again, we conducted all analyses with the random-effects model, and we calculated the $Q$ statistic and the $I^2$ statistic to assess heterogeneity.

## Publication Bias

Finally, we examined the possible impact of publication bias by inspecting funnel plots and applying Duval and Tweedie's (2000) trim-and-fill procedure (implemented in Comprehensive Meta-Analysis Version 2.2.064). This method yields an adjusted estimate of the pooled mean effect size and its 95% confidence intervals after publication bias has been taken into account. The random-effects model was applied in this procedure as well.

# Results

## Description of Included Studies

A flowchart of the study-selection process is presented in Figure 2. Through our combined search strategies, we identified a total of 152 RCTs of psychodynamic treatments. The intervention was based on principles derived from the work of Malan or Davanloo in 39 of these, and, after assessing our specific inclusion criteria, we were able to include 28 studies published between 1978 and 2014. A complete list of references and a table of study characteristics are provided in the online supplemental materials. In summary, the 28 studies encompassed a total of 1,782 patients, and the psychiatric conditions targeted in the primary studies were depression (seven studies), anxiety disorders (seven studies), personality disorders (six studies), mixed diagnoses (five studies), eating disorders (one study), adjustment disorder (one study), and complicated grief (one study). Seventeen studies reported data from follow-up assessments, with an average follow-up time of 11.5 months later ($SD = 10.9$; range: 3–48). Twenty-three studies implemented EDT as individual psychotherapy, four used group therapy formats, and one study tested a guided self-help program delivered through the Internet with therapist e-mail support. EDT was typically provided on a once-a-week basis, and the average number of sessions was 19.8 ($SD = 9.1$; range: 8–40 [$k = 27$]) across studies. The average number of therapists providing treatment in each study was 5.7 ($SD = 5.1$; range: 1–23 [$k = 24$]), and most of the studies ($k = 21$) reported using some form of adherence monitoring during the study period (typically weekly supervision based on case notes, sometimes with the aid of audio or video recordings). EDT was compared with an inactive control in 13 studies and with an active control in 11 studies. Four studies included both an inactive and an active control group. Twenty studies used ITT analyses, whereas eight studies reported the results for completers only.

## EDT Versus Inactive Controls

The results for comparison of EDT with inactive controls are presented in Table 1. We found significant medium-size between-groups effects in favor of EDT at posttreatment for general psychiatric symptoms, depression, interpersonal problems, and global functioning/quality of life and a significant small effect for anxiety. Heterogeneity was only significant for anxiety. Removing the study by Maina, Forner, and Bogetto (2005) reduced heterogeneity to nonsignificance ($Q = 9.68$, $p = .377$, $I^2 = 7.04$), but the effect estimate remained largely unchanged ($d = 0.34$, 95% confidence interval [CI] [0.16, 0.51], $Z = 3.84$, $p < .001$ [$k = 10$]). We also ran a sensitivity analysis for general psychiatric symptoms, removing the study by Brodaty and Andrews (1983), for which we imputed a pre–post correlation for the GSI, but the estimate did not change ($d = 0.53$, 95% CI [0.35, 0.70], $Z = 6.67$, $p < .001$ [$k = 15$]). Lastly, we repeated the analysis for general psychiatric symptoms, including only studies in which EDT was compared with wait-list conditions ($k = 6$), which yielded a somewhat larger estimate ($d = 0.62$, 95% CI [0.29, 0.95], $Z = 3.66$, $p < .001$) with nonsignificant heterogeneity ($Q = 9.37$, $p = .095$, $I^2 = 46.64$).

The advantage for EDT over inactive controls was essentially maintained at follow-up, indicated by significant medium-size
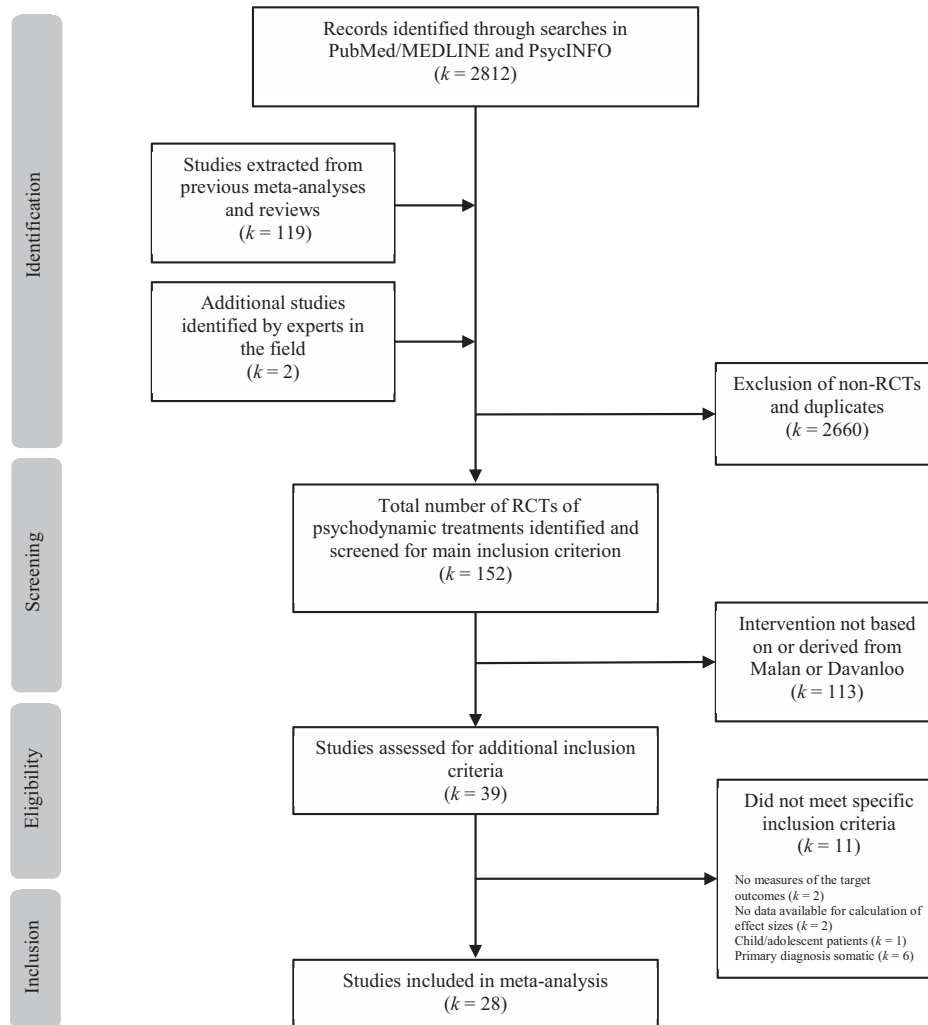
```
                          ┌──────────────────────────────────┐
                          │  Records identified through       │
                          │  searches in PubMed/MEDLINE and   │
                          │  PsycINFO (k = 2812)              │
                          └──────────────────────────────────┘

  ┌───────────────────────────┐
  │ Studies extracted from    │
  │ previous meta-analyses    │
  │ and reviews (k = 119)     │
  └───────────────────────────┘

  ┌───────────────────────────┐                    ┌───────────────────────────┐
  │ Additional studies        │                    │ Exclusion of non-RCTs     │
  │ identified by experts in  │                    │ and duplicates            │
  │ the field (k = 2)         │                    │ (k = 2660)                │
  └───────────────────────────┘                    └───────────────────────────┘

                    ┌──────────────────────────────────┐
                    │ Total number of RCTs of           │
                    │ psychodynamic treatments          │
                    │ identified and screened for main  │
                    │ inclusion criterion (k = 152)     │
                    └──────────────────────────────────┘

                                              ┌───────────────────────────┐
                                              │ Intervention not based    │
                                              │ on or derived from        │
                                              │ Malan or Davanloo         │
                                              │ (k = 113)                 │
                                              └───────────────────────────┘

                    ┌──────────────────────────────────┐
                    │ Studies assessed for additional   │
                    │ inclusion criteria (k = 39)       │
                    └──────────────────────────────────┘

                                              ┌───────────────────────────┐
                                              │ Did not meet specific     │
                                              │ inclusion criteria        │
                                              │ (k = 11)                  │
                                              └───────────────────────────┘

                    ┌──────────────────────────────────┐
                    │ Studies included in meta-analysis │
                    │ (k = 28)                          │
                    └──────────────────────────────────┘
```

Stages (left side): Identification, Screening, Eligibility, Inclusion

Did not meet specific inclusion criteria (k = 11):
No measures of the target outcomes (k = 2)
No data available for calculation of effect sizes (k = 2)
Child/adolescent patients (k = 1)
Primary diagnosis somatic (k = 6)

*Figure 2.* Flowchart of the selection of studies for the meta-analysis. RCT = randomized controlled trials.

between-groups effects for depression and anxiety. The estimate for general psychiatric symptoms was not significant. However, removing the study by Brodaty and Andrews (1983) increased the estimate to a significant medium effect ($d = 0.59$, 95% CI [0.29, 0.88], $Z = 3.93$, $p < .001$ [$k = 3$]). Heterogeneity was nonsignificant for all of the outcomes at follow-up, but the results must be interpreted with caution given the limited number of studies reporting follow-up data.

## EDT Versus Active Controls

Effect sizes for EDT in comparison with active controls (see also the forest plot in Figure 3) are presented in Table 2. We found no significant differences at posttreatment for any outcome category. Heterogeneity was low and nonsignificant, indicating little between-study variability. At follow-up, we found significant small to medium effects in favor of EDT over other active treatments for general psychiatric symptoms, depression, and anxiety, suggesting that EDT may outperform other active treatments in the

long run. However, heterogeneity was significant at follow-up; hence, the observed advantage for EDT may be specific in comparison with particular active controls.

To explore this possibility, we repeated the analyses separately for each type of active control. Because of the small number of comparisons, however, we were only able to compare EDT with cognitive–behavioral therapy (CBT) and manualized supportive therapies. We also had to restrict the analyses to the general psychiatric symptoms outcome (a table of the results is provided in the online supplemental materials). EDT was directly compared with CBT in five studies, and we found no evidence of any differences at posttreatment ($d = 0.02$, 95% CI [−0.24, 0.28], $Z = 0.15$, $p = .880$) or at follow-up ($d = 0.07$, 95% CI [−0.22, 0.36], $Z = 0.47$, $p = .638$ [$k = 4$]). There was no indication of heterogeneity at posttreatment ($Q = 2.16$, $p = .706$, $I^2 = 0.00$) or at follow-up ($Q = 0.65$, $p = .885$, $I^2 = 0.00$). EDT was compared with manualized supportive therapy in five studies, and, again, we found no significant differences at posttreatment ($d = 0.10$, 95%

Table 1
*Effect Sizes for EDT in Comparison With Inactive Controls*

| Comparison | $k$ | $d$ | 95% CI | $Z$ | $Q$ | $I^2$ (%) |
|---|---|---|---|---|---|---|
| EDT vs. inactive controls at posttreatment | | | | | | |
| General psychiatric symptoms | 16 | 0.52 | [0.35, 0.68] | 6.21** | 19.48 | 22.99 |
| Depression | 11 | 0.55 | [0.40, 0.71] | 6.84** | 6.92 | 0.00 |
| Anxiety | 11 | 0.39 | [0.15, 0.63] | 3.18** | 20.58* | 51.41 |
| Interpersonal problems | 3 | 0.65 | [0.33, 0.97] | 3.96** | 1.32 | 0.00 |
| Global functioning/quality of life | 4 | 0.51 | [0.02, 1.00] | 2.04* | 7.34 | 59.14 |
| EDT vs. inactive controls at follow-up | | | | | | |
| General psychiatric symptoms | 4 | 0.40 | [−0.03, 0.83] | 1.81 | 7.09 | 57.71 |
| Depression | 3 | 0.58 | [0.29, 0.87] | 3.88** | 0.17 | 0.00 |
| Anxiety | 2 | 0.62 | [0.22, 1.02] | 3.05** | 0.40 | 0.00 |
| Interpersonal problems | 0 | | | | | |
| Global functioning/quality of life | 3 | 0.26 | [−0.04, 0.55] | 1.70 | 1.11 | 0.00 |

*Note.* EDT = experiential dynamic therapy; CI = confidence interval.
* $p < .05$. ** $p < .01$.

CI [−0.25, 0.45], $Z = 0.57$, $p = .570$) and no significant heterogeneity ($Q = 5.54$, $p = .236$, $I^2 = 27.84$). However, at follow-up, there was a significant medium-size effect favoring EDT ($d = 0.75$, 95% CI [0.18, 1.32], $Z = 2.59$, $p = .010$), with indication of a moderate amount of heterogeneity ($Q = 12.63$, $p = .013$, $I^2 = 68.32$). This proved sensitive to the removal of Hellerstein et al. (1998), which reduced heterogeneity to nonsignificance ($Q = 3.93$, $p = .269$, $I^2 = 23.73$) and increased the advantage for EDT ($d = 0.97$, 95% CI [0.58, 1.36], $Z = 4.87$, $p < .001$ [$k = 4$]).

## Within-Group Effects

The estimates for each outcome domain are presented in Table 3. All of the pooled mean pre- to posttreatment effects were significant and indicate large effects for general psychiatric symptoms, depression, and anxiety. A medium-size effect was observed for global functioning/quality of life, and a small effect was observed for interpersonal problems. As expected, there was significant heterogeneity, and the $I^2$ estimate implied moderate or substantial true variance between studies for all outcomes except interpersonal problems. Inspection of the forest plots did not indicate that this variability was likely to be attributable to any individual study (a forest plot for general psychiatric symptoms is provided in the online supplemental materials). Heterogeneity in pre–post effects was further explored in subgroup analyses and in relation to study quality (detailed later).

Turning to the posttreatment to follow-up period, we found small but significant effects indicating further improvement after treatment termination in terms of general psychiatric symptoms, depression, and anxiety. Heterogeneity was significant for all three outcomes, however, and inspection of the forest plots indicated that the study by Maina et al. (2005) was an outlier regarding the posttreatment to follow-up effect for anxiety. Excluding this study reduced the estimate somewhat ($d = 0.27$, 95% CI [0.05, 0.50], $Z = 2.38$, $p = .017$ [$k = 9$]), and heterogeneity was no longer significant ($Q = 13.17$, $p = .106$, $I^2 = 21.43$).

## Subgroup Analyses

Because of the limited number of studies, we restricted our exploratory subgroup analyses to the pre–post effect sizes for general psychiatric symptoms where there was a moderate amount of heterogeneity ($I^2 = 71.58$). The results are presented in Table 4. Treatment characteristics, such as which EDT model was referenced or if there was a specific manual, did not significantly affect the estimates. Studies that combined EDT with an active add-on medication reported somewhat larger effects than did studies without add-on medication, but the difference was not significant ($p = .220$). However, significantly larger effects were reported for individual treatment compared with group treatment ($p = .003$). We also found significant differences between targeted diagnostic groups. Post hoc pairwise contrasts indicated that studies of depression had significantly larger effects compared with studies of personality disorders ($Q_{between} = 9.96$, $p = .002$), studies of anxiety disorders ($Q_{between} = 9.53$, $p = .002$), and studies of mixed samples ($Q_{between} = 14.08$, $p < .001$). No significant differences were found among the other groups. Regarding study characteristics, we found no effect of the use of adherence monitoring or blinding of raters. However, studies that reported ITT analyses had significantly larger effects compared with studies that reported the results for completers only. The $I^2$ statistic indicated moderate or substantial heterogeneity within most of the subgroups, underscoring the exploratory nature of these analyses.

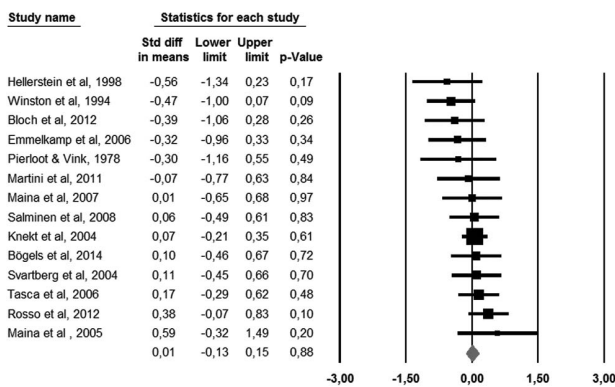| Study name | Statistics for each study | | | | |
|---|---|---|---|---|---|
| | Std diff in means | Lower limit | Upper limit | p-Value | |
| Hellerstein et al, 1998 | -0,56 | -1,34 | 0,23 | 0,17 | |
| Winston et al, 1994 | -0,47 | -1,00 | 0,07 | 0,09 | |
| Bloch et al, 2012 | -0,39 | -1,06 | 0,28 | 0,26 | |
| Emmelkamp et al, 2006 | -0,32 | -0,96 | 0,33 | 0,34 | |
| Pierloot & Vink, 1978 | -0,30 | -1,16 | 0,55 | 0,49 | |
| Martini et al, 2011 | -0,07 | -0,77 | 0,63 | 0,84 | |
| Maina et al, 2007 | 0,01 | -0,65 | 0,68 | 0,97 | |
| Salminen et al, 2008 | 0,06 | -0,49 | 0,61 | 0,83 | |
| Knekt et al, 2004 | 0,07 | -0,21 | 0,35 | 0,61 | |
| Bögels et al, 2014 | 0,10 | -0,46 | 0,67 | 0,72 | |
| Svartberg et al, 2004 | 0,11 | -0,45 | 0,66 | 0,70 | |
| Tasca et al, 2006 | 0,17 | -0,29 | 0,62 | 0,48 | |
| Rosso et al, 2012 | 0,38 | -0,07 | 0,83 | 0,10 | |
| Maina et al , 2005 | 0,59 | -0,32 | 1,49 | 0,20 | |
| | 0,01 | -0,13 | 0,15 | 0,88 | |

-3,00   -1,50   0,00   1,50   3,00

*Figure 3.* Forest plot of experiential dynamic therapy versus active controls for general psychiatric symptoms at posttreatment. Std diff = standardized difference.

Table 2
*Effect Sizes for EDT in Comparison With Active Controls*

| Comparison | $k$ | $d$ | 95% CI | $Z$ | $Q$ | $I^2$ (%) |
|---|---|---|---|---|---|---|
| EDT vs. active controls at posttreatment | | | | | | |
| General psychiatric symptoms | 14 | 0.01 | [−0.13, 0.15] | 0.16 | 12.99 | 0.00 |
| Depression | 8 | 0.09 | [−0.09, 0.26] | 0.99 | 4.81 | 0.00 |
| Anxiety | 8 | 0.13 | [−0.11, 0.36] | 1.07 | 9.45 | 25.95 |
| Interpersonal problems | 4 | 0.05 | [−0.16, 0.26] | 0.47 | 0.45 | 0.00 |
| Global functioning/quality of life | 2 | −0.15 | [−0.76, 0.45] | −0.50 | 2.89 | 65.40 |
| EDT vs. active controls at follow-up | | | | | | |
| General psychiatric symptoms | 10 | 0.38 | [0.06, 0.69] | 2.34* | 25.93** | 65.30 |
| Depression | 6 | 0.64 | [0.22, 1.06] | 3.01** | 18.07** | 72.33 |
| Anxiety | 7 | 0.63 | [0.16, 1.09] | 2.63** | 26.56** | 77.41 |
| Interpersonal problems | 4 | 0.05 | [−0.17, 0.45] | 0.45 | 2.40 | 0.00 |
| Global functioning/quality of life | 1 | 0.01 | [−0.27, 0.29] | 0.06 | | |

*Note.* EDT = experiential dynamic therapy; CI = confidence interval.
* $p < .05$. ** $p < .01$.

## Study Quality

The average overall quality of the included studies was 25.8 ($SD = 6.5$; range: 10–37, $Mdn = 27.3$), which is above the suggested cutoff of 24 for adequate study quality (Gerber et al., 2011). To explore the relationship between study quality and the effect-size estimates for EDT, we first performed a series of random-effects (method-of-moments) meta-regressions using effect size for general psychiatric symptoms as outcome. The analyses indicated a trend toward a positive relationship between study quality and the pre–post effect of EDT (intercept = 0.25, slope = 0.03, $p = .062$) and for the between-groups effects of EDT versus active controls (intercept = −0.73, slope = 0.02, $p = .071$). No association or trend was observed for the comparison of EDT and inactive controls (intercept = 0.40, slope = 0.01, $p = .793$).

To explore the impact of study quality further, we performed a post hoc subgroup analysis coding studies with a score of ≥24 on the RCT-PRQS as *high quality* ($k = 18$ [64.2%]) and studies with a score of ≤23 as *low quality* ($k = 10$ [35.7%]). The results indicated that significantly larger within-group effects were reported in high-quality studies compared with low-quality studies ($d = 1.36$ vs. $d = 0.60$, $Q_{between} = 18.81$, $p < .001$). There were no differences between high- and low-quality studies in terms of

between-groups effects comparing EDT with inactive controls ($d = 0.60$ vs. $d = 0.43$, $Q_{between} = 1.16$, $p = .283$). However, high-quality studies differed from low-quality studies with regard to between-groups effects comparing EDT with active controls ($d = 0.11$ vs. $d = −0.42$, $Q_{between} = 7.60$, $p = .001$), suggesting that the relative effect of EDT versus other active treatments may have been underestimated in low-quality studies (a table of these results is provided in the online supplemental materials). In addition to study quality, we explored the relationship between year of publication and reported pre–post effect for EDT. This analysis indicated that more recently published studies reported larger effects (intercept = −60.30, slope = 0.03, $p = .007$).

## Dropout Rates

Twenty-six studies reported the number of patients who dropped out during the treatment phase of the study. On average, 16.3% patients dropped out of EDT ($SD = 13.9$%; range: 0.0%–59.0%), 15.3% dropped out of inactive controls ($SD = 22.0$%; range: 0.0%–76.7%), and 16.7% dropped out of active control conditions ($SD = 14.6$%; range: 0.0%–53.6%). There was no significant difference in the risk of dropout from EDT compared with inactive controls ($RR = 0.85$, 95% CI [0.62, 1.17], $Z = −0.99$, $p = .320$

Table 3
*Within-Group Effect Sizes*

| Comparison | $k$ | $d$ | 95% CI | $Z$ | $Q$ | $I^2$ (%) |
|---|---|---|---|---|---|---|
| EDT pre- to posttreatment | | | | | | |
| General psychiatric symptoms | 26 | 1.11 | [0.88, 1.33] | 9.71** | 87.98** | 71.58 |
| Depression | 16 | 1.33 | [1.01, 1.65] | 8.16** | 70.35** | 78.68 |
| Anxiety | 16 | 1.09 | [0.83, 1.36] | 8.20** | 44.98** | 66.65 |
| Interpersonal problems | 6 | 0.55 | [0.26, 0.85] | 3.67** | 10.97 | 54.41 |
| Global functioning/quality of life | 7 | 0.86 | [0.53, 1.19] | 5.14** | 16.60* | 63.87 |
| EDT posttreatment to follow-up | | | | | | |
| General psychiatric symptoms | 17 | 0.22 | [0.01, 0.41] | 2.18* | 33.99** | 52.93 |
| Depression | 10 | 0.30 | [0.04, 0.56] | 2.24* | 24.10** | 62.66 |
| Anxiety | 10 | 0.40 | [0.09, 0.72] | 2.54* | 27.84** | 67.68 |
| Interpersonal problems | 5 | 0.16 | [−0.04, 0.35] | 1.58 | 1.33 | 0.00 |
| Global functioning/quality of life | 5 | 0.17 | [−0.10, 0.43] | −1.20 | 7.03 | 43.10 |

*Note.* CI = confidence interval; EDT = experiential dynamic therapy.
* $p < .05$. ** $p < .01$.

Table 4
*Subgroup Analyses of Pre–Post Effect Sizes for General Psychiatric Symptoms*

| Subgroup | $k$ | $d$ | 95% CI | $Z$ | $Q$ | $I^2$ (%) | $Q_{between}$ |
|---|---|---|---|---|---|---|---|
| EDT model | | | | | | | 0.26 |
|   Malan | 20 | 1.07 | [0.83, 1.32] | 8.57** | 65.41** | 70.95 | |
|   Davanloo | 6 | 1.23 | [0.66, 1.81] | 4.19** | 21.43** | 76.66 | |
| EDT reference | | | | | | | 0.07 |
|   Specific/manual | 19 | 1.13 | [0.89, 1.37] | 9.11** | 56.18** | 67.96 | |
|   Mixed/unclear | 7 | 1.05 | [0.50, 1.60] | 3.73** | 31.13** | 80.73 | |
| Treatment format | | | | | | | 9.37** |
|   Individual | 21 | 1.19 | [0.93, 1.45] | 8.93** | 71.26** | 71.94 | |
|   Group | 4 | 0.60 | [0.33, 0.87] | 4.40** | 0.00 | 0.00 | |
| Add-on medication | | | | | | | 1.53 |
|   Yes | 5 | 1.50 | [0.79, 2.22] | 4.11** | 20.98** | 80.94 | |
|   No | 21 | 1.03 | [0.80, 1.26] | 8.73** | 63.77** | 68.64 | |
| Target diagnostic group | | | | | | | 20.23** |
|   Depressive disorders | 6 | 1.88 | [1.58, 2.19] | 11.97** | 4.51 | 0.00 | |
|   Personality disorders | 5 | 1.04 | [0.62, 1.46] | 4.83** | 9.13 | 56.19 | |
|   Anxiety disorders | 7 | 1.03 | [0.59, 1.48] | 4.54** | 17.05** | 64.80 | |
|   Mixed disorders | 5 | 0.88 | [0.46, 1.31] | 4.09** | 14.83** | 73.03 | |
| Adherence monitoring | | | | | | | 0.00 |
|   Yes | 19 | 1.11 | [0.85, 1.36] | 8.53** | 58.11** | 69.03 | |
|   No/not reported | 7 | 1.10 | [0.60, 1.61] | 4.26** | 29.27** | 79.50 | |
| Blinding of raters[a] | | | | | | | 0.07 |
|   Yes | 9 | 1.47 | [1.02, 1.93] | 6.35** | 35.41** | 77.41 | |
|   No/not reported | 4 | 1.32 | [0.31, 2.34] | 2.55* | 30.26** | 90.01 | |
| Outcome analysis | | | | | | | 16.53** |
|   ITT | 19 | 1.30 | [1.04, 1.56] | 9.75** | 66.17** | 72.80 | |
|   Completers | 7 | 0.56 | [0.32, 0.80] | 4.59** | 3.86 | 0.00 | |

*Note.* CI = confidence interval; EDT = experiential dynamic therapy; ITT = intent to treat.
[a] Comparison was conducted on observer-rated measures only.
* $p < .05$. ** $p < .01$.

[$k = 10$]) and no indication of heterogeneity ($Q = 10.04$, $p = .348$, $I^2 = 10.33$). Similarly, we found no difference between EDT and active controls ($RR = 0.98$, 95% CI [0.76, 1.27], $Z = -0.14$, $p = .886$ [$k = 14$]) or indication of heterogeneity ($Q = 10.60$, $p = .644$, $I^2 = 0.00$).

## Publication Bias

Overall, we found very little indication that publication bias had any major effect on our results. The trim-and-fill procedure (Duval & Tweedie, 2000) led to minor adjustments of a few of the summary effects, but the adjusted estimates all remained in the same directions and with the same magnitude (funnel plots for the main comparisons are provided in the online supplemental materials). The only estimate that changed notably was the within-group posttreatment to follow-up effect for depression, which decreased from a significant (but small) effect ($d = 0.28$) to a nonsignificant effect ($d = 0.08$, 95% CI [$-0.21$, 0.37] [$k = 3$]).

## Discussion

The aim of this study was to evaluate the efficacy of EDT, a particular affect-focused subgroup of STPP based on treatment principles derived from Malan (1963, 1976, 1979) and/or Davanloo (1990, 2000, 2005). We found 28 RCTs that met our inclusion criteria, comparing EDT with inactive or active controls across a wide range of common psychiatric conditions. The results suggest that EDT moderately outperforms inactive controls across outcome domains at posttreatment and in terms of symptom measures

at follow-up. We found no indication of differences with other active treatments directly at posttreatment, but EDT outperformed supportive therapy in the long run. Within-group effects indicated that EDT is associated with large and broad improvements during treatment, which tend to increase further between posttreatment and follow-up. The average dropout rate of 16.3% suggests that EDT is tolerated similarly to psychotherapy in general (Swift & Greenberg, 2012), and we found no indication of differences in dropout rates for EDT compared with inactive or active controls conditions.

Overall, our results mirror those of recently published reviews of psychodynamic therapies (Abbass et al., 2014; Barber et al., 2013; de Maat et al., 2009; Leichsenring & Rabung, 2008; Town et al., 2011, 2012). For example, similar to our results, Abbass et al. (2014) found moderate between-groups effects ($d$s = 0.42–0.71) across symptom domains in 33 studies comparing STPP with inactive controls (nine studies overlapping with this review). In a meta-analysis that included 45 studies of psychodynamic treatments (10 overlapping studies), Town et al. (2012) reported a pre–post effect for general psychiatric symptoms ($d = 1.07$) and an effect for the follow-up period ($d = 0.22$) that were more or less identical to our findings for EDT (i.e., $d = 1.11$ and $d = 0.22$, respectively). Thus, in terms of general efficacy, EDT seems to be as efficacious as other psychodynamic treatments.

Interestingly, there were no significant differences between EDT and manualized supportive therapy at posttreatment, but EDT did better at follow-up. One possible interpretation is that expressive psychodynamic techniques (such as actively focusing on

affect and interrupting defenses), which are central to EDT but typically omitted from supportive therapies (Winston, Rosenthal, & Pinsker, 2004), may be particularly important for long-term changes. This would be in line with studies indicating that so-called *structural change* (i.e., integration of previously warded-off experiences and development of more mature and flexible defenses) is associated with better long-term outcomes of psychodynamic treatments (Grande et al., 2009; Perry & Bond, 2012).

Further, we found no significant differences between EDT and CBT at either posttreatment or follow-up. There was no indication of heterogeneity in these contrasts, suggesting low between-study variability. This appears to indicate another occurrence of the famous (some might say infamous) *Dodo bird verdict*, proposing that different bona fide psychotherapies have similar overall outcomes (Luborsky, Singer, & Luborsky, 1975; Rosenzweig, 1936; Wampold, 2001). It should be noted, however, that our result is limited to a small number of direct comparisons ($k = 5$), targeting mainly Cluster C personality disorders and generalized social anxiety, and that we were only able to compare the treatments in terms of the general psychiatric symptoms. Hence, we do not know how EDT and CBT might compare in other conditions or in terms of more specific outcomes. Further, the finding that EDT and CBT may have similar effects does not necessarily imply that the same processes are responsible for change. For example, some recent findings indicate that focusing on affect may have a different impact in EDT compared with CBT (Ulvenes et al., 2012). Clearly, further comparisons of EDT and CBT in specific disorders are warranted, and the impact of both common and specific treatment processes (as well as their interactions) should be examined further.

Looking more closely at some of the specific outcomes, EDT seems to have its largest effect on depressive symptoms. Again, it is notable that the overall pre–post effect on depression measures ($d = 1.33$) was very similar to the effect ($d = 1.34$) reported by Driessen et al. (2010) in a meta-analysis of 21 studies of STPP for depression (only two studies overlapping with this review). However, Driessen et al. found no indication of continued gains during follow-up, and they also reported small, but significant, between-groups effects, suggesting that STPP may be inferior to other psychotherapies at posttreatment ($d = -0.30$) and at 12-months follow-up ($d = -0.29$). In contrast, our results indicate that EDT is associated with continued improvement in depressive symptoms during follow-up (i.e., $d = 0.30$), and we found no differences between EDT and other active treatments at posttreatment. At follow-up, EDT actually outperformed other active treatments on depression measures (between-groups $d = 0.64$), but we were not able to perform separate comparisons with particular treatments (e.g., CBT, supportive therapy, medication) because of the small number of studies available. In any case, our results may indicate that an active focus on helping patients experience warded-off affects, characteristic of the EDT technique, may have particular benefits in terms of reducing depressive symptoms. In line with this interpretation, Driessen et al. also reported a numerical difference in pre–post effect for depression favoring STPPs that were categorized as emotion focused in their review, but the difference was not statistically significant ($d = 1.71$ vs. $d = 1.26$, $p = .17$). Hence, further studies of the effect of EDT on depression may be particularly warranted. Such studies should also investigate the specific mechanisms of change for depressive symptoms suggested by EDT theory.

Turning to anxiety symptoms, our results may be compared with those of a recent meta-analysis of 14 studies of psychodynamic psychotherapy (four studies overlapping with this review) in anxiety disorders (Keefe et al., 2014). The authors reported a medium-size between-groups effect (Hedge's $g = 0.64$) in comparison with inactive controls and a large pre–post effect ($g = 1.06$) on anxiety measures—again, similar to our findings for EDT (i.e., $d = 0.39$ and $d = 1.09$, respectively). Thus, EDT appears to be as effective as other psychodynamic treatments in reducing anxiety. However, it should be kept in mind that only seven studies in this review targeted specific anxiety disorders. Of these, three concerned social anxiety in its generalized form. Another three studies combined EDT with medication, two in the treatment of panic disorder and one in obsessive–compulsive disorder with comorbid major depression. Consequently, more studies are needed to evaluate EDT as a stand-alone treatment in specific anxiety disorders.

Heterogeneity was moderate in terms of pre–post effects, suggesting that the impact of EDT may be moderated by between-studies differences in terms of treatment delivery, patient characteristics, and study-design features. Our exploratory subgroup analyses yielded few significant results.

Perhaps this is because of significant heterogeneity within subgroups and low power in some of the comparisons. Still, a couple of indications emerged that may be relevant for clinical practice and future research. First, EDT had significant effect in studies of depressive disorders. This is in line with the results for EDT on depression measures discussed earlier, and it suggests that the current evidence base for EDT is strongest in this area. Further, individual EDT was more effective than group treatment, mirroring results of other reviews of STPP (e.g., Driessen et al., 2010). This indication may be directly relevant for clinical practice in situations in which individual therapy is not an option. One possible reason for lower effects of group therapy is that it may be more difficult for a therapist to formulate and adhere to an individual patient focus based on the two triangles in that setting. Using a couple of individual pretherapy sessions to collaboratively formulate a specific treatment focus for each patient may be one way to enhance STPP-based group therapy (Sandahl & Lindgren, 2006). Specific adaptations of EDT principles to a group therapy setting have also been suggested in the literature (e.g., Landra, 2012) and need to be evaluated in further research.

The mean quality score of the included studies was just above the suggested cutoff for adequate study quality. This is similar to the average qualities found in a recent review of 94 psychodynamic treatment studies (Gerber et al., 2011) and one of 120 studies of CBT for depression (Thoma et al., 2012). One encouraging finding in the present review was that higher quality studies reported significantly larger pre–post effects of EDT, indicating that some of the heterogeneity found may be explained by variance in study quality. Further, there was no difference between high-quality and low-quality studies in terms of the advantage of EDT over inactive controls, but higher quality studies reported better relative effects of EDT in comparison with other active treatments. Thus, our results suggest that EDT performs better when implemented in the context of methodologically sound trials. This contrasts with recent reviews of other forms of psychotherapy, for which the effects tend to diminish when method-

ological quality is taken into account (Cuijpers, van Straten, Bohlmeijer, Hollon, & Andersson, 2010; Thoma et al., 2012; Öst, 2014).

However, and perhaps somewhat surprisingly considering the impact of study quality, there was no indication that the use of a specific manual or adherence monitoring moderated the effects of EDT. Town et al. (2012) reported a similar finding regarding psychodynamic treatments in general, although an effect of manualization and adherence monitoring was found for outcome at follow-up (which we did not investigate here). Importantly, however, the lack of a manual or adherence monitoring does not necessarily imply that the treatments were less stringently implemented. Still, future studies should adhere to established standards regarding treatment delivery, including adherence and competence ratings, to evaluate the impact of specific EDT techniques.

Lastly, one interesting area for further research is the application of affect-focused psychodynamic principles and techniques without face-to-face contact with a therapist. The efficacy of Internet-delivered CBT (ICBT) has been established in a number of trials targeting various psychiatric conditions (Hedman, Ljótsson, & Lindefors, 2012), and the effects of ICBT seem to be largely equivalent to those of face-to-face treatments (Andersson, Cuijpers, Carlbring, Riper, & Hedman, 2014). The study by Johansson et al. (2013) suggests that Internet-delivered guided self-help based on EDT principles may also be efficacious for treating depression and anxiety, and the pre–post effect sizes were well in line with those for face-to-face EDT. Such programs should be further evaluated for patients with specific psychiatric disorders, including examination of treatment moderators (such as different patient characteristics) and potential mechanisms of change.

## Strengths and Limitations

Our combined search strategy yielded a total of 39 studies of EDT, of which 28 met all inclusion criteria. Although there is always the possibility that some unpublished trial remained undetected, we feel quite confident that this is very close to the total population of RCTs conducted in this area so far. Further, because we found very little indication of publication bias, the estimates are not likely to change dramatically given the existence of a few undetected studies. To evaluate EDT broadly, we examined between-groups and within-group effects as well as possible moderators and dropout rates. All estimations were based on the random-effects model, which yields more conservative and generalizable results. Heterogeneity was explored with sensitivity analyses and post hoc comparisons when indicated. Further, the examination of study quality and its impact on the effect estimates may be considered a particular strength of this review. We used an established instrument for the assessment of study quality that was particularly designed for psychotherapy studies, and the reliability and calibration of our raters were excellent.

There are also several limitations that warrant mentioning. First, the body of research evaluating EDT is incomplete in a number of ways. For example, there were not enough studies to conduct comparisons within specific diagnostic disorders, and we were only able to conduct subgroup analyses using the within-group effects for general psychiatric symptoms. In particular, our estimates of effects at follow-up and in the subgroup analyses should be interpreted with caution considering the low number of studies in several of the contrasts.

Because none of the primary studies reported correlations among pre-, post- and follow-up assessments, we calculated the within-group effects using the same formula as for independent groups. Although this is a common procedure in meta-analyses (e.g., Abbass et al., 2012; de Maat et al., 2009; Driessen et al., 2010; Keefe et al., 2014; Leichsenring & Rabung, 2008; Town et al., 2012), it should also be noted that treating assessment points as independent may overestimate effects somewhat (and underestimate their variance), particularly for studies with small sample sizes (Dunlap et al., 1996). Thus, the exact estimates and precision of our within-group effect sizes should be interpreted cautiously.

We did not evaluate the reliability of our two study coders; rather, they collaboratively assessed study inclusion criteria, effect sizes, and moderator variables, which may not be optimal in terms of reducing possible risk of bias. Also, there were a number of possible outcomes and moderators we did not consider for this review. For example, we did not include measures of personality, employment rate, or medication use. Nor did we code or analyze the primary studies in terms of allegiance effects, a well-known influence in psychotherapy research (Munder, Brütsch, Leonhart, Gerger, & Barth, 2013). Future reviews of EDT should expand on these areas and consider cost-effectiveness data (Abbass, 2003).

One additional limitation of the current review is that, although all included studies explicitly referenced the work of Malan and/or Davanloo, we do not know how experiential or affect focused the treatments actually were in practice. This may be a particular problem in the studies that mentioned other STPP models in their treatment description; however, these studies did not differ from studies with a clear treatment description or specific manual in our subgroup analysis. This issue could also be more problematic in older studies that were conducted before EDT emerged as a distinct subgroup of STPPs. In this regard, we find it interesting that the effects of EDT tended to increase with year of publication; perhaps this suggests that the models have become more powerful with recent theoretical and technical developments in this area. In line with this interpretation, Abbass et al. (2012) found that the current version of ISTDP was more effective than older (i.e., pre-1990) versions. This further underscores the need for more research on contemporary EDT models, including investigations of the treatment principles and presumed change mechanisms that underlie the models.

## Conclusion

In summary, the available research suggests that EDT outperforms inactive controls and is associated with robust treatment gains across symptom domains. These gains appear to be generally maintained or to increase toward follow-up. We found no evidence of any differences from other evidence-based treatments at post-treatment, but EDT was more efficacious than supportive therapy in the long run. The evidence for EDT is strongest when it comes to treating depressive symptoms and disorders. More studies evaluating contemporary versions EDT in specific psychiatric diagnoses are warranted, including examination of the mechanisms of change proposed by EDT theory. The finding that EDT performed better in higher quality studies strengthens these overall conclusions.

# References

References marked with an asterisk indicate studies included in the meta-analysis.

Abbass, A. A. (2003). The cost-effectiveness of short-term dynamic psychotherapy. *Expert Review of Pharmacoeconomics & Outcomes Research, 3,* 535–539. http://dx.doi.org/10.1586/14737167.3.5.535

Abbass, A. (2015). *Reaching through resistance: Advanced psychotherapy techniques.* Kansas City, MO: Seven Leaves Press.

Abbass, A. A., Hancock, J. T., Henderson, J., & Kisely, S. (2006). Short-term psychodynamic psychotherapies for common mental disorders [Review]. *The Cochrane Library, 4,* 1–47, CD004687. http://dx.doi.org/10.1002/14651858.CD004687.pub3

Abbass, A., Kisely, S., & Kroenke, K. (2009). Short-term psychodynamic psychotherapy for somatic disorders. Systematic review and meta-analysis of clinical trials. *Psychotherapy and Psychosomatics, 78,* 265–274. http://dx.doi.org/10.1159/000228247

Abbass, A. A., Kisely, S. R., Town, J. M., Leichsenring, F., Driessen, E., De Maat, S., . . . Crowe, E. (2014). Short-term psychodynamic psychotherapies for common mental disorders [Review]. *The Cochrane Library, 7,* 1–75, CD004687. http://dx.doi.org/10.1002/14651858.CD004687.pub4

*Abbass, A., Sheldon, A., Gyra, J., & Kalpin, A. (2008). Intensive short-term dynamic psychotherapy for DSM-IV personality disorders: A randomized controlled trial. *The Journal of Nervous and Mental Disease, 196,* 211–216. http://dx.doi.org/10.1097/NMD.0b013e3181662ff0

Abbass, A., Town, J., & Driessen, E. (2012). Intensive short-term dynamic psychotherapy: A systematic review and meta-analysis of outcome research. *Harvard Review of Psychiatry, 20,* 97–108. http://dx.doi.org/10.3109/10673229.2012.677347

*Ajilchi, B., Ahadi, H., Najati, V., & Delavar, A. (2013). The effectiveness of intensive short term dynamic psychotherapy in decrease of depression level. *European Journal of Experimental Biology, 3,* 342–346.

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., . . . Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience, 256,* 174–186. http://dx.doi.org/10.1007/s00406-005-0624-4

Anderson, E., & Lambert, M. J. (1995). Short-term dynamically oriented psychotherapy: A review and meta-analysis. *Clinical Psychology Review, 15,* 503–514. http://dx.doi.org/10.1016/0272-7358(95)00027-M

Andersson, G., Cuijpers, P., Carlbring, P., Riper, H., & Hedman, E. (2014). Guided Internet-based vs. face-to-face cognitive behavior therapy for psychiatric and somatic disorders: A systematic review and meta-analysis. *World Psychiatry, 13,* 288–295. http://dx.doi.org/10.1002/wps.20151

Barber, J. P., Muran, C. J., McCarthy, K. S., & Keefe, J. R. (2013). Research on dynamic therapies. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 443–494). Hoboken, NJ: Wiley.

Becker, B. J. (1988). Synthesizing standardized mean-change measures. *British Journal of Mathematical and Statistical Psychology, 41,* 257–278. http://dx.doi.org/10.1111/j.2044-8317.1988.tb00901.x

*Ben-Itzhak, S., Bluvstein, I., Schreiber, S., Aharonov-Zaig, I., Maor, M., Lipnik, R., & Bloch, M. (2012). The effectiveness of brief versus intermediate duration psychodynamic psychotherapy in the treatment of adjustment disorder. *Journal of Contemporary Psychotherapy, 42,* 249–256. http://dx.doi.org/10.1007/s10879-012-9208-6

*Bloch, M., Meiboom, H., Lorberblatt, M., Bluvstein, I., Aharonov, I., & Schreiber, S. (2012). The effect of sertraline add-on to brief dynamic psychotherapy for the treatment of postpartum depression: a randomized, double-blind, placebo-controlled study. *The Journal of Clinical Psychiatry, 73*(2), 235–241. http://dx.doi.org/10.4088/JCP.11m07117

Borenstein, M., Hedges, L. V., Higgins, J. P. T., & Rothstein, H. R. (2009). *Introduction to meta-analysis.* Chichester, England: Wiley. http://dx.doi.org/10.1002/9780470743386

*Bögels, S., Wijts, P., Oort, F., & Sallaerts, S. J. (2014). Psychodynamic psychotherapy versus cognitive behaviour therapy for social anxiety disorder: An efficacy and partial effectiveness trial. *Depression and Anxiety, 11,* 1–11. http://dx.doi.org/10.1002/da.22246

*Bressi, C., Porcellana, M., Marinaccio, P. M., Nocito, E. P., & Magri, L. (2010). Short-term psychodynamic psychotherapy versus treatment as usual for depressive and anxiety disorders: a randomized clinical trial of efficacy. *The Journal of Nervous and Mental Disease, 198*(9), 647–652. http://dx.doi.org/10.1097/NMD.0b013e3181ef3ebb

*Brodaty, H., & Andrews, G. (1983). Brief psychotherapy in family practice: A controlled prospective intervention trial. *British Journal of Psychiatry, 143,* 11–19. http://dx.doi.org/10.1192/bjp.143.1.11

Cicchetti, D. V. (1994). Guidelines, criteria, and rules of thumb for evaluating normed and standardized assessment instruments in psychology. *Psychological Assessment, 6,* 284–290. http://dx.doi.org/10.1037/1040-3590.6.4.284

Cohen, J. (1992). A power primer. *Psychological Bulletin, 112,* 155–159. http://dx.doi.org/10.1037/0033-2909.112.1.155

Cuijpers, P., Sijbrandij, M., Koole, S. L., Andersson, G., Beekman, A. T., & Reynolds, C. F., III. (2014). Adding psychotherapy to antidepressant medication in depression and anxiety disorders: A meta-analysis. *World Psychiatry, 13,* 56–67. http://dx.doi.org/10.1002/wps.20089

Cuijpers, P., van Straten, A., Bohlmeijer, E., Hollon, S. D., & Andersson, G. (2010). The effects of psychotherapy for adult depression are overestimated: A meta-analysis of study quality and effect size. *Psychological Medicine, 40,* 211–223. http://dx.doi.org/10.1017/S0033291709006114

Davanloo, H. (1990). *Unlocking the unconscious.* Chichester, England: Wiley.

Davanloo, H. (2000). *Intensive short-term dynamic psychotherapy: Selected papers of Habib Davanloo.* Chichester, England: Wiley.

Davanloo, H. (2005). Intensive short-term dynamic psychotherapy. In B. J. Sadock, V. A. Sadock, & H. I. Kaplan (Eds.), *Kaplan and Sadock's comprehensive textbook of psychiatry* (pp. 2628–2652). Philadelphia: Lippincott Williams & Wilkins.

de Maat, S., de Jonghe, F., Schoevers, R., & Dekker, J. (2009). The effectiveness of long-term psychoanalytic therapy: A systematic review of empirical studies. *Harvard Review of Psychiatry, 17,* 1–23. http://dx.doi.org/10.1080/10673220902742476

Despland, J. N., de Roten, Y., Despars, J., Stigler, M., & Perry, J. C. (2001). Contribution of patient defense mechanisms and therapist interventions to the development of early therapeutic alliance in a brief psychodynamic investigation. *Journal of Psychotherapy Practice & Research, 10,* 155–164.

Diener, M. J., & Hilsenroth, M. J. (2009). Affect-focused techniques in psychodynamic psychotherapy. In R. A. Levy & S. A. Ablon (Eds.), *Handbook of evidence-based psychodynamic psychotherapy* (pp. 227–247). New York: Humana Press. http://dx.doi.org/10.1007/978-1-59745-444-5_10

Diener, M. J., Hilsenroth, M. J., & Weinberger, J. (2007). Therapist affect focus and patient outcomes in psychodynamic psychotherapy: A meta-analysis. *American Journal of Psychiatry, 164,* 936–941. http://dx.doi.org/10.1176/ajp.2007.164.6.936

Driessen, E., Cuijpers, P., de Maat, S. C. M., Abbass, A. A., de Jonghe, F., & Dekker, J. J. M. (2010). The efficacy of short-term psychodynamic psychotherapy for depression: A meta-analysis. *Clinical Psychology Review, 30,* 25–36. http://dx.doi.org/10.1016/j.cpr.2009.08.010

Dunlap, W. P., Cortina, J. M., Vaslow, J. B., & Burke, M. J. (1996). Meta-analysis of experiments with matched groups or repeated measures designs. *Psychological Methods, 1,* 170–177. http://dx.doi.org/10.1037/1082-989X.1.2.170

Duval, S. J., & Tweedie, R. L. (2000). A nonparametric "trim and fill" method of accounting for publication bias in meta-analysis. *Journal of the American Statistical Association, 95,* 89–98.

Edwards, D. W., Yarvis, R. M., Mueller, D. P., Zingale, H. C., & Wagman, W. J. (1978). Test-taking and the ability of adjustment scales: Can we assess patient deterioration? *Evaluation Quarterly, 2,* 275–291. http://dx.doi.org/10.1177/0193841X7800200206

*Emmelkamp, P. M. G., Benner, A., Kuipers, A., Feiertag, G. A., Koster, H. C., & van Apeldoorn, F. J. (2006). Comparison of brief dynamic and cognitive-behavioural therapies in avoidant personality disorder. *The British Journal of Psychiatry: The Journal of Mental Science, 189,* 60–64. http://dx.doi.org/10.1192/bjp.bp.105.012153

Fosha, D. (2000). *The transforming power of affect: A model for accelerated change*. New York: Basic Books.

Fosha, D., Siegel, D. J., & Solomon, M. F. (Eds.). (2009). *The healing power of emotion: Affective neuroscience, development and clinical practice*. New York: Norton.

Gerber, A. J., Kocsis, J. H., Milrod, B. L., Roose, S. P., Barber, J. P., Thase, M. E., . . . Leon, A. C. (2011). A quality-based review of randomized controlled trials of psychodynamic psychotherapy. *American Journal of Psychiatry, 168,* 19–28. http://dx.doi.org/10.1176/appi.ajp.2010.08060843

Gerostathos, A., de Roten, Y., Berney, S., Despland, J.-N., & Ambresin, G. (2014). How does addressing patient's defenses help to repair alliance ruptures in psychodynamic psychotherapy? An exploratory study. *Journal of Nervous and Mental Disease, 202,* 419–424. http://dx.doi.org/10.1097/NMD.0000000000000112

Grande, T., Dilg, R., Jakobsen, T., Keller, W., Krawietz, B., Langer, M., . . . Rudolf, G. (2009). Structural change as a predictor of long-term follow-up outcome. *Psychotherapy Research, 19,* 344–357. http://dx.doi.org/10.1080/10503300902914147

Hedman, E., Ljótsson, B., & Lindefors, N. (2012). Cognitive behavior therapy via the Internet: A systematic review of applications, clinical efficacy and cost-effectiveness. *Expert Review of Pharmacoeconomics & Outcomes Research 2012, 12,* 745–764. http://dx.doi.org/10.1586/erp.12.67

*Hellerstein, D. J., Rosenthal, R. N., Pinsker, H., Samstag, L. W., Muran, J. C., & Winston, A. (1998). A randomized prospective study comparing supportive and dynamic therapies. Outcome and alliance. *Journal of Psychotherapy Practice & Research, 7,* 261–271.

Higgins, J. P., Thompson, S. G., Deeks, J. J., & Altman, D. G. (2003). Measuring inconsistency in meta-analyses. *BMJ: British Medical Journal, 327,* 557–560. http://dx.doi.org/10.1136/bmj.327.7414.557

Hilsenroth, M. J., Ackerman, S. J., Blagys, M. D., Baity, M. R., & Mooney, M. A. (2003). Short-term psychodynamic psychotherapy for depression: An examination of statistical, clinically significant, and technique-specific change. *Journal of Nervous and Mental Disease, 191,* 349–357. http://dx.doi.org/10.1097/01.NMD.0000071582.11781.67

Hobson, R. F. (1985). *Forms of feeling: The heart of psychotherapy*. London: Tavistock.

*Johansson, R., Björklund, M., Hornborg, C., Karlsson, S., Hesser, H., Ljótsson, B., . . . Andersson, G. (2013). Affect-focused psychodynamic psychotherapy for depression and anxiety through the Internet: A randomized controlled trial. *PeerJ, 1,* e102. http://dx.doi.org/10.7717/peerj.102

Johansson, R., Frederick, R. J., & Andersson, G. (2013). Using the Internet to provide psychodynamic psychotherapy. *Psychodynamic Psychiatry, 41,* 513–540. http://dx.doi.org/10.1521/pdps.2013.41.4.513

Johansson, R., Town, J. M., & Abbass, A. (2014). Davanloo's intensive short-term dynamic psychotherapy in a tertiary psychotherapy service: Overall effectiveness and association between unlocking the unconscious and outcome. *PeerJ, 2,* e548. http://dx.doi.org/10.7717/peerj.548

Keefe, J. R., McCarthy, K. S., Dinger, U., Zilcha-Mano, S., & Barber, J. P. (2014). A meta-analytic review of psychodynamic therapies for anxiety disorders. *Clinical Psychology Review, 34,* 309–323. http://dx.doi.org/10.1016/j.cpr.2014.03.004

Kiesler, D. J. (1988). *Therapeutic metacommunication: Therapist impact disclosure as feedback in psychotherapy*. Palo Alto, CA: Consulting Psychologist Press.

*Knekt, P., & Lindfors, O. (Eds.) (2004). *A randomized trial of the effect of four forms of psychotherapy on depressive and anxiety disorders. Design, methods, and results on the effectiveness of short-term psychodynamic psychotherapy and solution-focused therapy during a one-year follow-up* [Sataunnaistettu kiininen koe neljan psykoterapiamuodon vaikuttavuudesta masennustiloihin ja ahdistuneisuushairioihin]. Helsinki: Studies in Social Security and Health, iHelsinki, Finland: Edita Prima Ltd.

*Knijnik, D. Z., Blanco, C., Salum, G. A., Moraes, C. U., Mombach, C., Almeida, E., . . . Eizirik, C. L. (2008). A pilot study of clonazepam versus psychodynamic group therapy plus clonazepam in the treatment of generalized social anxiety disorder. *European Psychiatry: The Journal of the Association of European Psychiatrists, 23,* 567–574. http://dx.doi.org/10.1016/j.eurpsy.2008.05.004

*Knijnik, D. Z., Kapczinski, F., Chachamovich, E., Margis, R., & Eizirik, C. L. (2004). Psychodynamic group treatment for generalized social phobia. *Revista Brasileira de Psiquiatria, 26,* 77–81. http://dx.doi.org/10.1590/S1516-44462004000200003

Kocsis, J. H., Gerber, A. J., Milrod, B., Roose, S. P., Barber, J., Thase, M. E., . . . Leon, A. C. (2010). A new scale for assessing the quality of randomized clinical trials of psychotherapy. *Comprehensive Psychiatry, 51,* 319–324. http://dx.doi.org/10.1016/j.comppsych.2009.07.001

Kramer, U., Pascual-Leone, A., Despland, J., & de Roten, Y. (2015). One minute of grief: Emotional processing in short-term dynamic psychotherapy for adjustment disorder. *Journal of Consulting and Clinical Psychology, 83,* 187–198.

Landra, S. (2012). Group intensive experiential–dynamic psychotherapy in a public mental health service. In F. Osimo & M. J. Stein (Eds.), *Theory and practice of experiential dynamic psychotherapy* (pp. 331–372). London: Karnac Books.

Leichsenring, F., & Rabung, S. (2008). Effectiveness of long-term psychodynamic psychotherapy: A meta-analysis. *JAMA: Journal of the American Medical Association, 300,* 1551–1565. http://dx.doi.org/10.1001/jama.300.13.1551

Leichsenring, F., & Salzer, S. (2014). A unified protocol for the transdiagnostic psychodynamic treatment of anxiety disorders: An evidence-based approach. *Psychotherapy, 51,* 224–245. http://dx.doi.org/10.1037/a0033815

Leichsenring, F., & Schauenburg, H. (2014). Empirically supported methods of short-term psychodynamic therapy in depression—Towards an evidence-based unified protocol. *Journal of Affective Disorders, 169,* 128–143. http://dx.doi.org/10.1016/j.jad.2014.08.007

Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: A manual for supportive–expressive treatment*. New York: Basic Books.

Luborsky, L., & Crits-Christoph, P. (1998). *Understanding transference: The core conflictual relationship theme method* (2nd ed.). Washington, DC: American Psychological Association. http://dx.doi.org/10.1037/10250-000

Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapy: Is it true that "everyone has won and all must have prizes"? *Archives of General Psychiatry, 32,* 995–1008. http://dx.doi.org/10.1001/archpsyc.1975.01760260059004

*Maina, G., Forner, F., & Bogetto, F. (2005). Randomized controlled trial comparing brief dynamic and supportive therapy with waiting list condition in minor depressive disorders. *Psychotherapy and Psychosomatics, 74,* 43–50. http://dx.doi.org/10.1159/000082026

*Maina, G., Rosso, G., Crespi, C., & Bogetto, F. (2007). Combined brief dynamic therapy and pharmacotherapy in the treatment of major depres-

sive disorder: A pilot study. *Psychotherapy and Psychosomatics, 76,* 298–305. http://dx.doi.org/10.1159/000104706

*Maina, G., Rosso, G., & Bogetto, F. (2009). Brief dynamic therapy combined with pharmacotherapy in the treatment of major depressive disorder: Long-term results. *Journal of Affective Disorders, 114,* 200–207. http://dx.doi.org/10.1016/j.jad.2008.07.010

*Maina, G., Rosso, G., Rigardetto, S., Chiadò Piat, S., & Bogetto, F. (2010). No effect of adding brief dynamic therapy to pharmacotherapy in the treatment of obsessive-compulsive disorder with concurrent major depression. *Psychotherapy and Psychosomatics, 79,* 295–302. http://dx.doi.org/10.1159/000318296

Malan, D. H. (1963). *A study of brief psychotherapy.* London: Tavistock.

Malan, D. H. (1976). *The frontier of brief psychotherapy.* New York: Plenum Press. http://dx.doi.org/10.1007/978-1-4684-2220-7

Malan, D. H. (1979). *Individual psychotherapy and the science of psychodynamics.* London: Butterworth.

Malan, D. (1986a). Beyond interpretation: Initial evaluation and technique in short-term dynamic psychotherapy. Part I. *International Journal of Intensive Short-Term Dynamic Psychotherapy, 1,* 59–82.

Malan, D. (1986b). Beyond interpretation: Initial evaluation and technique in short-term dynamic psychotherapy. Part II. *International Journal of Intensive Short-Term Dynamic Psychotherapy, 1,* 83–106.

*Marmar, C. R., Horowitz, M. J., Weiss, D. S., Wilner, N. R., & Kaltreider, N. B. (1988). A controlled trial of brief psychotherapy and mutual-help group treatment of conjugal bereavement. *American Journal of Psychiatry, 145,* 203–209.

*Martini, B., Rosso, G., Chiodelli, D. F., De Cori, D., & Maina, G. (2011). Brief dynamic therapy combined with pharmacotherapy in the treatment of panic disorder with concurrent depressive symptoms. *Clinical Neuropsychiatry, 8,* 204–211.

McCullough, L. (1999). Short-term psychodynamic therapy as a form of desensitization: Treating affect phobias. *In Session: Psychotherapy in Practice, 4,* 35–53. http://dx.doi.org/10.1002/(SICI)1520-6572(199924)4:4<35::AID-SESS4>3.0.CO;2-G

McCullough, L., Kuhn, N., Andrews, S., Kaplan, A., Wolf, J., & Hurley, C. L. (2003). *Treating affect phobia: A manual for short-term dynamic psychotherapy.* New York: Guilford Press.

McCullough, L., & Magill, M. (2009). Affect-focused short-term dynamic therapy: Empirically supported strategies for resolving affect phobias. In R. A. Levy & J. S. Aboln (Eds.), *Handbook of evidence-based psychodynamic psychotherapy* (pp. 249–277). New York, NY: Humana Press.

Munder, T., Brütsch, O., Leonhart, R., Gerger, H., & Barth, J. (2013). Researcher allegiance in psychotherapy outcome research: An overview of reviews. *Clinical Psychology Review, 33,* 501–511. http://dx.doi.org/10.1016/j.cpr.2013.02.002

Osimo, F. (2003). *Experiential short-term dynamic psychotherapy: A manual.* Bloomingdale, IN: First Books.

Osimo, F., & Stein, M. J. (Eds.). (2012). *Theory and practice of experiential dynamic psychotherapy.* London: Karnac Books.

Öst, L.-G. (2014). The efficacy of acceptance and commitment therapy: An updated systematic review and meta-analysis. *Behaviour Research and Therapy, 61,* 105–121. http://dx.doi.org/10.1016/j.brat.2014.07.018

Perry, J. C., & Bond, M. (2012). Change in defense mechanisms during long-term dynamic psychotherapy and five-year outcome. *American Journal of Psychiatry, 169,* 916–925. http://dx.doi.org/10.1176/appi.ajp.2012.11091403

*Pierloot, R., & Vinck, J. (1978). Differential outcome of short-term dynamic psychotherapy and systematic desensitization in the treatment of anxious out-patients: A preliminary report. *Psychologica Belgica, 18,* 87–98.

*Piper, W. E., Azim, H. F., McCallum, M., & Joyce, A. S. (1990). Patient suitability and outcome in short-term individual psychotherapy. *Journal of Consulting and Clinical Psychology, 58,* 475–481. http://dx.doi.org/10.1037/0022-006X.58.4.475

*Reneses, B., Galián, M., Serrano, R., Figuera, D., Fernandez Del Moral, A., López-Ibor, J. J., . . . Trujillo, M. (2013). A new time limited psychotherapy for BPD: Preliminary results of a randomized and controlled trial. *Actas Españolas de Psiquiatría, 41,* 139–148.

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry, 6,* 412–415. http://dx.doi.org/10.1111/j.1939-0025.1936.tb05248.x

*Rosso, G., Martini, B., & Maina, G. (2012). Brief dynamic therapy and depression severity: A single-blind, randomized study. *Journal of Affective Disorders, 147,* 101–106. http://dx.doi.org/10.1016/j.jad.2012.10.017

Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide.* New York: Guilford Press.

*Salminen, J. K., Karlsson, H., Hietala, J., Kajander, J., Aalto, S., Markkula, J., . . . Toikka, T. (2008). Short-term psychodynamic psychotherapy and fluoxetine in major depressive disorder: A randomized comparative study. *Psychotherapy and Psychosomatics, 77,* 351–357. http://dx.doi.org/10.1159/000151388

Salvadori, A. (2010). *Is the experiencing of affect therapeutic? An investigation into the relationship between affect experiencing, degree of inhibition and distress in intensive short-term dynamic psychotherapy* (Unpublished doctoral dissertation). University of Sheffield, Sheffield, England.

Sandahl, C., & Lindgren, A. (2006). Focused group therapy: An integrative approach. *Journal of Contemporary Psychotherapy, 36,* 113–119. http://dx.doi.org/10.1007/BF02729054

Schore, A. N. (2001). The effects of early relational trauma on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal, 22,* 201–269. http://dx.doi.org/10.1002/1097-0355(200101/04)22:1<201::AID-IMHJ8>3.0.CO;2-9

Schore, A. N. (2002). Dysregulation of the right brain: A fundamental mechanism of traumatic attachment and the psychopathogenesis of posttraumatic stress disorder. *Australian and New Zealand Journal of Psychiatry, 36,* 9–30. http://dx.doi.org/10.1046/j.1440-1614.2002.00996.x

Shrout, P. E., & Fleiss, J. L. (1979). Intraclass correlations: Uses in assessing rater reliability. *Psychological Bulletin, 86,* 420–428. http://dx.doi.org/10.1037/0033-2909.86.2.420

Slavin-Mulford, J., & Hilsenroth, M. J. (2012). Evidence-based psychodynamic treatments for anxiety disorders; a review. In R. A. Levy, J. S. Ablon, & H. Kaechele (Eds.), *Psychodynamic psychotherapy research: Evidence-based practice and practice-based evidence* (pp. 117–137). New York: Springer. http://dx.doi.org/10.1007/978-1-60761-792-1_7

Strupp, H., & Binder, J. (1984). *Psychotherapy in a new key: A guide to time-limited dynamic psychotherapy.* New York: Basic Books.

Svartberg, M., & Stiles, T. C. (1991). Comparative effects of short-term psychodynamic psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology, 59,* 704–714. http://dx.doi.org/10.1037/0022-006X.59.5.704

*Svartberg, M., Stiles, T. C., & Seltzer, M. H. (2004). Randomized, controlled trial of the effectiveness of short-term dynamic psychotherapy and cognitive therapy for cluster C personality disorders. *American Journal of Psychiatry, 161,* 810–817. http://dx.doi.org/10.1176/appi.ajp.161.5.810

Swift, J. K., & Greenberg, R. P. (2012). Premature discontinuation in adult psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology, 80,* 547–559. http://dx.doi.org/10.1037/a0028226

*Tasca, G., Ritchie, K., Conrad, G., Balfour, L., Gayton, J., Lybanon, V., & Bissada, H. (2006). Attachment scales predict outcome in a randomized controlled trial of two group therapies for binge eating disorder: An aptitude by treatment interaction. *Psychotherapy Research, 16,* 106–121. http://dx.doi.org/10.1080/10503300500090928

Thoma, N. C., McKay, D., Gerber, A. J., Milrod, B. L., Edwards, A. R., & Kocsis, J. H. (2012). A quality-based review of randomized controlled

trials of cognitive–behavioral therapy for depression: An assessment and metaregression. *American Journal of Psychiatry, 169,* 22–30. http://dx .doi.org/10.1176/appi.ajp.2011.11030433

Tingey, R., Lambert, M., Burlingame, G., & Hansen, N. (1996). Assessing clinical significance: Proposed extensions to method. *Psychotherapy Research, 6,* 109–123. http://dx.doi.org/10.1080/10503309612331331638

Town, J. M., Abbass, A., & Bernier, D. (2013). Effectiveness and cost effectiveness of Davanloo's intensive short-term dynamic psychotherapy: Does unlocking the unconscious make a difference? *American Journal of Psychotherapy, 67,* 89–108.

Town, J. M., Abbass, A., & Hardy, G. (2011). Short-term psychodynamic psychotherapy for personality disorders: A critical review of randomized controlled trials. *Journal of Personality Disorders, 25,* 723–740. http:// dx.doi.org/10.1521/pedi.2011.25.6.723

Town, J. M., Diener, M. J., Abbass, A., Leichsenring, F., Driessen, E., & Rabung, S. (2012). A meta-analysis of psychodynamic psychotherapy outcomes: Evaluating the effects of research-specific procedures. *Psychotherapy, 49,* 276–290. http://dx.doi.org/10.1037/a0029564

Town, J. M., Hardy, G. E., McCullough, L., & Stride, C. (2012). Patient affect experiencing following therapist interventions in short-term dynamic psychotherapy. *Psychotherapy Research, 22,* 208–219. http://dx .doi.org/10.1080/10503307.2011.637243

Ulvenes, P. G., Berggraf, L., Hoffart, A., Stiles, T. C., Svartberg, M., McCullough, L., & Wampold, B. E. (2012). Different processes for different therapies: Therapist actions, therapeutic bond, and outcome. *Psychotherapy, 49,* 291–302. http://dx.doi.org/10.1037/a0027895

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings.* Mahwah, NJ: Erlbaum.

Wampold, B. E., Minami, T., Baskin, T. W., & Callen Tierney, S. (2002). A meta-(re)analysis of the effects of cognitive therapy versus "other therapies" for depression. *Journal of Affective Disorders, 68,* 159–165. http://dx.doi.org/10.1016/S0165-0327(00)00287-1

Whelton, W. J. (2004). Emotional processes in psychotherapy: Evidence across therapeutic modalities. *Clinical Psychology & Psychotherapy, 11,* 58–71. http://dx.doi.org/10.1002/cpp.392

*Wiborg, I. M., & Dahl, A. A. (1996). Does brief dynamic psychotherapy reduce the relapse rate of panic disorder? *Archives of General Psychiatry, 53,* 689–694. http://dx.doi.org/10.1001/archpsyc.1996 .01830080041008

*Winston, A., Laikin, M., Pollack, J., Samstag, L. W., McCullough, L., & Muran, J. C. (1994). Short-term psychotherapy of personality disorders. *The American Journal of Psychiatry, 151,* 190–194.

Winston, A., Rosenthal, R. N., & Pinsker, H. (2004). *Introduction to supportive psychotherapy.* Washington, DC: American Psychiatric Publishing.