

# The effectiveness of psychoanalysis and psychoanalytic psychotherapy: A literature review of recent international and Australian research

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## Introduction

Recent research with professionals affiliated with the *Psychotherapy and Counselling Federation of Australia* (PACFA) showed that 28% of respondents held specialist qualifications in psychoanalytic/psychodynamic therapy and 30% regarded this area to be their primary theoretical orientation ([Schofield, 2008](#)). Given the prominence of psychoanalytic psychotherapies, it is desirable to keep practitioners informed about the latest evidence on the effectiveness of these treatments.

Psychoanalysis and psychoanalytic psychotherapy may best be considered umbrella terms, which encompass many, divergent theories on mental functioning and treatment ([Lemma, 2003](#)). Different schemas for classifying the schools of psychoanalytic thought exist, with one distinction being between classical views (Sigmund Freud and the “Freudians”, Melanie Klein and the “Kleinians”, and the “British Independents”) and post-classical perspectives (e.g., [Ferenczi’s, Balint’s, and Sullivan’s contributions to relational, interpersonal, intersubjective psychoanalyses, respectively; de Maat et al., 2013](#)). The key difference here is intrapersonal conflict is central within classical perspectives (e.g., a drive-defence model) and post-classical views focus on developmental needs (e.g., to feel, loved, connected, appreciated, and protected). Despite marked differences between these theories, there are several key assumptions upon which they rest, including that (a) there are both conscious and unconscious aspects of mental life; (b) causality is a feature of both external events and processes in the psychic world; (c) experiences in early life contribute to the development of mental representations of relationships that are affectively coloured; (d) internal worlds shape responses to situations in the external world, and these experiences influence internal worlds; (e) in the context of therapy, the patient’s developmental history and present functioning must both be understood; and (f) in therapy, both developmental pathology and conflict pathology are being addressed, but the emphasis on each will vary between patients ([Lemma, 2003](#)).

The nomenclature commonly used in the research literature is largely dependent on the anticipated length of treatment ([de Maat et al., 2013](#)). The three treatment modalities (one short-term and two long-term) that are frequently described are: short-term psychoanalytic psychotherapy (STPP; sometimes referred to as short-term, or time-

limited psychodynamic psychotherapy), long-term psychoanalytic psychotherapy (LTPP; sometimes referred to as long-term psychodynamic psychotherapy), and psychoanalysis (sometimes referred to as psychoanalysis proper or couch analysis). The most common points of differentiation between LTPP and psychoanalysis are the positioning of the therapist and patient (in psychoanalysis the patient lies on a couch with the therapist sitting on a chair behind him or her, whereas in LTPP the patient and therapist sit on chairs facing each other) and the frequency of sessions (LTPP typically occurs once or twice per week, whereas psychoanalysis usually occurs two to five times per week). The goals of LTPP and psychoanalysis can also differ ([Huber, Henrich, Clarkin, & Klug, 2013](#)). Whereas psychoanalysis is an insight-oriented approach focused on restructuring representations of maladaptive relationships that underlie psychological disturbances, the work done in LTPP centres on here-and-now conflicts that serve to sustain psychological symptoms. If treatment is firmly grounded in orthodox approaches (e.g., Freud), the key focus is the interpretation of the unconscious, as is revealed in symptoms, parapraxes (e.g., slips of the tongue), reports of dreams, and so forth. Such approaches are also psychosexual, rather than psychosocial. The distinction between the short-term and long-term approaches is somewhat arbitrary, with LTPP typically defined as lasting at least 40 to 50 sessions over a year ([de Maat, de Jonghe, Schoevers, & Dekker, 2009](#); [Smit et al., 2012](#)). Some of these modalities have been being extended to provide additional options for therapists. Short-term psychoanalytic supportive psychotherapy, which combines psychoanalytic theory with supportive techniques, is an example of such an approach ([de Jonghe et al., 2013](#)).

Although psychotherapists, researchers, and writers generally refer to their work as being psychoanalytically – or psychodynamically – oriented, these terms are often used interchangeably in the research literature, and review articles tend to incorporate both modalities together in their syntheses (e.g., [Smit et al., 2012](#)). For this reason, the reader may also wish to refer to the review, commissioned by the PACFA, on the effectiveness of psychodynamic psychotherapy ([Gaskin, 2012](#)). One of the main conclusions from this review was that research evidence supports the use of psychodynamic psychotherapy for the treatment of depressive disorders, some anxiety disorders (especially generalised anxiety disorder), somatic symptoms and some somatoform disorders (e.g., hypochondriasis), and some personality disorders (primarily borderline and Cluster C personality disorders). The review also showed that gains made during psychodynamic psychotherapy typically endure beyond the completion of treatment. In comparison studies, psychodynamic psychotherapy was found to be generally superior to treatment as usual and of equivalent effectiveness to other psychotherapies. Given that the effectiveness of psychodynamic psychotherapy was reviewed in this report, the present review focuses on the effectiveness of treatments labelled as psychoanalysis or psychoanalytic psychotherapy.

The purpose of this paper is to present the findings of a literature review of recent international and Australian research on the effectiveness of psychoanalysis and psychoanalytic psychotherapy. In developing this review, specific attention was paid,

where possible, to different schools of psychoanalytic thought (specifically, Freudian, post-Freudian, Jungian, Lacanian, object relations, Kleinian, and child psychoanalysis).

## Method

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Given the breadth of the subject matter, a narrative review was most appropriate for synthesising the literature in this field. Consistent with current practices for conducting and reporting narrative reviews ([Gasparyan, Ayvazyan, Blackmore, & Kitas, 2011](#)), a search method to guide the selection of studies for this review was established and used. Using inclusion and exclusion criteria and providing information about the databases searched lends weight to the objectivity of the main messages and conclusions of this review.

## Search strategy

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Studies were identified through searching the following electronic databases: Academic Search Complete and PsycINFO. The review was focused on international and Australian research published in the last five years (i.e., 2009 to 2013). Limits were applied to language (English only) and publication type (periodicals, peer reviewed). The terms used in the search for recent studies were *psychoanaly\**, *outcome*, *effective\**, and *efficacy*. Studies conducted in Australia were identified from the papers obtained in this search. This search strategy is presented in Appendix A. The search was current as at 28 November 2013.

## Eligibility Criteria

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**Inclusion criteria.** Studies were included in this review if they reported the effect of psychoanalysis or psychoanalytic psychotherapy on at least one outcome of interest (i.e., affective, behavioural, or cognitive outcome measures). Systematic reviews, meta-analyses, randomised controlled trials, quasi-experimental studies, and descriptive studies were eligible for inclusion in this review. No restrictions were placed on studies with respect to the ages of participants.

**Exclusion criteria.** Studies in which the treatment was psychodynamic psychotherapy, rather than psychoanalysis or psychoanalytic psychotherapy, were excluded from the review. Studies, or findings within studies, were also excluded if psychoanalysis or psychoanalytic psychotherapy was initiated at the same time as other treatments (e.g., medications, other psychotherapeutic approaches), which could confound the results. Papers in which findings pertinent to this review were duplicated from other publications included in the review were excluded. Narrative reviews were also excluded from the review.

## Findings

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Of the 1,231 records retrieved from the two databases, 47 papers were identified as being potentially relevant to this review based on their titles and abstracts. Of these 47 papers, 21 were excluded from the review after obtaining and reading them. The most common reasons why papers were excluded at this point were that it was evident that they: (a) were discussion papers ( $n = 4$ ), (b) did not include information on the effectiveness of psychotherapies ( $n = 3$ ), (c) focused on psychodynamic, rather than psychoanalytic, psychotherapies ( $n = 3$ ), and (d) were study protocols ( $n = 3$ ). None of the included studies were conducted in Australia.

The 26 included studies focused on psychoanalysis ( $n = 6$  studies), long-term psychoanalytic psychotherapy ( $n = 14$ ), and short-term psychoanalytic psychotherapy ( $n = 13$ ). The numbers of studies in parentheses exceeds the total number of studies included in this review, because some studies used more than one type of psychotherapy.

## Psychoanalysis

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During the last 5 years, a systematic review ([de Maat et al., 2009](#)) and meta-analysis ([a method of quantitatively pooling the findings of relevant studies; de Maat et al., 2013](#)) provided tentative support for the use of psychoanalysis with patients presenting with complex mental disorders. The, more recent, meta-analysis included 14 studies (involving 603 adult patients) that were published between 1970 and 2011, including the Knekt et al. ([Knekt, Lindfors, Laaksonen, et al., 2011](#); [Knekt, Lindfors, Renlund, et al., 2011](#)) and the Berghout, Zevalkink et al. ([Berghout & Zevalkink, 2009](#); [Berghout, Zevalkink, Katzko, & de Jong, 2012](#)) studies, which met the selection criteria for the present review. The patients in the 14 studies had been diagnosed with comorbid Axis I and Axis II disorders, with depressive disorders (prevalence rates ranging from 39% to 100% between studies), anxiety disorders (39% to 100% between studies), and personality disorders (20% to 100%) being common. All patients received between 234 and 921 sessions of psychoanalysis, with the treatments lasting between 2.5 and 6.5 years. No indication was provided about which schools of psychoanalytic thought informed treatment.

Across all outcome measurements (i.e., measures of symptoms, personality, and psychosocial functioning), there was a mean average improvement of just over one pooled standard deviation ( $d = 1.27$ , 95% confidence interval [CI] [1.03, 1.50],  $p < .01$ ) between patients' pre-treatment scores and their scores at the termination of treatment ([de Maat et al., 2013](#)). The improvements on measures of symptoms ( $d = 1.52$ , 95% CI [1.20, 1.84],  $p < .01$ ) were similar to those for personality and psychosocial functioning ( $d = 1.08$ , 95% CI [0.89, 1.26],  $p < .01$ ). Follow up results published for five of the studies for periods of 1 to 3.5 years indicated that the improvements gained during treatment were maintained following termination of therapy. Of clinical importance, 77% of patients had scores under clinically defined cut-off criteria for symptom measures at termination and 62% had scored likewise for measures of personality and psychosocial functioning. There was no difference in outcomes achieved with respect to the frequency of sessions per week (two to three sessions versus three to five sessions).

Although these findings appear to strongly support the efficacy of psychoanalysis, the quality of the studies was variable ([de Maat et al., 2013](#)). One of the most significant limitations of these studies is that 13 of the 14 studies were conducted without a control condition. Also, analyses typically did not take into account patients who refused to participate (ranging from 13% to 40% in the four studies in which this information was reported) and those who dropped out (ranging from 3% to 33%). The design of these studies reduces the certainty that the psychoanalysis caused the observed changes. Other factors, such as the patients' maturation, may partially or fully explain the changes that occurred. Patients dropping out from therapy or refusing to participate in the studies may have also served to inflate the outcomes. The methodological issues apparent in these studies reduce the confidence that can be had in the validity of the study findings.

The findings of recent studies not included in these reviews (they were published outside the time frame used as part of the selection criteria) are also supportive of the efficacy of psychoanalysis ([Huber et al., 2013](#); [Salzer et al., 2010](#)). With patients who had a diagnosis of unipolar depression, Huber et al. found that both psychoanalytic (mean duration: 39 months; mean dose: 234 sessions) and psychodynamic (mean duration: 34 months; mean dose: 88 sessions) psychotherapies were effective in improving depressive and global psychiatric symptoms, personality functioning, and social relations post-treatment and at one-, two-, and three-year follow-up points. Similarly, Salzer et al. ([2010](#)) concluded that psychoanalytic psychotherapy was effective for treating people with depressive (77%), anxiety (45%), and personality (39%) disorders. On average, the treatment durations was 269.57 ( $SD = 84.91$ ) sessions, or about 3.5 years ( $M = 1274.16$  days;  $SD = 483.70$ ). Substantial reductions in the general amount of interpersonal problems were observed at the end of treatment (baseline to end of treatment:  $d = 1.37$ ) and at follow up (baseline to follow-up:  $d = 1.60$ ). The therapy was effective for all identified interpersonal subtypes ("Submissive", "Socially Avoidant", "Overly Nurturant", and "Exploitable").

One question that arises is what effect does psychoanalysis have on patients' lives, many years following the termination of therapy? This question has started to be answered in a case study that involved a 25-year follow up of a person who had received psychoanalysis as a child ([Tyson, 2009](#)). As an eight-year-old, Peter was severely disturbed and received psychoanalysis for his issues. During psychoanalysis, Peter was guided in exploring his anxieties and defences and labelled his feelings, which enabled Peter to gain some feelings of mastery. The writer speculated that the acquisition of these tools for mastery seemed to have stayed with Peter, helping him through some of the more difficult times in his life.

## **Long-Term Psychoanalytic Psychotherapy**

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Authors of a recent systematic review ([de Maat et al., 2009](#)) and a meta-analysis of randomised controlled trials ([Smit et al., 2012](#)) reached different conclusions about the effectiveness of LTPP. Whereas de Maat et al. concluded that LTPP was effective for a broad range of psychopathologies, Smit et al. questioned the validity of this finding on the basis that de Maat et al. had focused on the changes that had occurred between pre-

treatment and treatment termination, and not between LTPP and control conditions. That is, the de Maat et al. review did not account for the possibility that factors other than the therapy itself (e.g., maturation, life events) may have influenced the observed changes over time.

The de Maat et al. (2009) included 27 studies (involving 5,063 adult patients, 3,632 of whom had undergone LTPP) published between 1970 and 2007. In this review, no distinction was made between psychoanalytic and psychodynamic psychotherapies. Collectively, the studies showed that there had been large improvements on outcome measures between pre-treatment and treatment termination for patients with moderate or mixed pathology (defined as patients meeting the full range of “regular” indications for ambulatory LTPP, such as mood, anxiety, sexual dysfunction, and personality disorders; weighted mean effect size [ES] = 0.78) and this effect was maintained at follow up (ES = 0.94; mean duration = 3.2 years). The effect sizes were similar for patients with severe personality disorders, such as borderline personality disorder (pre/post ES = 0.94, follow up ES = 1.02). Therapists generally perceived that LTPP was successful at addressing symptoms ( $M = 69\%$  success rate, range = 30% to 95%), and personality-related issues ( $M = 57\%$  success rate, range = 49% to 79%). Patients’ perceptions of success were broadly consistent with those of their therapists. As mentioned, however, a limitation of this review was that the effectiveness of LTPP was not compared with any control conditions (e.g., alternative treatments, no treatment). This omission leaves the possibility that the successful outcomes may have been due to factors other than LTPP.

Smit et al. (2012) addressed this limitation through evaluation the effectiveness of LTPP in comparison to other treatments or no treatment. Eleven randomised controlled trials were included in their meta-analysis. These trials included patients with borderline personality disorder ( $n = 6$  trials), anxiety or depressive disorders ( $n = 2$ ), eating disorder or anorexia ( $n = 2$ ), and Cluster C personality disorders ( $n = 1$ ). The LTPP interventions were varied markedly between trials (e.g., self psychological treatment, mentalisation-based therapy, focal analytic psychotherapy), as were the comparison conditions (e.g., various psychotherapies, including schema-focused therapy, dialectical behaviour therapy, and cognitive therapy, as well as medication and outpatient treatment). With respect to recovery (the primary outcome, the risk difference at the longest available follow-up was 0.00 (95% CI [-0.17, 0.17],  $p = .96$ ), indicating no differences between the effectiveness of LTPP and alternative conditions. This limited difference was also evidence for secondary outcomes: target problems (Hedge’s  $g = -0.05$ , 95% CI [-0.55, 0.46],  $p = .86$ ), general psychiatric symptoms ( $g = 0.69$ , 95% CI [-0.19, 1.57],  $p = .13$ ), personality pathology ( $g = 0.17$ , 95% CI [-0.25, 0.59],  $p = .42$ ), social functioning ( $g = 0.20$ , 95% CI [-0.10, 0.50],  $p = .19$ ), overall effectiveness ( $g = 0.33$ , 95% CI [-0.31, 0.96],  $p = .32$ ), and quality of life ( $g = 0.37$ , 95% CI [-0.78, 0.04],  $p = .08$ ). Although these results do not appear favourable to LTPP, one of the problems with these analyses is that the comparison conditions in 7 of the 11 studies were other forms of psychotherapy, including psychodynamic psychotherapy. Inspection of the effect sizes for each of the 11 studies (Smit et al. did not report summary statistics) revealed that LTPP was equivalent to alternative specialised psychotherapies in 4 of 7 studies, and superior to no specialised

psychotherapy in 2 of 4 studies. Smit et al. also found that the quality of the studies was variable, which decreases confidence in the validity of the results. Ultimately, given the heterogeneity with LTPP protocols, control treatments, and study populations, it is difficult to derive firm conclusions about the effectiveness of long-term psychoanalytic psychotherapy with any confidence.

Studies of psychoanalytic psychotherapy using naturalistic designs have generally returned positive findings ([Lindgren, Werbart, & Philips, 2010](#); [Sugar & Berkovitz, 2011a, 2011b](#); [Vermote et al., 2009](#)). In providing hospital based psychoanalytic treatment for 70 patients with personality disorders, for example, Vermote et al. found that patient symptoms improved minimally during the first three months, improved considerably between the fourth and twelfth months, and sustained at these levels 12-month follow-up ( $d = 1.08$ , 95% CI [0.85, 1.32]). Although this result is impressive, a range of factors associated with treatment could have affected the outcome. For these patients, treatment involved (a) group and individual psychoanalytic psychotherapy, (b) nonverbal group therapies (music therapy, psychomotor therapy, and creativity therapy), (c) psychiatric consultation, (d) social work, (e) group and individual sessions with nurses, and (f) patient-staff meetings. Because all of these aspects of treatment (and, possibly, additional factors) may have contributed to the positive outcomes, it is uncertain what the specific effect of psychoanalytic psychotherapy may have been (i.e., the internal validity of the study was compromised).

In the Lindgren et al. ([2010](#)) study, the researchers investigated the effects of individual and group psychoanalytic psychotherapy for young adults. Consistent with the traditions of child and adolescent psychopathology, the psychoanalytic psychotherapy was focused on this transitional period between adolescence and young adulthood, rather than any particular psychiatric diagnoses. The researchers endeavoured to strengthen their naturalistic design through assessing factors that may reasonably be expected to influence the study outcomes, thus increasing the certainty with which the observed outcomes could be attributed to psychoanalytic psychotherapy. Treatment ranged in duration from 1 to 55 months ( $M = 19$ ,  $SD = 14$ ). The findings showed large improvements on symptom measures ( $ES = 1.27-1.33$  for three measures) and more modest improvements on personality measures ( $ES = 0.32-0.80$  for three measures) between intake and termination. These gains were maintained at follow up. Lower therapist-rated alliance was associated with greater changes in psychiatric symptoms, indicating that the therapists may have identified problematic interactions and made efforts to solve the issues that had manifested.

Two studies have shown that psychoanalytic psychotherapy may have enduring effects on adolescents who receive this type of treatment ([Sugar & Berkovitz, 2011a, 2011b](#)). In one of these studies, for example, three females who had met the DSM III criteria for borderline personality disorder during adolescence completed questionnaires 15 to 30 years after their initial psychotherapeutic contact ([Sugar & Berkovitz, 2011b](#)). The findings showed that all women had (a) completed the developmental tasks associated with adolescence, (b) met criteria for being in remission, and (c) had fulfilling, successful adult

lives. The women were not entirely free of psychopathology, however. Sugar and Berkovitz (2011a) reported similar findings for their case series of eight men treated with psychoanalytic psychotherapy. All men had completed the developmental tasks associated with adolescence, but their adult outcomes were mixed. Those who the researchers deemed to be doing well in adulthood also had good therapeutic alliances during adolescent psychotherapy, whereas those who were doing less well had weaker relationships with the therapist during treatment, were less introspective, and had more severe psychopathology and physical illness during adolescence.

## Short-Term Psychoanalytic Psychotherapy

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Few randomised controlled trials on the effectiveness of short-term psychoanalytic psychotherapy were identified in the search (Faramarzi et al., 2013; Salomonsson & Sandell, 2011a, 2011b). One trial with 49 patients who had functional dyspepsia showed that brief psychoanalytic psychotherapy (16 sessions over 4 months using the core conflictual relationship theme method; Book, 1998) was superior to usual medical treatment in improving gastrointestinal symptoms (heartburn, nausea, fullness, bloating, and upper and lower abdominal pain) and many psychological symptoms (mature defences, neurotic defences, immature defences, difficulties in identifying feelings, and difficulties in describing feelings), and alexithymia (Faramarzi et al., 2013). Although this finding seems to support the efficacy of brief psychoanalytic psychotherapy in the treatment of functional dyspepsia, the researchers suggested that another plausible explanation for the differences between the two conditions was that participants in the experimental condition simply received more treatment (i.e., medical treatment plus psychotherapy) than those in the control condition.

A second randomised controlled trial investigated the efficacy of psychoanalytic treatment with mothers who had infants aged less than 18 months (Salomonsson & Sandell, 2011a, 2011b). Each of the 75 mothers had expressed significant concerns (lasting > 2 weeks) regarding one or more of the following: (a) herself as a mother, (b) her infant's well-being, or (c) her relationship with her infant. The participants were randomly assigned to receive either psychoanalytic treatment plus Child Health Centre care or Child Health Centre care alone (i.e., treatment as usual). Standardised mean-change scores were statistically significant and in favour of psychoanalytic psychotherapy for improving postnatal depression (Becker's  $\delta = 0.57$ ) and mother-baby relationships ( $\delta = 0.84$ ), but not statistically significant for infant social and emotional functioning ( $\delta = 0.25$ ). Mother's suitability for psychoanalysis predicted improvements in mother-baby relationships. Superior effects of psychoanalytic psychotherapy were observed in mothers who wanted to take an active part in therapy and perceived that they had somehow contributed to present problems, with infants affected by the relationship disturbances.

Quasi-experimental studies on the effectiveness of short-term psychoanalytically-oriented psychotherapy have provided mixed results (Deakin & Nunes, 2009; Nanzer et al., 2012; Tonge, Pullen, Hughes, & Beaufoy, 2009). In the Deakin and Nunes study, the authors concluded that a 12-month psychoanalytic psychotherapy intervention was effective for the treatment of female children (6 to 11 years) with internalising disorders. Close



examination of the results, however, suggests that the findings are unclear. First, the authors did not perform statistical analyses comparing children in the treatment and control conditions while accounting for differences in baseline scores. Second, the change scores for children in both conditions were similar. Third, the actual changes within conditions, relative to the variation within these conditions, were quite modest.

In the Tonge et al. (2009) study, patients attending a Child and Adolescent Mental Health Service were offered psychoanalytic psychotherapy when psychotherapists became available. Those who accepted the offer received psychoanalytic psychotherapy received therapy once or twice weekly for 4 to 12 months. Almost two-thirds of participants (64%) had multiple Axis I diagnoses, with more adolescents in the psychotherapy condition having multiple Axis I diagnoses than those in the treatment as usual condition (91% vs 45%). Parent-child relational problems were the most common secondary diagnosis ( $n = 13$ ). At 12 months, greater reductions in depressive ( $\eta^2 = .16$ ) and attention ( $\eta^2 = .10$ ) issues for participants in the psychotherapy condition than for those receiving treatment as usual. Although these results seem to indicate the clear benefit of psychotherapy, two major confounding factors need to be kept in mind. First, the participants in the two conditions had different diagnostic profiles. Second, there was substantial dropout, with 17 of 40 adolescents assigned to psychotherapy not engaging in the treatment, and 25 of 80 adolescents not completing the 12-month assessment (one of whom received therapy). These factors may have distorted the findings.

A pilot study of a brief psychoanalytic intervention (four sessions) with pregnant women presenting with depressive symptoms has shown promising results (Nanzer et al., 2012). This intervention was based on Cramer and Palacio Espasa's manual of mother-infant therapy (see Cramer, 1995). The participants in the treatment condition experienced a substantial reduction in depressive symptoms. That is, 78% of the women in the treatment condition had clinically-relevant scores pre-intervention, but no such scores were observed post-intervention. The post-intervention scores for women in the treatment condition were similar to those women in the control condition, who did not have depressive symptoms. The mother-infant relationships of those who received treatment were also well adapted by the termination of the intervention.

Brief psychoanalytic psychotherapy (four to eleven sessions) with children under 5 years and their families appears to have produced positive results (Pozzi-Monzo, Lee, & Likierman, 2012). The psychotherapy was informed by the work of several authors, including Klein (1926-1961), Winnicott (1941), Bion (1962), and Fraiberg et al. (1975). Parents of six of the seven children who presented at a Child and Adolescent Mental Health Service, and underwent brief psychoanalytic psychotherapy, reported that their children had exhibited a marked reduction or termination of the symptoms that had originally resulted in their referral to the service (e.g., eating disorders, sleeping difficulties, and toilet training issues).

In a case study, Adamo and de Cristofaro (2011) described the psychotherapy provided for an adolescent boy in a paediatric hospital who had refused medical treatment. The refusals came after his body was severely damaged during medical treatments. In

psychotherapy, several meanings of his refusal were identified, and included his wish to regain control over his body and life, anger towards adults whom he perceived as dangerous and incompetent, depressed and self-attacking parts, and his defences against primitive anxieties of melting. Parallel to the efforts of the medical staff, a psychotherapeutic relationship was established, within which work was undertaken to decrease the risk of splitting and acting out. This psychotherapy enabled the boy to continue his treatment, which was ultimately successful, and his developmental process.

## **Comparison between Psychoanalysis and Psychoanalytic Psychotherapies**

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There has been limited work comparing the effectiveness of psychoanalysis and different forms of psychoanalytic psychotherapies ([Huber et al., 2013](#); [Knekt, Lindfors, Laaksonen, et al., 2011](#)). In one such study, Knekt, Lindfors, Laaksonen et al. (2011) found that psychoanalysis, LTPP, and STPP were all effective in reducing the symptoms associated with mood and anxiety disorders, as well as improving work ability and functional capacity, in 326 psychiatric outpatients. The relative superiority of one type of psychotherapy over the others seemed closely tied to when assessments took place. The STPP (20 sessions over 20 weeks) was shown to be most effective during the first year, the LTPP (2 to 3 times per week over approximately 3 years) yielded superior outcomes at the 3 year point, and psychoanalysis (4 times per week over approximately 5 years) generated better outcomes at 5 years. Although STPP and LTPP arguably achieved benefits more quickly than psychoanalysis, Knekt, Lindfors, Renlund, et al. (2011) found that the need for auxiliary treatments (e.g., additional psychotherapy, psychotropic medication, or hospitalization) was greater for outpatients who received STPP or LTPP, especially during the first year after the commencement of psychotherapy. In a second study, psychoanalytic psychotherapy was superior to psychodynamic psychotherapy in the treatment of unipolar depression ([Huber et al., 2013](#)). The average duration of treatments, in this study, were similar (39 months versus 34 months for psychoanalytic psychotherapy and psychodynamic psychotherapy, respectively), but substantially more psychoanalytic psychotherapy sessions were provided (234 versus 88 sessions). Perhaps the greater frequency of sessions was one factor that contributed to the lower need for auxiliary treatments for those assigned to receive psychoanalysis in the Knekt, Lindfors, Renlund, et al. study and the superior treatment outcomes in the Huber et al. study.

## **Mechanisms of Change**

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Some work has been undertaken to investigate mechanisms of change in psychoanalytic psychotherapy (e.g., [Palmstierna & Werbart, 2013](#); [Stefini et al., 2013](#); [Taubner, Kessler, Buchheim, Kächele, & Staun, 2011](#)). In one study, Palmstierna and Werbart (2013) investigated the experiences of the therapeutic process and outcomes of 11 young adult outpatients, with whom long-term therapeutic success had been achieved. Common issues among these young adults included depressive mood, anxiety, problems in their relationships with parents, and low self-esteem. The material from the interviews indicated that several in-therapy factors (appreciating the therapist's way of working and

the therapeutic relationship, feeling safe due to continuity and therapeutic frames, and experiencing and overcoming obstacles in therapy), helpful factors in patients' everyday lives (getting support outside of therapy and in close relationships), and positive impacts and experienced changes (managing strains in life, feeling stronger and more confident, becoming reconciled with oneself and one's past, acting differently, reflecting and gaining insight, and applying experiences from therapy after termination) were perceived to have contributed to the successful outcomes.

Stefini et al. (2013) investigated the effect of attachment style on the outcomes of manualised, long-term psychoanalytic psychotherapy (Hartmann, Horn, Winkelmann, Geiser-Elze, & Kronmüller, 2001) with children and adolescents with a broad range of mental disorders. Over the course of treatment, the severity of the patients' impairments substantially improved ( $ES = 1.95$ ). Although the percentage of patients with secure attachments increased from 23% to 63% during psychotherapy, there was no significant difference between the attachment styles of those with good and poor therapeutic outcomes. There was a modest correlation ( $r = -.25$ ) between the number of therapy sessions and secure attachment behaviour, however, which contributed to the researchers' conclusion that attachment style may be a mediator, rather than a moderator, of treatment outcomes.

## Discussion

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Given that psychoanalysis, psychoanalytic psychotherapies, and psychodynamic psychotherapies share the same theoretical principles and many of the same techniques (Huber et al., 2013), it is suggested that this review is read in conjunction with *The effectiveness of psychodynamic psychotherapy: A systematic review of recent international and Australian research* (Gaskin, 2012), previously compiled for PACFA. Although the information on psychoanalysis is unique to the present review, findings on the effectiveness of the long- and short-term psychotherapies can be found in both reviews. Because researchers have typically preferred the term *psychodynamic* over *psychoanalytic* when describing their long- and short-term psychotherapies, more robust findings on the effectiveness of these types of psychotherapy is provided in the previous review. In this Discussion section, the findings of the previous review will be drawn upon to add depth to the conclusions.

Before discussing the effectiveness of psychoanalysis and psychoanalytic psychotherapy, a brief comment on research in this area is warranted. Despite the origins of psychoanalysis and psychoanalytic psychotherapy dating back to the late 1800s, the research base on the effectiveness of these treatments is rather limited. In the introduction to their paper, Busch et al. (2009) outlined several of the reasons why the amount of research generated in this area has been relatively poor. These reasons include (a) the difficulties of conducting randomised controlled trials over the long-term with treatments that address a broad range of issues, and (b) the beliefs held among some psychoanalysts that (i) clinical experience had already demonstrated the effectiveness of psychoanalytic psychotherapies, (ii) psychoanalytic concepts are too

complex to study systematically, (iii) research protocols disrupt treatment, and (iv) treatments are unable to be manualised and adherence to such manuals are impossible to assess. Although a review of the merits of these arguments is not needed here, it suffices to say that such lines of thought may help to explain why more research has not been conducted.

The comments about the relatively limited amount of research that has been conducted perhaps apply most strongly to the study of psychoanalysis. In the most recent meta-analysis ([de Maat et al., 2013](#)), only 14 studies were identified as having been conducted over a 42-year period (1970 to 2011). Although these studies showed that psychoanalysis was consistently associated with clinically meaningful, positive changes in symptoms, personality, and psychosocial functioning for people with a broad range of depressive, anxiety, and personality disorders, the methodological weaknesses of these studies means that it is impossible to rule out the possibility that the reported improvements could have occurred without psychoanalysis. Thus, only tentative support for the effectiveness of psychoanalysis can be drawn from the literature.

Three main conclusions can be drawn from the literature on the effectiveness of long-term psychoanalytic psychotherapy. First, from comparisons of pre- and post-treatment scores on pertinent outcome measures, meaningful improvements have been observed for people with a range of conditions, most notably mood, anxiety, sexual dysfunction, and personality disorders. This conclusion is broadly consistent with the findings of the previous review ([Gaskin, 2012](#)), in which it was found that psychodynamic psychotherapy was effective for the treatment of depressive disorders, some anxiety disorders (especially generalised anxiety disorder), somatic symptoms and some somatoform disorders (e.g., hypochondriasis), and some personality disorders (primarily borderline and Cluster C personality disorders). Second, the effectiveness of long-term psychoanalytic psychotherapy seems to be equivalent to other psychotherapies. Again, this conclusion is in line with previous studies in which psychotherapeutic interventions have been shown to have comparable benefits (e.g., [Barth et al., 2013](#); [Gaskin, 2012](#)). Third, the effects of long-term psychoanalytic psychotherapy endure following the termination of therapy. In many instances, the effects of long-term psychoanalytic psychotherapy may endure for several decades ([Sugar & Berkovitz, 2011a, 2011b](#)). This conclusion is also consistent with findings on psychodynamic psychotherapy ([Gaskin, 2012](#)).

A strength of the recent research on the effectiveness of short-term psychoanalytic psychotherapy is that studies have been conducted in a range of settings, including mental health services, paediatric wards, and private practice. The studies of the effectiveness of short-term psychoanalytic psychotherapy yielded unclear results, however. Although the results of all the studies on short-term psychoanalytic psychotherapy reported that the treatments were effective, deeper reading of how the studies were conducted and how the findings were derived raises questions as to whether a broad range of confounding variables may have influenced the outcomes. The fact that these findings are broadly consistent with, more tightly controlled studies on the

effectiveness of short-term psychodynamic psychotherapy (e.g., [Abbass, Kisely, & Kroenke, 2009](#); [Abbass, Town, & Driessen, 2011](#); [Driessen et al., 2010](#)), however, may lend weight to claims that short-term psychoanalytic psychotherapy is effective.

Notwithstanding the relatively limited amount of research that has been conducted on psychoanalysis, perceptions that psychoanalytic/psychodynamic psychotherapies lack empirical support may be exaggerated ([Shedler, 2010](#)). Biases in the dissemination of research findings may be partly to blame for this incongruence between perceptions and evidence. Shedler argued that, in decades gone by, the medical establishment's denial of psychoanalytic training for non-medical doctors and their dismissive stance towards research created a lingering distaste among mental health professionals. A consequence of this period of dominance was that research supporting the efficacy of non-psychoanalytic approaches was widely discussed and disseminated. In contrast, research supporting the efficacy of psychoanalytic and psychodynamic approaches seems to have been largely overlooked. This review will hopefully contribute to facilitating a more balance perspective about the efficacy of psychoanalytic psychotherapies.

One of the objectives of this review was to pay particular attention to the different schools of psychoanalytic thought. Unfortunately, in most of the papers included in this review, researchers did not include such information. In one study ([Pozzi-Monzo et al., 2012](#)), the researchers mentioned that the psychotherapy was informed by the works of Klein ([1926-1961](#)), Winnicott ([1941](#)), Bion ([Bion, 1962](#)), and Fraiberg et al. ([1975](#)), and in several other studies (e.g., [Faramarzi et al., 2013](#); [Nanzer et al., 2012](#); [Stefini et al., 2013](#)) the researchers referred therapists using treatment manuals to guide their work (e.g., [Book, 1998](#); [Cramer, 1995](#); [Hartmann et al., 2001](#)). Given this very limited amount of detail in the papers, no conclusions can be reached about the effectiveness of treatments from different schools of psychoanalytic thought. Any claims about the effectiveness of psychotherapy using one school of psychoanalytic thought over another, therefore represent personal biases rather than evidence-based positions.

A limitation of the literature is that the terms *psychoanalytic* and *psychodynamic* are often used interchangeably. Although it is debatable whether psychoanalytic and psychodynamic theories are one and the same, and differences may exist in the training of therapists in each of these treatment modalities, researchers often tend to treat them as one and the same (e.g., [Smit et al., 2012](#)). At this point in time, therefore, no conclusions can be drawn about the relative effectiveness of psychoanalytic and psychodynamic psychotherapies, which means there are no reasons for privileging one over the other.

Although the literature reviewed broadly supports the effectiveness of psychoanalysis and psychoanalytic psychotherapy for the treatment of several conditions, one pertinent issue is whether these therapies remove the need for additional treatment. This question has not been, thus far, adequately addressed in the psychotherapeutic literature, but the recent Knekt, Lindfors, Renlund, et al. ([2011](#)) research suggests that auxiliary treatment is sometimes needed to produce lasting recovery (or, at least, to reduce the need for further treatment). In their study of psychiatric outpatients, most of whom had mood or anxiety

disorders, patients who were randomised to the short-term psychodynamic psychotherapy condition received an average of 19 sessions of short-term psychodynamic psychotherapy and an additional 51 sessions of auxiliary treatment (psychotropic medication, further psychotherapy, hospitalisation); those randomised to the long-term psychodynamic psychotherapy condition received an average of 232 sessions of long-term psychodynamic psychotherapy and an additional 8 sessions of auxiliary treatment; and those who self-selected for psychoanalysis received an average of 646 sessions of long-term psychodynamic psychotherapy and an additional 24 sessions of auxiliary treatment. The use of auxiliary treatment was more common among recipients of short-term psychodynamic psychotherapy (74%) than for those who received long-term psychodynamic psychotherapy (56%) or psychoanalysis (40%). Although the longer versions of psychotherapy may produce better outcomes ([Knekt, Lindfors, Laaksonen, et al., 2011](#)) and less requirement for auxiliary treatment ([Knekt, Lindfors, Renlund, et al., 2011](#)), shorter versions of psychotherapy with auxiliary treatments may be more cost effective (i.e., fewer sessions are needed, overall, to produce satisfactory outcomes). Further work in this area, however, is clearly needed to ascertain the most clinically- and cost-effective methods of treatment.

One feature of the research literature on psychoanalysis and psychoanalytic psychotherapy is that DSM criteria are sometimes used as part of participant selection procedures. Given the misfit between psychoanalytic formulations of psychopathologies and the categories of the DSM ([Ingram, 1981](#)), decisions to use DSM categories as part of selection criteria seem misguided. Psychoanalytically-oriented practitioners typically regard DSM diagnostic categories as insufficient for making complete diagnoses and deciding upon treatment options ([de Maat et al., 2013](#)). Moreover, many practitioners may be reluctant to offer diagnoses, with the view that doing so adds little value, or could even be detrimental, to their work ([Bernardi, 2013](#)). Although the use of DSM criteria may assist in the scientific comparison of alternative treatments and in the communication of evidence with the broader mental health field, researchers should more readily acknowledge the limitations of DSM criteria in their work. When the efficacy of psychoanalytically-based treatments are being studied, psychoanalytic diagnoses should be used instead of, or in addition to, other diagnostic categories.

## **Implications for Practitioners**

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Given the extent to which psychoanalytic and psychodynamic psychotherapies are considered similar, it makes sense to develop implications using both sets of literature. Therefore, the implications presented here draw on the findings of both this review and the one on the effectiveness of psychodynamic psychotherapy ([Gaskin, 2012](#)). In terms of short- and long-term psychoanalytic/psychodynamic psychotherapies, the evidence supports their use in the treatment of mood disorders (in particular, depressive disorders), some anxiety disorders (especially generalised anxiety disorder), somatic symptoms and some somatoform disorders (e.g., hypochondriasis), sexual dysfunctions, and some

personality disorders (primarily borderline and Cluster C personality disorders). With respect to psychoanalysis, research evidence provides tentative support for its use to treat some depressive, anxiety, and personality disorders.

The findings that (a) psychoanalysis and the psychoanalytic/psychodynamic psychotherapies seem to be of equivalent effectiveness to other psychotherapies, (b) factors other than the theoretical paradigms and associated techniques used in practice seemed to influence outcomes, and (c) the high dropout rates recorded in some psychoanalysis and psychoanalytic/psychodynamic psychotherapy studies (e.g., [de Maat et al., 2013](#); [Tonge et al., 2009](#)) draw attention to the work on common factors ([see, for example, Duncan, Miller, Wampold, & Hubble, 2010](#)). The apparent equivalence of psychotherapies in the research reviewed lends support for the Dodo bird verdict ([Rosenzweig, 1936](#)), which is the notion that all psychotherapies have equal effectiveness. This conclusion is reached, however, in full awareness that the Dodo bird verdict is the subject of substantial controversy in psychology, with positions for and against its validity being vigorously put forward ([Budd & Hughes, 2009](#); [Hunsley & Di Giulio, 2002](#); [Luborsky et al., 2002](#); [Westmacott & Hunsley, 2007](#)). In terms of the research presented in this review, the limited number of rigorously-designed comparison studies means that firm conclusions about the relative superiority or inferiority of psychoanalysis and psychoanalytic psychotherapies cannot be made at this time.

Early evidence suggests that factors other than the theoretical paradigms and associated techniques used in practice (e.g., the quality of therapeutic relationships, supportive factors in patients' lives) contribute to successful outcomes ([Palmstierna & Werbart, 2013](#)). If these results were replicated on a larger scale, it would advance the thesis that common factors underpin therapeutic outcomes rather than specific therapies. Support for common factors does not negate the importance of theoretical orientations (indeed, they are a necessary ingredient of successful psychotherapy), but highlights the importance of other aspects of therapy, such as the healing setting, the therapeutic relationship, and the cogency of the rationale for the treatment approach and its acceptance by the patient ([Anderson, Lunnen, & Ogles, 2010](#)).

The high dropout rates recorded in some psychoanalysis and psychoanalytic psychotherapy studies (e.g., [de Maat et al., 2013](#); [Tonge et al., 2009](#)) should be a finding of concern. Although there may be many reasons for patients to terminate therapy prematurely, an inescapable deduction is that many of these *dropouts* represent treatment failures. One notable reason why many clients may drop out of psychotherapy is because they find the treatment rationales and techniques unacceptable ([Anderson et al., 2010](#)). Such circumstances may occur more often in psychotherapy research, where therapists often do not have the freedom to tailor manualised offerings in ways that will be acceptable to patients. The lesson here is that practitioners need to be alert to expressions of resistance to treatment and be flexible in their approaches. Another reason why patients may discontinue therapy is because of problems with the therapeutic relationship (e.g., [Garcia & Weisz, 2002](#)). Such a finding emphasises the importance of developing rapport and focusing on agreed goals during therapy.

## Conclusions

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The key objective of psychotherapy research is to establish what works. Meeting this objective requires a considerable amount of effort to be applied to designing and conducting high-quality studies. For a variety of reasons, the impetus to perform this work with psychoanalytic psychotherapy (especially in the case of psychoanalysis) does not seem to have been that strong. Evidence is building, however, that short- and long-term psychoanalytic/psychodynamic psychotherapies are effective for treating a broad range of mental health conditions. Tentative support is also available for psychoanalysis as effective in the treatment of these conditions. More concerted effort from the research community is required to solidify the evidence base on the effectiveness of psychoanalysis and psychoanalytic psychotherapy.

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## Appendix A

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Search strategy for recent studies: Academic Search Complete and PsycINFO (EBSCOhost)

01. psychoanaly\*

02. outcome

03. effective\*

04. efficacy

05. 2 or 3 or 4

06. 1 and 5

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