

Bias Toward Psychodynamic Therapy: Framing the Problem and Working Toward a Solution

Although psychodynamic therapy (PDT) is an evidence-based intervention for a broad spectrum of psychiatric conditions, there is often notable bias in the way PDT is depicted both in the popular media and in the scientific literature. This has contributed to a negative view of PDT, which hampers both patient access to this treatment and researcher access to funding for further research on PDT. The adverse effects of these distortions and biases are detrimental not only to PDT but also to the overall field of psychotherapy, raising questions about its credibility. Here we summarize current evidence for PDT, describe existing biases, and formulate a set of recommendations to foster a more balanced perspective on PDT.

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Introduction to Guest Column

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This column had its origins on the 161st birthday of Sigmund Freud on May 6, 2017, while I was listening to Garrison Keillor's *Writer's Almanac* piece for that day on National Public Radio. Keillor cited Freud's birthday in his piece, but after describing Freud's seminal work on dreams and his focus on the centrality of unconscious factors in determining human behavior, Keillor concluded his comments by stating that science had by now largely debunked Freud's theories. I was dumbstruck by this offhanded and completely inaccurate statement from a usually knowledgeable radio commentator. It reminded me of other examples I had come across of gross misinformation and bias with respect to psychoanalysis and psychodynamic therapy (PDT). For example, among general psychiatrist colleagues with whom I work in the American Psychiatric Association (APA) Assembly, no one would ever utter a joke about a minority group, but periodic jokes poking fun at psychoanalysts still turn up now and then. About a month later, I saw the *PsychiatryOnline* version of a

paper by Steinert et al¹ and her group that was in press in the *American Journal of Psychiatry*, reporting "equivalence" of PDT with other forms of therapy. I knew then that I wanted to do a column on the problem of implicit bias toward PDT and psychoanalysis.

As I hope has been clear in all of these columns to date, they are about psychotherapy in general and do not favor one school of psychotherapy over another. We have too much work to do together to persuade a field that tends toward biological reductionism in its thinking about etiology and treatment of disorders for this column or this columnist to join the proverbial "circular firing squad," in which psychotherapists from competing schools argue with one another about who has the best therapy or the best research. This implicit bias, as the guest columnists show, goes beyond needless competition between schools and it reflects poorly on the credibility of psychotherapy as a form of treatment and on the quality of psychotherapy research of all kinds. It also runs counter to the recommendation from the Institute of Medicine's *Report on Psychosocial Interventions in Mental Health and Substance Use Disorders* that we increase efforts to

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A.A., P.L., C.S., and F.L. research, teach, and practice psychodynamic therapy (PDT) and have published books dealing with PDT.

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identify shared elements across forms of therapy that are associated with change.² We cannot allow implicit bias to lead us to ignore science. I am delighted and grateful that these 4 leading PDT researchers agreed to take on the task of describing these biases, citing evidence that unmask them, and making recommendations to move forward.

Bias Toward PDT: Framing the Problem and Working Toward a Solution

Guest Columnists, Allan Abbass, MD, FRCPC, Patrick Luyten, PhD, Christiane Steinert, PhD, and Falk Leichsenring, DSc

PDT as a family of treatments is an evidence-based intervention for a broad spectrum of psychiatric conditions.³⁻⁵ PDT has been shown to be as effective as other psychosocial interventions, including the family of treatments known under the rubric of cognitive behavioral therapy (CBT).¹ Despite this, PDT continues to receive what seems to be biased treatment in treatment guidelines, reviews, and related publications, and in media that inform the public's perception and ultimately patient access to this effective treatment modality.

EVIDENCE FOR PDT

The efficacy and effectiveness of PDT for common mental disorders have been supported by several systematic reviews and meta-analyses. A Cochrane review investigating the efficacy of brief (under 40 sessions) PDT for common mental disorders, for instance, found that PDT outperformed waitlist, treatment as usual, and minimal contact comparisons at both short-term and long-term follow-up.³ Longer term PDT has been found to be effective in complex mental disorders, including in patients with personality disorders, chronic mental disorders, or multiple mental disorders.⁶⁻⁸ In complex mental disorders, the longer term versions of PDT seem to be more effective than short-term therapies. According to the Chambless and Hollon criteria⁹ for empirically supported therapies, PDT is "efficacious" or "probably efficacious" in most common mental disorders.¹⁰ In addition, meta-analyses have found no statistically significant differences in outcome between individual PDT and other forms of individual psychotherapy in patients with anxiety or depressive disorders,^{11,12} and in patients with more complex mental disorders.^{13,14} A recent meta-analysis specifically designed to test for

equivalence in outcomes found PDT to be as efficacious as treatments with established efficacy, such as CBT, across various mental disorders.¹

BIAS IN THE DEPICTION OF PDT

Despite the evidence for PDT, biases in the depiction of PDT and of PDT research remain and threaten to reduce the further development of and thereby limit patient access to PDT. Many of these biases seem to be due to 5 general biases that have been documented in scientific research, most notably researcher allegiance and the application of double standards.^{15,16}

Bias 1. Distorted Depictions of PDT as a Science

Many textbooks of clinical psychology and basic psychology describe psychodynamic approaches, at best, as historically important in psychology's development but as currently outdated and obsolete. At worst, psychodynamic approaches are depicted as unscientific or even pseudoscientific.¹⁷ What these depictions have in common is that they are typically based on caricatured versions of early psychoanalytic assumptions (example: repressed libido as the only dynamic force), while ignoring contemporary psychodynamic approaches and the considerable empirical evidence for these views that has emerged over the past few decades.¹⁸ Unfortunately, this distorted image of current PDT has penetrated popular media and university curricula, damaging the perspectives of both mental health professionals and prospective patients.^{19,20}

Bias 2. Exclusion or Distortion of Evidence Related to PDT in Treatment Guidelines

Several treatment guidelines exclude or downgrade PDT, often under the guise of the purportedly smaller evidence base for PDT, even though a higher number of studies does not in and of itself provide evidence for superiority. For instance, in the treatment of anxiety disorders, a recent meta-analysis²¹ showed that > 80% of 121 trials of CBT focusing on anxiety disorders used waitlist control groups; only 17% of studies were of high quality. However, even when there are a large number of trials available for PDT of a specific condition, this does not necessarily

lead to a comparable and unbiased presentation of PDT. For instance, the recently published Canadian Guidelines for the Management of Adults with Major Depressive Disorder (Canadian Network for Mood & Anxiety Disorders or CANMAT)²² placed brief PDT as a second-line rather than a first-line treatment for depression, despite citing a 54-study meta-analysis showing large persistent effects and equal effects between individual PDT and other individual treatment modalities.¹¹ Furthermore, even when this inconsistency was pointed out, the guideline committee did not revise its conclusions and also neglected to consider the outcomes of large studies showing noninferiority of PDT to CBT.²³ A similar struggle occurred recently in Sweden where the National Board of Health and Welfare recruited a skewed mix of professionals to develop treatment guidance: the opinions of the few PDT professionals were outvoted leading to guidance undervaluing PDT.²⁴

Research bodies such as the US National Institute of Mental Health (NIMH) similarly seem to perpetuate distorted or biased information about PDT. For example, in the Health Topics section of the NIMH website, under the categories of anxiety disorders, borderline personality disorder, depression, and eating disorders, there is no mention of PDT as a valid treatment option.²⁵ In a separate section describing psychotherapies,²⁶ there is a notable absence of discussion of psychodynamic as well as other contributions to psychotherapy. The focus in these descriptions is on cognitive and behavioral processes, while the language used is typical of CBT, which could mislead the public to believe that the only relevant psychotherapy approach is CBT.

As another example, a recent comprehensive review of psychosocial interventions in anxiety disorders²⁷ completely downplayed the evidence for PDT in the treatment of these disorders, even when confronted with evidence from meta-analyses showing similar effects of PDT compared with other treatments in these conditions.^{12,28}

Bias 3. Exclusion of Psychodynamic Researchers From Funding and Guidelines Committees

Although there are considerable regional differences, psychodynamic researchers are often excluded from

committees responsible for developing treatment guidelines or for reviewing research and making decisions about research funding. For example, the CANMAT group mentioned above initially included PDT researchers, but they were subsequently removed from the group without explanation, leaving PDT data to be interpreted by researchers with allegiances to different schools of therapy.²⁹

Bias 4. Use of Neutered Versions of “Psychodynamic Therapy” in Randomized Clinical Trials: The “Straw Man” Bias

A particularly pernicious problem has been the use of neutered versions of “psychodynamic therapy” in some trials. For example, in a study of posttraumatic stress disorder, therapists delivering the PDT model were restricted from speaking about the trauma itself, a withholding that patients must have found both unusual and frustrating.³⁰ The use of diluted PDT methods as “straw man” controls that are intended to fail was described for the first time more than 3 decades ago by Smith et al^{31(p119)}: “A comparison condition might be set up as a kind of straw man over which the favored therapy would prevail. The comparison condition (often an ‘insight therapy’) would be treated with fairly obvious disdain, and would not be given as much opportunity for success”. Surprisingly, this bias still exists, as has been amply documented in a number of recent reviews.^{15,32,33} This bias among others affects the replicability, validity, and credibility of all psychotherapy research.³⁴

Bias 5. Biased Study Selection in Meta-Analyses

The selection of studies in meta-analyses is frequently biased against PDT. It has been easy to demonstrate that, in some meta-analyses, typically including researchers with allegiance to a single and different form of therapy, study selection is performed in ways that exclude valid PDT studies, on the one hand, and that include flawed PDT studies, on the other. A meta-analysis by Marcus et al,³⁵ for example, which purportedly claimed to investigate the effectiveness of CBT versus other treatment modalities (including PDT) included only 3 questionable studies of PDT, but omitted a large number of RCTs comparing PDT with other bona fide psychotherapies. Baardseth et al³⁶

showed that several studies of bona fide psychotherapies, including PDT, were excluded in a similar way for unclear reasons in another meta-analysis purporting to find a consistent advantage for a particular family of treatments.³⁷ Table 1 summarizes the varieties of bias toward PDT.

A WAY FORWARD

If this problem of bias is not addressed, we not only risk that patients will be denied access to effective treatments, but we miss the opportunity for dialog and collaboration that could enhance the credibility of scientific psychosocial interventions—at present, the credibility of research in psychology is severely questioned.³⁸ We propose the following steps to help move the field in a more sensible and healthy direction. These recommendations are in accordance with Chambers’ manifesto³⁸ for reforming the culture of scientific practice.

Clearly, for the public to have balanced information, researchers and clinicians who are knowledgeable about the current literature on PDT should be routinely included in committees charged with guideline development, funding decisions, webpage publications, and organizations furthering psychotherapy as a collective treatment approach. Furthermore, researcher allegiances and other conflicts of interest should be collected and consistently disclosed, so readers have a context for the materials.

Given the shared objective of all psychotherapy proponents to increase the effectiveness and scope of psychosocial interventions, collaborative research should be performed using what has been called “adversarial collaboration” to further develop

TABLE 1. Five Kinds of Bias Against Psychodynamic Therapy

Distorted depiction of psychodynamic theory based on caricatured versions
Exclusion or distortion of evidence concerning psychodynamic therapy in treatment guidelines
Exclusion of psychodynamic researchers from funding and guideline committees
Use of restricted versions of “psychodynamic therapy” in trials (“straw man” therapy, “intent-to-fail”)
Study selection in meta-analyses biased against psychodynamic therapy

TABLE 2. Recommendations for a Bias-free Way Forward in Psychotherapy Research

Collaborative outcome research, including proponents of different models
Collaborative development of guidelines, including researchers on psychodynamic therapy
Routine inclusion of researchers on psychodynamic therapy in public and research bodies
Shared research on questions affecting the whole field of psychotherapy: making psychotherapy greater as a collective
Collaborative research on shared elements of therapy impacting outcomes across treatment models

psychotherapy as a collective. Those conducting meta-analyses and review groups should consult with researchers from other models beyond the allegiance of the core group to yield a richer synthesis and contextualization of findings. Finally, shared research should continue on key therapy elements versus overall therapy models toward identifying which interventions work best for whom. This may be especially relevant in relation to therapeutic factors such as emotional experience/exposure³⁹ or change in person-environment exchanges⁴⁰ as presumed key ingredients across treatment modalities. Table 2 presents recommendations for corrective action.

REFERENCES

- Steinert C, Munder T, Rabung S, et al. Psychodynamic therapy: as efficacious as other empirically supported treatments? A meta-analysis testing equivalence of outcomes. *Am J Psychiatry*. 2017. [Epub ahead of print]. Available at: <https://doi.org/10.1176/appi.ajp.2017.17010057>. Accessed July 31, 2017.
- Institute of Medicine (IOM). *Psychosocial Interventions for Mental Health and Substance Use Disorders: A Framework for Establishing Evidence-based Standards*. Washington, DC: The National Academies Press; 2015.
- Abbass A. *Reaching Through Resistance: Advanced Psychotherapy Techniques*. Kansas City, MO: Seven Leaves Press; 2015.
- Leichsenring F, Luyten P, Hilsenroth MJ, et al. Psychodynamic therapy meets evidence-based medicine: a systematic review using updated criteria. *Lancet Psychiatry*. 2015;2:648–660.
- Fonagy P. The effectiveness of psychodynamic psychotherapies: an update. *World Psychiatry*. 2015;14:137–150.
- Leichsenring F, Abbass A, Luyten P, et al. The emerging evidence for long-term psychodynamic therapy. *Psychodyn Psychiatry*. 2013;41:361–384.
- Leichsenring F, Rabung S. Effectiveness of long-term psychodynamic psychotherapy: a meta-analysis. *JAMA*. 2008;300:1551–1565.

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8. Leichsenring F, Rabung S. Long-term psychodynamic psychotherapy in complex mental disorders: update of a meta-analysis. *Br J Psychiatry*. 2011;199:15–22.
9. Chambless DL, Hollon SD. Defining empirically supported therapies. *J Consult Clin Psychol*. 1998;66:7–18.
10. Leichsenring F, Leweke F, Klein S, et al. The empirical status of psychodynamic psychotherapy—an update: Bambi's alive and kicking. *Psychother Psychosom*. 2015;84:129–148.
11. Driessen E, Hegelmaier LM, Abbass AA, et al. The efficacy of short-term psychodynamic psychotherapy for depression: a meta-analysis update. *Clin Psychol Rev*. 2015;42:1–15.
12. Keefe JR, McCarthy KS, Dinger U, et al. A meta-analytic review of psychodynamic therapies for anxiety disorders. *Clin Psychol Rev*. 2014;34:309–323.
13. Cristea IA, Gentili C, Cotet CD, et al. Psychotherapy for borderline personality disorder: a systematic review and meta-analysis. *JAMA Psychiatry*. 2017;74:319–328.
14. Leichsenring F, Leibing E. The effectiveness of psychodynamic therapy and cognitive behavior therapy in the treatment of personality disorders: a meta-analysis. *Am J Psychiatry*. 2003;160:1223–1232.
15. Leichsenring F, Rabung S. Double standards in psychotherapy research. *Psychother Psychosom*. 2011;80:48–51. Author reply 53–54.
16. Munder T, Brutsch O, Leonhart R, et al. Researcher allegiance in psychotherapy outcome research: an overview of reviews. *Clin Psychol Rev*. 2013;33:501–511.
17. Luyten P, Blatt SJ, Corveleyn J. Minding the gap between positivism and hermeneutics in psychoanalytic research. *J Am Psychoanal Assoc*. 2006;54:571–610.
18. Luyten P, Mayes LC, Fonagy P, et al. *Handbook of Psychodynamic Approaches to Psychopathology*. New York: The Guilford Press; 2015.
19. McWilliams N. On teaching psychoanalysis in antianalytic times: a polemic. *Am J Psychoanal*. 2000;60:371–390.
20. Redmond J, Shulman M. Access to psychoanalytic ideas in American undergraduate institutions. *J Am Psychoanal Assoc*. 2008;56:391–408.
21. Cuijpers P, Cristea IA, Karyotaki E, et al. How effective are cognitive behavior therapies for major depression and anxiety disorders? a meta-analytic update of the evidence. *World Psychiatry*. 2016;15:245–258.
22. Parikh SV, Quilty LC, Ravitz P, et al. CANMAT Depression Work Group. Canadian Network for Mood and Anxiety Treatments. 2016 Clinical Guidelines for the management of adults with major depressive disorder: section 2. psychological treatments. *Can J Psychiatry*. 2016;61:524–539.
23. Town JM, Abbass A, Driessen E, et al. Updating the evidence and recommendations for short-term psychodynamic psychotherapy in the treatment of major depressive disorder in adults. *Can J Psychiatry*. 2017;62:73–74.
24. Philips B, Lilliengren P, Klingström A. Socialstyrelsens riktlinjer är ett haveri [The guidelines from the National Board of Health and Welfare are a wreck]. *Svenska Dagbladet*, 2017. [Epub ahead of print].
25. National Institute of Mental Health. Health Topics. Available at: <https://www.nimh.nih.gov/index.shtml>. Accessed June 9, 2017.
26. National Institute of Mental Health. Psychotherapies. Available at: <https://www.nimh.nih.gov/health/topics/psychotherapies/index.shtml>. Accessed June 9, 2017.
27. Craske MG, Stein MB. Anxiety. *Lancet*. 2016;388:3048–3059.
28. Steinert C, Leichsenring F. No psychotherapy monoculture for anxiety disorders. *Lancet*. 2017;389:1882–1883.
29. Leichsenring F, Steinert C. Further evidence for short-term psychodynamic therapy in major depressive disorder. *Can J Psychiatry*. 2017;62:75–76.
30. Gilboa-Schechtman E, Foa EB, Shafran N, et al. Prolonged exposure versus dynamic therapy for adolescent PTSD: a pilot randomized controlled trial. *J Am Acad Child Adolesc Psychiatry*. 2010;49:1034–1042.
31. Smith ML, Glass GV, Miller TI. *The Benefits of Psychotherapy*. Baltimore, MD: Johns Hopkins University Press; 1980.
32. Wampold BE, Fluckiger C, Del Re AC, et al. In pursuit of truth: a critical examination of meta-analyses of cognitive behavior therapy. *Psychother Res*. 2017;27:14–32.
33. Wampold BE, Imel ZE. *The Great Psychotherapy Debate: The Evidence for What Makes Psychotherapy Work*. New York/London: Taylor & Francis; 2015.
34. Leichsenring F, Abbass A, Hilsenroth MJ, et al. Biases in research: risk factors for non-replicability in psychotherapy and pharmacotherapy research. *Psychol Med*. 2017;47:1000–1011.
35. Marcus DK, O'Connell D, Norris AL, et al. Is the Dodo bird endangered in the 21st century? A meta-analysis of treatment comparison studies. *Clin Psychol Rev*. 2014;34:519–530.
36. Baardseth TP, Goldberg SB, Pace BT, et al. Cognitive-behavioral therapy versus other therapies: redux. *Clin Psychol Rev*. 2013;33:395–405.
37. Tolin DF. Is cognitive-behavioral therapy more effective than other therapies? A meta-analytic review. *Clin Psychol Rev*. 2010;30:710–720.
38. Chambers C. *The 7 Deadly Sins of Psychology, A Manifesto for Reforming the Culture of Scientific Practice*. Princeton, NJ: Princeton University Press; 2017.
39. Abbass AA, Kisely SR, Town JM, et al. Short-term psychodynamic psychotherapies for common mental disorders. *Cochrane Database Syst Rev*. 2014;7:CD004687.
40. Fonagy P, Luyten P, Allison E, et al. What we have changed our minds about: part 2. borderline personality disorder, epistemic trust and the developmental significance of social communication. *Borderline Personal Disord Emot Dysregul*. 2017;4:9.