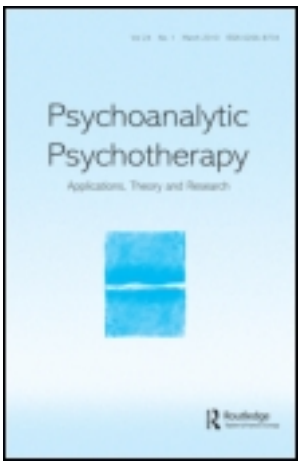

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Evidence for psychodynamic psychotherapy in specific mental disorders: a systematic review

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Evidence for psychodynamic psychotherapy in specific mental disorders: a systematic review

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This article reviews the empirical evidence for psychodynamic therapy for specific mental disorders in adults. According to the results presented here, there is evidence from randomized controlled trials (RCTs) that psychodynamic therapy is efficacious in common mental disorders, including depressive disorders, anxiety disorders, somatoform disorders, personality disorders, eating disorders, complicated grief, posttraumatic stress disorder (PTSD), and substance-related disorders. These results clearly contradict assertions repeatedly made by representatives of other psychotherapeutic approaches claiming that psychodynamic psychotherapy is not empirically supported. However, further research is required, both on outcome and processes of psychodynamic psychotherapy. There is a need, for example, for RCTs of psychodynamic psychotherapy of PTSD. Furthermore, research on long-term psychotherapy for specific mental disorders is required.

Keywords: psychodynamic psychotherapy; empirically supported treatments; psychotherapy outcome research; evidence-based medicine

In this article, the available evidence for psychodynamic psychotherapy (PDT) in adults is reviewed. The focus will be on randomized controlled trials (RCTs), which are regarded as the 'gold standard' for demonstrating treatment efficacy. Previous reviews have been undertaken, for example, by Fonagy, Roth, and Higgitt (2005), Leichsenring, Klein, and Salzer (in press), Shedler (2010), and Gerber et al. (2011). Shedler (2010) came to the conclusion that effect sizes of PDT are as large as those reported for other forms of psychotherapy that are regarded as 'empirically supported.' In addition, he found that effects of PDT were stable or tended to improve after the end of treatment. In a quality-based review of RCTs, Gerber et al. (2011) found PDT to be at least as efficacious as another active treatment in 34 of 39 studies (87%). In comparison with inactive conditions, PDT was superior in 18 of 24 adequate comparisons (75%).

In another quality-based review of RCTs, Thoma et al. (2012) examined the methodological quality of RCTs of cognitive-behavioral therapy (CBT) in

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depression. Contrary to their expectation, the authors found no significant differences in methodological quality between RCTs of CBT in depression and RCTs of PDT. Taking the frequently put forward criticism of the methodological quality of studies of PDT into account (e.g., Bhar & Beck, 2009), the result reported by Thoma et al. (2012) is of some importance. In another context, we showed that often double standards were applied when studies of PDT were criticized by representatives of other approaches (Leichsenring & Rabung, 2011).

Evidence-based medicine and empirically supported treatments

Several proposals have been made to grade the available evidence of both medical and psychotherapeutic treatments (Canadian Task Force on the Periodic Health Examination, 1979; Chambless & Hollon, 1998; Clarke & Oxman, 2003; Cook, Guyatt, Laupacis, Sacket, & Goldberg, 1995; Nathan & Gorman, 2002). Apart from other differences, all available proposals regard RCTs (efficacy studies) as the 'gold standard' for the demonstration that a treatment is effective. According to this view, only RCTs can provide level I evidence, which is the highest level of evidence. RCTs are conducted under controlled experimental conditions, allowing one to control for variables systematically influencing the outcome apart from the treatment. The defining feature of an RCT is the random assignment of subjects to the different conditions of treatment (Shadish, Cook, & Campbell, 2002). Randomization is regarded as indispensable in order to ensure that a priori existing differences between subjects are equally distributed. The goal of randomization is to attribute the observed effects exclusively to the applied therapy. Thus, randomization is used to ensure the internal validity of a study (Shadish et al., 2002). Gabbard, Gunderson, and Fonagy (2002) discuss different types of RCTs that provide different levels of evidence. The most stringent test of efficacy is achieved by comparison with rival treatments, thus controlling for specific and unspecific therapeutic factors (Chambless & Hollon, 1998, p. 8). Furthermore, such comparisons provide explicit information regarding the relative benefits of competing treatments. Treatments that are found to be superior to rival treatments are more highly valued.

As RCTs are carried out under controlled experimental conditions, their internal validity is usually high. However, for this very reason, their external validity may be limited, in that their results may not be fully representative of clinical practice. In contrast to RCTs, naturalistic studies (observational or effectiveness studies) are conducted under the conditions of clinical practice. Thus, their results are usually more representative for clinical practice with regard to patients, therapists, and treatments (external validity). RCTs and observational studies address different questions of research, i.e., efficacy under controlled experimental conditions versus effectiveness under the conditions of clinical practice (Leichsenring, 2004). For this reason, RCTs are not 'bad' and observational studies are not 'good' or vice versa. Their relationship is complementary rather than one of rival (Leichsenring, 2004).

Methods

Definition of PDT

PDT operates on an interpretive-supportive continuum (Gunderson & Gabbard, 1999; Wallerstein, 1989). Interpretive interventions enhance the patient's insight about repetitive conflicts sustaining his or her problems (Gabbard, 2004; Luborsky, 1984). Supportive interventions aim to strengthen abilities ('ego-functions') that are temporarily not accessible to a patient due to acute stress (e.g., traumatic events) or that have not been sufficiently developed (e.g., impulse control in borderline personality disorder; BPD). Thus, supportive interventions maintain or build ego functions (Wallerstein, 1989). Supportive interventions include, for example, fostering a therapeutic alliance, setting goals, or strengthening ego functions such as reality testing or impulse control (Luborsky, 1984). The use of more supportive or more interpretive (insight-enhancing) interventions depends on the patient's needs. The more severely disturbed a patient is, or the more acute his or her problem is, the more supportive and less interpretive interventions are required and vice versa (Luborsky, 1984; Wallerstein, 1989). Borderline patients, as well as healthy subjects, in an acute crisis or after a traumatic event may need more supportive interventions (e.g., stabilization, providing a safe and supportive environment). Thus, a broad spectrum of psychiatric problems and disorders can be treated with PDT, ranging from milder adjustment disorders or stress reactions to severe personality disorders such as BPD or psychotic conditions.

Inclusion and exclusion criteria

The following inclusion and exclusion criteria were applied: (1) PDT according to the definition above was applied, (2) RCT, (3) reliable and valid measures for diagnosis and outcome, (4) use of treatment manuals, and (5) study of specific mental disorders. Studies examining the combination of psychodynamic therapy and medication were not included, however, concomitant medication in both treatment arms was allowed.

We collected studies of PDT that were published between 1970 and September 2013 by use of a computerized search of MEDLINE, PsycINFO, and Current Contents. The following search terms were used: (psychodynamic or dynamic or psychoanalytic*) and (therapy or psychotherapy or treatment) and (study or studies or trial*) and (outcome or result* or effect* or change*) and (psych* or mental*) and (RCT* or control* or compare*). Manual searches in articles and textbooks were performed. In addition, we communicated with authors and experts in the field.

Efficacy studies of PDT in specific mental disorders

A total of 47 RCTs providing evidence for the efficacy of PDT in specific mental disorders were identified and included in this review. These studies are presented in Table 1.

Table 1. Randomized controlled studies of psychodynamic psychotherapy in specific mental disorders.

Study	Disorder	*N* (PP)	Comparison group	Concept of PP	Treatment duration
Depressive disorders					
Barber et al. (2012)	Major depression	51	Pharmacotherapy: $N = 55$ Placebo: $N = 50$	Luborsky	20 sessions 16 weeks
Barkham et al. (1996)	Major depression	18	CBT: $N = 18$	Shapiro and Firth	8 versus 16 sessions
Driessen et al. (2013)	Major depression	177	CBT: $N = 164$	de Jonghe	16 sessions
Gallagher-Thompson and Steffen (1994)	Major, minor or intermittent depression	30	CBT: $N = 36$	Mann; Rose and DelMaestro	16–20 sessions
Johansson et al. (2012)	Major depression	46	Structured support: $N = 46$	Internet-guided self-help; Silverberg	10 weeks
Maina et al. (2005)	Dysthymic disorder	10	Supportive therapy: $N = 10$ Waiting list: $N = 10$	Malan	15–30 session $M = 19.6$
Salminen et al. (2008)	Major depression	26	Fluoxetine: $N = 25$	Mann; Malan	16 sessions
Shapiro et al. (1994)	Major depression	58	CBT: $N = 59$	Shapiro and Firth	8 versus 16 sessions
Thompson et al. (1987)	Major depression	24	BT: $N = 25$ CBT: $N = 27$ Waiting list: N = 19	Horowitz and Kaltreider	16–20 sessions
Anxiety disorders					
Bögels et al. (2003)	Social phobia	22	CBT: $N = 27$	Malan	36 sessions
Crits-Christoph et al. (2005)	Generalized anxiety disorder	15	Supportive therapy: $N = 16$	Luborsky; Crits-Christoph et al.	16 sessions

(*Continued*)

Table 1 – *continued*

Study	Disorder	*N* (PP)	Comparison group	Concept of PP	Treatment duration
Knijnik et al. (2004)	Social phobia	15	Credible placebo control group: $N = 15$	Knijnik et al.	12 sessions
Leichsenring et al. (2009)	Generalized anxiety disorder	28	CBT: $N = 29$	Luborsky; Crits-Christoph et al.	30 sessions
Leichsenring et al. (2013a)	Social phobia	207	Cognitive therapy: $N = 209$ Waiting list: $N = 79$	Luborsky; Leichsenring; Beutel; Leibing	30 sessions
Milrod et al. (2007)	Panic disorder	26	CBT (Applied relaxation), $N = 23$	Milrod et al.	24 sessions
Mixed samples of depressive and anxiety disorders					
Bressi et al. (2010)	Depressive and anxiety disorders	30	TAU: $N = 30$	Malan	40 sessions
Knekt et al. (2008b)	Depressive and anxiety disorders	128, 101	Solution-focused therapy: $N = 97$	Malan; Sifneos; Gabbard	1 year 235 sessions; 49.9 sessions; 29.9 sessions
PTSD					
Brom et al. (1989)	PTSD	29	Desensitization: $N = 31$ Hypnotherapy: $N = 29$	Horowitz	18.8 sessions
Somatoform disorders					
Creed et al. (2003)	Irritable bowel	59	Paroxetine: $N = 43$ TAU: $N = 86$	Hobson; Shapiro and Firth	8 sessions
Faramarzi et al. (2013)	Functional dyspepsia	24	Medical treatment: $N = 25$	Luborsky, Book	16 sessions
Guthrie et al. (1991)	Irritable bowel	50	Supportive listening: $N = 46$	Hobson; Shapiro and Firth	8 sessions

Hamilton et al. (2000)	Functional dyspepsia	37	Supportive therapy: $N = 36$	Shapiro and Firth	7 sessions
Monsen and Monsen (2000)	Somatoform Pain disorder	20	TAU/no therapy: $N = 20$	Monsen and Monsen	33 sessions
Sattel et al. (2012)	Multi-somatoform disorder	107	Enhanced medical care: $N = 104$	Hardy; Barkham et al.	12 sessions
Eating disorders					
Bachar et al. (1999)	Anorexia nervosa, Bulimia nervosa	17	Cognitive therapy: $N = 17$ Nutritional counseling: $N = 10$	Barth; Goodsitt; Geist	46 sessions
Dare et al. (2001)	Anorexia nervosa	21	Cognitive-analytic therapy (Ryle): $N = 22$ Family therapy: $N = 22$ Routine treatment: $N = 19$	Malan; Dare et al.	$M = 24.9$ sessions
Zipfel et al. (2013)	Anorexia nervosa	80	Enhanced CBT: $N = 80$ Optimized TAU: $N = 82$	Schauenburg et al.	LTPP: 39.9 sessions Enhanced CBT: 44.8 sessions Optimized TAU: 50.8 sessions
Fairburn et al. (1986)	Bulimia nervosa	11	CBT: $N = 11$	Rosen; Stunkard; Bruch	19 sessions
Garner et al. (1993)	Bulimia nervosa	25	CBT: $N = 25$	Luborsky	19 sessions
Gowers et al. (1994)	Anorexia nervosa	20	TAU: $N = 20$	Crisp	12 sessions
Tasca et al. (2006)	Binge eating disorder	48	Group CBT: $N = 47$ Waiting list: $N = 40$	Tasca et al.	16 sessions

(*Continued*)

Table 1 – *continued*

Study	Disorder	*N* (PP)	Comparison group	Concept of PP	Treatment duration
Substance related disorders					
Crits-Christoph et al. (1999, 2001)	Cocain dependence	124	CBT+ group DC: $N = 97$ Individual DC: $N = 92$ Individual DC + group DC: $N = 96$	Mark and Luborsky + group DC	Up to 36 individual and 24 group sessions; 4 months
Sandahl et al. (1998)	Alcohol dependence	25	CBT: $N = 24$	Foulkes	15 sessions ($M = 8.9$)
Woody et al. (1983, 1990)	Opiate dependence	31	DC: $N = 35$ CBT + DC: $N = 34$	Luborsky + DC	12 sessions
Woody et al. (1995)	Opiate dependence	57	DC: $N = 27$	Luborsky + DC	26 sessions
Borderline personality disorder					
Bateman and Fonagy (1999, 2001)	BPD	19	TAU: $N = 19$	Bateman and Fonagy	18 months
Bateman and Fonagy (2009)	BPD	71	Structured clinical management: $N = 63$	Bateman and Fonagy	18 months
Clarkin et al. (2007)	BPD	30	Dialectical behavioral therapy: $N = 30$; supportive therapy: $N = 30$	Kernberg; Clarkin et al.	12 months
Doering et al. (2010)	BPD	43	Treatment by experienced community therapists: $N = 29$	Clarkin et al.	Assessment after 1 year
Giesen-Bloo et al. (2006)	BPD	42	CBT: $N = 44$	Kernberg; Clarkin et al.	3 years with sessions twice a week
Gregory et al. (2008)	BPD	15	TAU: $N = 15$	Gregory and Remen	24.9 sessions

Munroe-Blum and Marziali (1995)	BPD	31	Interpersonal group therapy: $N = 25$	Kernberg	17 sessions
Cluster C personality disorders					
Muran et al. (2005)	Cluster C personality disorders	22	Brief relational therapy: $N = 33$ CBT: $N = 29$	Pollack et al.	30 sessions
Svartberg et al. (2004)	Cluster C personality disorders	25	CBT: $N = 25$	Malan; McCullough Vaillant	40 sessions
Avoidant personality disorder					
Emmelkamp et al. (2006)	Avoidant personality disorder	23	CBT: $N = 21$ Waiting list: $N = 18$	Malan; Luborsky; Luborsky and Mark; Pinsker et al.	20 sessions
Samples of mixed personality disorders					
Abbass et al. (2008)	Heterogeneous personality disorders	14	Minimal contact: $N = 14$	Davenloo	27.7 sessions (mean)
Hellerstein et al. (1998)	Primarily Cluster C personality disorders	25	Brief supportive psychotherapy: $N = 24$	Davenloo	40 sessions
Winston et al. (1994)	Heterogeneous personality disorders	25	Brief adaptive psychotherapy: $N = 30$ Waiting list: $N = 26$	Davenloo	40 weeks, $M = 40.3$ sessions

Note: CBT, cognitive-behavioral therapy; PP, psychodynamic psychotherapy; PTSD, posttraumatic stress disorder; BT, behavioral therapy; TAU, treatment as usual; DC, drug counseling; LTPP, long-term psychodynamic psychotherapy; BPD, borderline personality disorder.

Models of PDT

In the studies identified, different forms of PDT were applied (Table 1). The models developed by Luborsky (1984), Shapiro and Firth (1985), and Malan (1976) were used most frequently.

Evidence for the efficacy of PDT in specific mental disorders

The studies of PDT included in this review will be presented for different mental disorders. However, from a psychodynamic perspective, the results of a therapy for a specific psychiatric disorder (e.g., depression, agoraphobia) are influenced by the underlying psychodynamic features (e.g., conflicts, defenses, personality organization), which may vary considerably within one category of psychiatric disorder (Kernberg, 1996). These psychodynamic factors may affect treatment outcome and may have a greater impact on outcome than the phenomenological DSM categories (Piper, McCallum, Joyce, Rosie, & Ogrodniczuk, 2001).

Depressive disorders

At present, several RCTs are available that provide evidence for the efficacy of PDT compared to CBT in major depressive disorder (Barkham et al., 1996; Driessen et al., 2013; Gallagher-Thompson & Steffen, 1994; Shapiro et al., 1994; Thompson, Gallagher, & Breckenridge, 1987). It is of note that due to the large sample size the RCT by Driessen et al. (2013) was sufficiently powered for an equivalence trial. Different models of PDT were applied (Table 1). Thase (2013) concluded from this RCT: 'On the basis of these findings, there is no reason to believe that psychodynamic psychotherapy is a less effective treatment of major depressive disorder than CBT.'

In another RCT by Salminen et al. (2008), PDT was found to be equally efficacious as fluoxetine in reducing symptoms of depression and improving functional ability. However, with sample sizes of $N_1 = 26$ and $N_2 = 25$, statistical power may have not been sufficient to detect possible differences between treatments. In a small RCT, Maina, Forner, and Bogetto (2005) examined the efficacy of PDT and brief supportive therapy in the treatment of minor depressive disorders (dysthymic disorder, depressive disorder not otherwise specified, or adjustment disorder with depressed mood). Both treatments were superior to a waiting-list condition at the end of treatment. At six-month follow-up, PDT was superior to brief supportive therapy. In a recent study by Barber, Barrett, Gallop, Rynn, and Rickels (2012), PDT and pharmacotherapy were equally effective in the treatment of depression. However, neither PDT nor pharmacotherapy was superior to placebo.

An earlier meta-analysis (Leichsenring, 2001) found PDT and CBT to be equally effective with regard to depressive symptoms, general psychiatric symptoms, and social functioning. These results are consistent with the findings

of more recent meta-analyses by Barth et al. (2013) and Driessen et al. (2010; Abbass & Driessen, 2010). Barth et al. (2013) did not find significant differences in outcome between different forms of psychotherapy of depression. Driessen et al. (2010) found PDT significantly superior to control conditions. If group therapy was included, PDT was less efficacious compared to other treatments at the end of therapy. If only individual therapy was included, there were no significant differences between PDT and other treatments (Abbass & Driessen, 2010). In three-month and nine-month follow-ups, no significant differences between treatments were found.

Meanwhile, internet-guided self-help is also available for PDT. In an RCT, Johansson et al. (2012) found internet-guided self-help based on PDT significantly more efficacious than a structured support intervention (psychoeducation and scheduled weekly contacts online) in patients with major depressive disorder. Treatment effects were maintained at 10-month follow-up. Psychodynamically oriented self-help was based on the concept by Silverberg (2005). Silverberg's internet-guided self-help based on PDT is a promising approach, especially for patients who do not receive psychotherapy. Further studies should be carried out.

In summary, several RCTs provide evidence for the efficacy of PDT in depressive disorders.

Pathological grief

In two RCTs by McCallum and Piper (1990) and Piper et al. (2001), the treatment of prolonged or complicated grief by short-term psychodynamic group therapy was studied. In the first study, short-term psychodynamic group therapy was significantly superior to a waiting list (McCallum & Piper, 1990). In the second study, a significant interaction was found. With regard to grief symptoms, patients with high quality of object relations improved more in interpretive therapy, and patients with low quality of object relations improved more in supportive therapy. For general symptoms, clinical significance favored interpretive therapy over supportive therapy (Piper et al., 2001).

Anxiety disorders

For anxiety disorders, several RCTs are presently available (Table 1). With regard to *panic disorder* (with or without agoraphobia), Milrod et al. (2007) showed in an RCT that PDT was more successful than applied relaxation. For *social phobia*, three RCTs of psychodynamic therapy exist. In the first study, short-term psychodynamic group treatment for generalized social phobia was superior to a credible placebo control (Knijnik, Kapczinski, Chachamovich, Margis, & Eizirik, 2004).

In a study by Bögels, Wijts, and Sallerts (2003), PDT proved to be as effective as CBT in the treatment of (generalized) social phobia. However, with sample

sizes of $N = 22$ and $N = 24$, statistical power may have not been sufficient to detect possible differences between treatments.

In a large-scale multicenter RCT, the efficacy of PDT and cognitive therapy (CT) in the treatment of social phobia was studied (Leichsenring et al., 2013a). In an outpatient setting, 495 patients with a primary diagnosis of social phobia were randomly assigned to CT, PDT, or the waiting list. Treatments were carried out according to manuals and treatment fidelity was carefully controlled for. Both treatments were significantly superior to the waiting list. Thus, this trial provides evidence that PDT is effective in the treatment of social phobia according to the criteria proposed by Chambless and Hollon (1998). There were no differences between PDT and CT with regard to response rates for social phobia (52% vs. 60%) and reduction of depression. There were significant differences between CT and PDT in favor of CT, however, with regard to remission rates (36% vs. 26%), self-reported symptoms of social phobia, and reduction of interpersonal problems. Differences in terms of between-group effect sizes, however, were small and below the priori set threshold for clinical significance (Leichsenring, Salzer, & Leibing, in press; Leichsenring et al., 2013a). Taking these results referring to clinically significant differences into account, recommending CBT over PDT in social anxiety disorders is not warranted. As Kraemer (2011, p. 1350) puts it: 'Only if the ES [effect size] is greater than some value d* [threshold of clinical significance] is a strong clinical recommendation of one treatment over the other warranted.' For the comparison of PDT with CBT, this was not the case. Furthermore, in the follow-up study 6, 12, and 24 months after end of therapy, neither statistically significant nor clinically significant differences were found between CT and PDT in any outcome measure (Leichsenring et al., 2013b). In general, the differentiation between statistical and clinical significance has not yet been sufficiently taken into account in psychotherapy research. From small, but statistically significant differences, the conclusion is drawn that one treatment is superior to another (Leichsenring et al., in press).

In a randomized controlled feasibility study of *generalized anxiety disorder*, PDT was equally effective as a supportive therapy with regard to continuous measures of anxiety, but significantly superior on symptomatic remission rates (Crits-Christoph, Connolly Gibbons, Narducci, Schamberger, & Gallop, 2005). However, the sample sizes of that study were relatively small ($N = 15$ vs. $N = 16$), and the study was not sufficiently powered to detect more possible differences between treatments. In another RCT of generalized anxiety disorder, PDT was compared to CBT (Leichsenring et al., 2009). PDT and CBT were equally effective with regard to the primary outcome measure. However, in some secondary outcome measures, CBT was found to be superior, both at the end of therapy and at the six-month follow-up. Other differences may exist that were not detected due to the limited sample size and power (CBT: $N = 29$; PDT: $N = 28$). In the one-year follow-up, results proved to be stable (Salzer, Winkelbach, Leweke, Leibing, & Leichsenring, 2011). Contrary to short-term PDT (STPP), a

core element in the applied method of CBT consisted of a modification of worrying. This specific difference between the treatments may explain the superiority of CBT in the Penn State Worry Questionnaire (Meyer, Miller, Metzger, & Borkovec, 1990) and, in part, also in the State-Trait Anxiety Inventory (trait measure) (Spielberger, Gorsuch, & Lushene, 1970) – the latter also contains several items related to worrying. The results of that study may suggest that the outcome of STPP in generalized anxiety disorder may be further optimized by employing a stronger focus on the process of worrying. In PDT, worrying can be conceptualized as a mechanism of defense that protects the subject from fantasies or feelings that are even more threatening than the contents of his or her worries (Crits-Christoph, Wolf-Palacio, Ficher, & Rudick, 1995).

According to the available RCTs, PDT is efficacious in anxiety disorders. If differences between PDT and CBT were found, they showed up in secondary outcome measures or corresponded to small differences in effect size. This is consistent with a recent meta-analysis by Baardseth et al. (2013) who did not find significant differences in favor of CBT compared to bona fide treatments.

For CBT, a recent historical review showed that the efficacy of treatments for anxiety disorders has not increased but rather decreased from the 1980s to the present (Öst, 2008). Furthermore, a substantial proportion of patients do not sufficiently benefit from the treatments and the proportion of nonresponders does not appear to have decreased over time (Öst, 2008). For these reasons, there is a need to further improve the treatment of anxiety disorders (Schmidt, 2012). This is true not just for CBT, but also for PDT as well (Leichsenring, Klein, Salzer, 2014). In one of the most promising approaches to address this problem, psychotherapy research is moving from single-disorder-focused manualized approaches toward 'transdiagnostic' and modular treatments (e.g., Barlow, Allen, & Choate, 2004; McHugh, Murray, & Barlow, 2009). The rationale for transdiagnostic treatments focuses on similarities among disorders, particularly in a similar class of diagnoses (e.g., anxiety disorders), including high rates of comorbidity and improvements in comorbid conditions when treating a principal disorder (Barlow et al., 2004; McHugh et al., 2009). For these reasons, researchers in the field of CBT have developed transdiagnostic treatment protocols (e.g., Barlow et al., 2004; McHugh et al., 2009; Norton & Phillip, 2008). It is an advantage that PDT is traditionally less tailored to single mental disorders, but focuses on core underlying processes of mental disorders. A recent review has shown that the empirically supported methods of PDT for specific anxiety disorders have core treatment components in common (Leichsenring & Salzer, in press). These components have been distilled and integrated into an evidence-based Unified Psychodynamic Protocol for ANXiety disorders (UPP-Anx; Leichsenring & Salzer, in press).

Integrating treatment elements of empirically supported methods of PDT for specific anxiety disorders, the manualized UPP-Anx has the potential to: (1) be more effective than single-disorder psychotherapy, (2) be more effective than routine PDT, (3) improve comorbid symptoms, (4) enhance patients' quality of

life, (5) facilitate translation of research into clinical practice of mental health professionals, (6) facilitate training for practitioners and dissemination of the approach relative to training in several distinct single-disorder treatments, (7) be more cost efficient (e.g., by additionally improving comorbid symptoms), and (8) have an impact on both the health-care system and public health. As a next step, we are planning to evaluate the UPP-Anx in a RCT.

Mixed samples of depressive and anxiety disorders

Knekt et al. (2008a, 2008b) compared STPP, long-term psychodynamic psychotherapy (LTPP), and solution-focused therapy (SFT) in patients with depressive or anxiety disorders. STPP was more effective than LTPP during the first year. During the second year of follow-up, no significant differences were found between long-term and short-term treatments. In the three-year follow-up, LTPP was more effective; no significant differences were found between the short-term treatments. With regard to specific mental disorders, it is of note that after three years significantly more patients recovered from anxiety disorders in LTPP (90%) compared to STPP (67%) and SFT (65%). For depressive disorders, no such differences occurred. In an RCT by Bressi, Porcellana, Marinaccio, Nocito, and Magri (2010), PDT was superior to Treatment as Usual (TAU) in a sample of patients with depressive or anxiety disorders.

Posttraumatic stress disorder

In an RCT by Brom, Kleber, and Defares (1989), the effects of PDT, behavioral therapy, and hypnotherapy in patients with posttraumatic stress disorder (PTSD) were studied. All of the treatments proved to be equally effective. The results reported by Brom et al. (1989) are consistent with that of a more recent meta-analysis by Benish, Imel, and Wampold (2008), which found no significant differences between bona fide treatments of PTSD. In a response to the meta-analysis by Benish et al. (2008), Ehlers et al. (2010) critically reviewed the study by Brom et al. (1989). A comprehensive discussion with a convincing reply to the critique by Ehlers et al. (2010) was given by Wampold et al. (2010). In the present context, we shall only address the critique put forward by Ehlers et al. (2010) against the study by Brom et al. (1989). Ehlers et al. (2010) reviewed the study by Brom et al. (1989) in the following way (p. 273, italics by the authors): 'In this study, neither hypnotherapy nor psychodynamic therapy was consistently more effective than the waiting-list control condition across the analyses used . . .' In addition, Brom et al. (1989) pointed out that 'Patients in psychodynamic therapy showed slower overall change than those in the other two treatment conditions, and did *not* improve in intrusive symptoms significantly . . .'

Results are different for different outcome measures. For the avoidance scale and the total score of the Impact of Event Scale (Horowitz, Wilner, & Alvarez, 1979), PDT was significantly superior to the waiting-list condition, both after

therapy and at follow-up (Brom et al., 1989, p. 610, Table 1). While effect sizes for PDT were somewhat smaller at posttreatment (avoidance: 0.66, total: 1.10), PDT achieved the largest effect sizes at follow-up (avoidance: 0.92, total: 1.56) as compared to CBT (avoidance: 0.73, total: 1.30) and hypnotherapy (avoidance: 0.88, total: 1.54).

For the intrusion scale of the Impact of Event Scale, the primary outcome measure, it is true that PDT was not superior to waiting list both at posttest and at three-month follow-up. Intrusion is one of the core symptoms of PTSD. Pre–post differences of PDT, however, were significant and the pre–post and pre-follow-up effect sizes were large (0.95 and 1.55, respectively). In contrast, the pre–post effect size for the waiting list was small (0.34). For the CBT condition (trauma desensitization), the pre–post and pre-follow-up effect sizes were 1.66 and 1.43, respectively. Thus, at follow-up, PDT achieved a larger effect size than CBT. While the effect size of CBT tended to decrease at follow-up, it tended to increase for PDT; as will be shown below, this is true for the avoidance scale and the total score of the Impact of Event Scale. For this reason, it is strange that the difference between PDT and the control condition was reported by Brom et al. (1989) to be not significant at follow-up. For intrusion, PDT achieved the lowest score of all conditions at follow-up. These results, however, were not reported by Ehlers et al. (2010). The figure presented by Ehlers et al. (2010, p. 273, Figure 2) only included the pre–post effect sizes, but not the pre-follow-up effect sizes, for which PDT achieved larger effect sizes, as shown above. In a critical review, results of all analyses should be presented, not only the results that support one's own perspective. Furthermore, for general symptoms, Brom et al. (1989) wrote that PDT 'seems to withstand the comparison [with waiting list] best' (p. 610). Thus, after all, it seems to take (a little bit, i.e., three months!) longer for PDT to achieve its effects, but these effects are at least as large as those of CBT.

Further studies of PDT in PTSD are required. At present, only one RCT of PDT in PTSD is presently available.

Somatoform disorders

At present, five RCTs of PDT in somatoform disorders that fulfill the inclusion criteria are available (Table 1). In the RCT by Guthrie, Creed, Dawson, and Tomenson (1991), patients with irritable bowel syndrome, who had not responded to standard medical treatment over the previous six months, were treated with PDT in addition to standard medical treatment. This treatment was compared to standard medical treatment alone. According to the results, PDT was effective in two-thirds of the patients. In another RCT, PDT was significantly more effective than routine care, and as effective as medication (paroxetine) in the treatment of severe irritable bowel syndrome (Creed et al., 2003). During the follow-up period, however, PDT, but not paroxetine, was associated with a significant reduction in health-care costs compared with TAU. In an RCT by

Hamilton et al. (2000), PDT was compared to supportive therapy in the treatment of patients with chronic intractable functional dyspepsia, who had failed to respond to conventional pharmacological treatments. At the end of treatment, PDT was significantly superior to the control condition. The effects were stable in the 12-month follow-up.

An RCT by Faramarzi et al. (2013) corroborated these results with PDT combined with medical treatment being superior to medical treatment alone, with regard to gastrointestinal symptoms, defense mechanisms, and alexithymia, both at the end of therapy and at the 1- and 12-month follow-up. Monsen and Monsen (2000) compared PDT of 33 sessions with a control condition (no treatment or TAU) in the treatment of patients with chronic pain. PDT was significantly superior to the control group on measures of pain, psychiatric symptoms, interpersonal problems, and affect consciousness. The results remained stable or even improved in the 12-month follow-up. In a recent study, Sattel et al. (2012) compared PDT with enhanced medical care in patients with multi-somatoform disorders. At follow-up, PDT was superior to enhanced medical care with regard to improvements in patients' physical quality of life.

Abbass, Kisely, and Kroenke (2009) carried out a review and meta-analysis on the effects of PDT in somatic disorders. They included both RCTs and controlled before and after studies. Meta-analysis was possible for 14 studies. It revealed significant effects on physical symptoms, psychiatric symptoms, and social adjustment, which were maintained in long-term follow-up. Thus, specific forms of PDT can be recommended for the treatment of somatoform disorders.

Bulimia nervosa

For the treatment of bulimia nervosa, three RCTs of PDT are available (Table 1). Significant and stable improvements in bulimia nervosa after PDT were demonstrated in the RCTs by Fairburn, Kirk, O'Connor, and Cooper (1986), Fairburn et al. (1995), and Garner et al. (1993). In the primary disorder-specific measures (bulimic episodes, self-induced vomiting), PDT was as effective as CBT (Fairburn et al., 1986, 1995; Garner et al., 1993). Again, however, the studies were not sufficiently powered to detect possible differences (see Table 1 for sample sizes). Apart from this, CBT was superior to PDT in some specific measures of psychopathology (Fairburn et al., 1986). However, in a follow-up (Fairburn et al., 1995) of the Fairburn et al. (1986) study using a longer follow-up period, both forms of therapy proved to be equally effective and were partly superior to a behavioral form of therapy. Accordingly, for a valid evaluation of the efficacy of PDT in bulimia nervosa, longer-term follow-up studies are necessary. In another RCT, PDT was significantly superior to both a nutritional counseling group and CT (Bachar, Latzer, Kreitler, & Berry, 1999). This was true of patients with bulimia nervosa and a mixed sample of patients with bulimia nervosa or anorexia nervosa.

Anorexia nervosa

For the treatment of anorexia nervosa, however, evidence-based treatments are barely available (Fairburn, 2005). This applies to both PDT and CBT. In an RCT by Gowers, Norton, Halek, and Crisp (1994), PDT combined with four sessions of nutritional advice yielded significant improvements in patients with anorexia nervosa (Table 1). Weight and body mass index (BMI) changes were significantly more improved than in a control condition (TAU). Dare, Eisler, Russell, Treasure, and Dodge (2001) compared PDT with a mean duration of 24.9 sessions to cognitive-analytic therapy, family therapy, and routine treatment in the treatment of anorexia nervosa (Table 1). PDT yielded significant symptomatic improvements and PDT and family therapy were significantly superior to the routine treatment with regard to weight gain. However, the improvements were modest – several patients were undernourished at the follow-up. A recent RCT compared manual-guided psychodynamic therapy, enhanced CBT, and optimized TAU in the treatment of anorexia nervosa (Zipfel et al., 2013). After 10 months of treatment, significant improvements were found in all treatments, with differences in the primary outcome measure (BMI). At the 12-months follow-up, however, psychodynamic therapy was significantly superior to optimized TAU, whereas enhanced CBT was not (Zipfel et al., 2013). Recovery rates were 35% versus 19% versus 13% for psychodynamic therapy enhanced CBT and optimized TAU. Thus, the method of psychodynamic therapy specifically tailored to the treatment of anorexia nervosa yielded promising effects.

Binge eating disorder

In an RCT by Tasca et al. (2006), a psychodynamic group treatment was as efficacious as CBT and superior to a waiting-list condition in binge eating disorder (e.g., days binged, interpersonal problems). For the comparison of PDT with CBT, again the question of statistical power arises ($N_1 = 48$, $N_2 = 47$, $N_3 = 40$).

Substance-related disorders

Woody et al. (1983; Woody, Luborsky, McLellan, & O'Brien, 1990) studied the effects of PDT and CBT, both of which were given in addition to drug counseling, in the treatment of opiate dependence (Table 1). PDT plus drug counseling yielded significant improvements on measures of drug-related symptoms and general psychiatric symptoms. At seven-month follow-up, PDT and CBT, plus drug counseling, were equally effective, and both conditions were superior to drug counseling alone. In another RCT, PDT of 26 sessions given in addition to drug counseling was also superior to drug counseling alone in the treatment of opiate dependence (Woody, McLellan, Luborsky, & O'Brien, 1995). At six-month follow-up, most of the gains made by the patients who had received

psychodynamic therapy remained. In an RCT conducted by Crits-Christoph et al. (1999, 2001), PDT of up to 36 individual sessions was combined with 24 sessions of group drug counseling in the treatment of cocaine dependence. The combined treatment yielded significant improvements and was as effective as CBT, which was combined with group drug counseling as well. However, CBT and PDT plus group drug counseling were not more effective than group drug counseling alone. Furthermore, individual drug counseling was significantly superior to both forms of therapy concerning measures of drug abuse. With regard to psychological and social outcome variables, all treatments were equally effective (Crits-Christoph et al., 1999, 2001). In an RCT by Sandahl, Herlitz, Ahlin, and Rönnberg (1998), PDT and CBT were compared concerning their efficacy in the treatment of alcohol abuse. PDT yielded significant improvements on measures of alcohol abuse, which were stable at a 15-month follow-up. PDT was significantly superior to CBT in the number of abstinent days and in the improvement of general psychiatric symptoms.

Borderline personality disorder

At present, seven RCTs are available for PDT in BPD (Bateman & Fonagy, 1999, 2009; Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Doering et al., 2010; Giesen-Bloo et al., 2006; Gregory et al., 2008; Munroe-Blum & Marziali, 1995). Of these studies, several showed that PDT was superior to TAU (Bateman & Fonagy, 1999; Doering et al., 2010; Gregory et al., 2008). Bateman and Fonagy (1999, 2001) studied psychoanalytically oriented partial hospitalization treatment for patients with BPD. The major difference between the treatment group and the control group was the provision of individual and group psychotherapy in the former. The treatment lasted a maximum of 18 months. PDT was significantly superior to standard psychiatric care, both at the end of therapy and at the 18-month follow-up. In a recent RCT, Transference-Focused Psychotherapy (TFP) based on Kernberg's model (Clarkin, Yeomans, & Kernberg, 1999) was compared to a treatment carried out by experienced community psychotherapists in borderline outpatients (Doering et al., 2010). TFP was superior with regard to borderline psychopathology, psychosocial functioning, personality organization, inpatient admission, and dropouts. Another RCT compared PDT ('dynamic deconstructive psychotherapy') with TAU in the treatment of patients with BPD and co-occurring alcohol use disorder (Gregory et al., 2008). In this study, PDT, but not TAU, achieved significant improvements in outcome measures of parasuicide, alcohol misuse, and institutional care (Gregory et al., 2008). Furthermore, PDT was superior with regard to improvements in borderline psychopathology, depression, and social support. No difference was found in dissociation. This was true although TAU participants received higher average treatment intensity. Another recent RCT found mentalization-based treatment (MBT) to be superior to manual-driven structured clinical management with regard to the primary (suicidal and self-injurious behaviors, hospitalization) and

secondary outcome measures (e.g., depression, general symptom distress, interpersonal functioning) (Bateman & Fonagy, 2009).

With regard to the comparison of PDT to specific forms of psychotherapy, one RCT reported PDT as equally effective as an interpersonal group therapy (Munroe-Blum & Marziali, 1995). PDT yielded significant improvements on measures of borderline-related symptoms, general psychiatric symptoms, and depression, and was as effective as an interpersonal group therapy. Power, however, may have been insufficient to detect differences between treatments ($N_1 = 22$, $N_2 = 26$). Giesen-Bloo et al. (2006) compared PDT (TFP) with schema-focused therapy (SFT), a form of CBT. Treatment duration was three years with two sessions a week. The authors reported statistically and clinically significant improvements for both treatments. However, SFT was found to be superior to TFP in several outcome measures. Furthermore, a significantly higher dropout risk for TFP was reported. This study, however, had serious methodological flaws. The authors used scales for adherence and competence for both treatments, for which they adopted an identical cutoff score of 60 indicating competent application. According to the data published by the authors (Giesen-Bloo et al., 2006, p. 651), the median competence level for applying SFT methods was 85.67. For TFP, a value of 65.6 was reported. While the competence level for SFT clearly exceeded the cutoff, the competence level for TFP just surpassed it. Furthermore, the competence level for SFT is clearly higher than that for TFP. Accordingly, both treatments were not equally applied in terms of therapist competence. Thus, the results of that study are questionable. The difference in competence was not taken into account by the authors, neither with regard to the analysis of resulting data nor in the discussion of the results. Thus, this study raises serious concerns about an investigator allegiance effect (Luborsky et al., 1999).

Another RCT compared PDT (TFP), dialectical behavior therapy (DBT), and psychodynamic supportive psychotherapy (Clarkin et al., 2007). Patients treated with all three modalities showed general improvement in the study. However, TFP was shown to produce improvements not demonstrated by either DBT or supportive therapy. Those participants who received TFP were more likely to move from an insecure attachment classification to a secure one. They also showed significantly greater changes in mentalizing capacity and narrative coherence compared to the other two groups. TFP was associated with significant improvement in 10 of the 12 variables across the six symptomatic domains, compared to six in supportive therapy and five in DBT. Only TFP made significant changes in impulsivity, irritability, verbal assault, and direct assault. TFP and DBT reduced suicidality to the same extent. Here as well, power may have been insufficient to detect further possible differences ($N_1 = 23$, $N_2 = 17$, $N_3 = 22$).

In summary, there is clear evidence that specific forms of manual-guided PDT are efficacious in BPD (Leichsenring, Leibing, Kruse, New, & Leweke, 2011). For TFP and MBT, two RCTs carried out in independent research settings

are available which provide evidence that both MBT and TFP are efficacious and specific treatments of BPD, according to the criteria of empirically supported treatments proposed by Chambless and Hollon (1998). Studies of both psychotherapy and pharmacotherapy in BPD were recently reviewed by Leichsenring, Leibing et al. (2011). For bona fide treatments, including MBT, TFP, DBT, and schema-focused therapy there is no evidence that one form of psychotherapy is superior to another (Leichsenring, Leibing et al., 2011).

Cluster C personality disorders

There is also evidence for the efficacy of PDT in the treatment of Cluster C personality disorders (i.e., avoidant, compulsive, or dependent personality disorder). In an RCT conducted by Svartberg, Stiles, and Seltzer (2004), PDT of 40 sessions in length was compared to CBT (Table 1). Both PDT and CBT yielded significant improvements in patients with DSM-IV Cluster C personality disorders. The improvements refer to symptoms, interpersonal problems, and core personality pathology. The results were stable at 24-months follow-up. No significant differences were found between PDT and CBT with regard to efficacy. However, this study was also not sufficiently powered to detect possible differences ($N_1 = 25$, $N_2 = 25$). Muran, Safran, Samstag, and Winston (2005) compared the efficacy of psychodynamic therapy, brief relational therapy, and CBT in the treatment of Cluster C personality disorders and personality disorders not otherwise specified. Treatments lasted for 30 sessions. With regard to mean changes in outcome measures, no significant differences were found between the treatment conditions, neither at termination nor at follow-up. Furthermore, there were no significant differences between the treatments with regard to the patients achieving clinically significant change in symptoms, interpersonal problems, features of personality disorders, or therapist ratings of target complaints. At termination, CBT and brief relational therapy were superior to PDT in one outcome measure (patient ratings of target complaints). However, this difference did not persist at follow-up. With regard to the percentage of patients showing change, no significant differences were found, either at termination or at the follow-up, except in one comparison: at termination, CBT was superior to PDT on the Inventory of Interpersonal Problems (Horowitz, Alden, Wiggins, & Pincus, 2000). Again, this difference did not persist at follow-up. The conclusion is that only a few significant differences were found between the treatments but these differences did not persist at follow-up.

Avoidant personality disorder

Avoidant personality disorder (AVPD) is among the above-mentioned Cluster C personality disorders. In a recent RCT, Emmelkamp et al. (2006) compared CBT to PDT and a waiting-list condition in the treatment of AVPD. The authors reported CBT as more effective than waiting-list control and PDT. However, the study suffers from several methodological shortcomings (Leichsenring &

Leibing, 2007). In contrast to CBT, for example, no disorder-specific manual was used for PDT. Some outcome measures applied by Emmelkamp et al. (2006) were specifically tailored to effects for CBT (e.g., to beliefs). Furthermore, an arbitrary level of significance ($p = 0.10$) was set by the authors so that a usually not significant difference ($p = 0.09$) achieved significance in favor of CBT. At follow-up, no differences between CBT and PDT were found in primary outcome measures. In addition, Emmelkamp et al. (2006) reported that PDT was not superior to the waiting-list group. This was true, but may be attributed to the small sample size and low power of the study. Furthermore, CBT was superior to the waiting-list group in only two of six measures (Leichsenring & Leibing, 2007). Thus, design, statistical analyses and reporting of results raise serious concerns about an investigator allegiance effect (Luborsky et al., 1999).

Heterogeneous samples of patients with personality disorders

Winston et al. (1994) compared PDT with brief adaptive psychotherapy or waiting-list patients in a heterogeneous group of patients with personality disorders. Most of the patients showed a Cluster C personality disorder. Patients with paranoid, schizoid, schizotypal, borderline, and narcissistic personality disorders were excluded. Mean treatment duration was 40 weeks. In both treatment groups, patients showed significantly more improvements than the patients on the waiting list. No differences in outcome were found between the two forms of psychotherapy. Hellerstein et al. (1998) compared PDT to brief supportive therapy in a heterogeneous sample of patients with personality disorders. Again, most of the patients showed a Cluster C personality disorder. The authors reported similar degrees of improvement both at termination and at six-month follow-up. However, the studies by Winston et al. (1994) and Hellerstein et al. (1998) were not sufficiently powered to detect possible differences (see Table 1 for sample sizes). Abbass, Sheldon, Gyra, and Kalpin (2008) compared PDT (intensive short-term dynamic psychotherapy, ISTDP) with a minimal contact group in a heterogeneous group of patients with personality disorders. The most common Axis II diagnoses were borderline (44%), obsessive compulsive (37%), and AVPD (33%). Average treatment duration was 27.7 sessions. PDT was significantly superior to the control condition in all primary outcome measures. When control patients were treated, they experienced benefits similar to the initial treatment group. In the long-term follow-up, two years after the end of treatment, the whole group maintained their gains and had an 83% reduction of personality disorder diagnoses. In addition, treatment costs were thrice offset by reductions in medication and disability payments. This preliminary study of ISTDP suggests that it is efficacious and cost-effective in the treatment of personality disorders.

At present, two meta-analyses on the effects of PDT in personality disorders are available (Leichsenring & Leibing, 2003; Town, Abbass, & Hardy, 2011). A meta-analysis addressing the effects of PDT and CBT in personality disorders

reported that PDT yielded large effects sizes not only for comorbid symptoms, but also for core personality pathology (Leichsenring & Leibing, 2003). This was true especially for BPD. A more recent meta-analysis by Town et al. (2011) included seven RCTs on STPP in personality disorders. The authors drew the preliminary conclusion that PDT may be considered an efficacious empirically supported treatment option for a wide range of personality disorders, producing significant and medium to long-term improvements for a large percentage of patients.

Discussion

Under the requirements of the criteria proposed by the Task Force modified by Chambless and Hollon (1998), several RCTs are presently available that provide evidence for the efficacy of PDT in specific mental disorders (Leichsenring et al., in press). There is evidence for the efficacy of PDT in depressive disorders, prolonged or complicated grief, anxiety disorders, PTSD, eating disorders, somatoform disorders, substance-related disorders, and personality disorders, including both less severe (Cluster C) and severe personality disorders (BPD). For PTSD, only one RCT exists (Brom et al., 1989). Thus, we urgently need further studies showing that PDT is effective in complex PTSDs, i.e., in patients suffering from childhood abuse. With regard to personality disorders, no RCTs exist for Cluster A personality disorders (e.g., paranoid, schizoid) and for some relevant Cluster B personality disorders (e.g., narcissistic). This is true, however, for CBT as well. In addition, further RCTs of PDTLTPP, especially in complex mental disorders, are required.

In the studies reviewed here, PDT was either more effective than placebo therapy, supportive therapy or TAU, or no differences between PDT and CBT, or between PDT and pharmacotherapy, were found.

In a few studies, PDT was superior to a method of CBT (Milrod et al., 2007); in another study, PDT was superior to CBT in some outcome measures (Clarkin et al., 2007). However, most of the studies that found no differences in efficacy between PDT and another bona fide treatment were not sufficiently powered. As reported above, testing for non-inferiority (i.e., equivalence) requires $N_1 = N_2 = 86$ patients to detect an at least medium differences (effect size $d = 0.5$) between two treatments with a sufficient power ($\alpha = 0.05$, two-tailed test, $1\text{-}\beta = 0.90$) (Cohen, 1988). At present, only four RCT comparing PDT with a bona fide treatment fulfill this criterion (Crits-Christoph et al., 1999; Driessen et al., 2013; Knekt et al., 2008a; Leichsenring et al., 2013a). The issue of small sample size studies, however, is not specific to studies of PDT, since many studies of CBT are also not sufficiently powered (Leichsenring & Rabung, 2011).

For comparisons of PDT with bona fide therapies, the between-group effect sizes were found to be small (Driessen et al., 2013; Leichsenring, 2001; Leichsenring, Salzer et al., 2011; Leichsenring et al., 2013a). Thus, it is an open

question of research whether more highly powered studies would find significant differences. Furthermore, the question has to be addressed whether these (possibly small) differences are clinically relevant or significant (Jacobson & Truax, 1991).

It is important, however, to realize which mental disorders lack any RCTs of PDT. This is true, for example, for dissociative disorders and for some specific forms of personality disorders (e.g., narcissistic). For PTSD, only one RCT is presently available (Brom et al., 1989).

Some studies reported differences, at least in some measures, in favor of CBT. This is true, for example, for the studies on bulimia nervosa by Fairburn et al. (1986) and Garner et al. (1993), and for the studies on generalized anxiety disorder (Leichsenring et al., 2009) and social phobia (Leichsenring et al., 2013a). For the study on generalized anxiety disorder (Leichsenring et al., 2009), we discussed above whether a stronger focus on the process of worrying would possibly improve the results of PDT. In general, future research should address the question whether the efficacy of PDT can be improved by putting a stronger focus on the specific mechanisms that maintain the psychopathology of the respective disorder. Mentalization-based therapy or TFP may serve as good examples for psychodynamic treatments that focus on the assumed processes or deficits maintaining a disorder.

According to the results of this review, further research of PDT in specific mental disorders is necessary, including studies of both the outcome and the active ingredients of PDT in these disorders. Not only measures of symptoms and DSM criteria of a disorder should be applied, but also measures more specific to PDT. Future studies should also examine if there are specific gains achieved only by PDT, i.e., the question of 'added value.' Furthermore, those methods of therapy that have proved to work under experimental conditions of RCTs need to be studied for their effectiveness in the field (effectiveness studies). The perception that PDT lacks empirical support is not consistent with available empirical evidence and may reflect selective dissemination of research findings (Shedler, 2010).

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