The effectiveness of psychodynamic psychotherapy:

A systematic review of recent international and Australian research

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Psychotherapy & Counselling Federation of Australia

Suggested citation:
Gaskin, C. (2012), *The Effectiveness of psychodynamic psychotherapy: A systematic review of recent international and Australian research.* Melbourne: PACFA.

Acknowledgments:
The review was generously funded by an anonymous philanthropic body.

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Foreword

This document is a literature review of research into the effectiveness of psychodynamic psychotherapy, intended as a resource for counsellors and psychotherapists. It was written on behalf of the PACFA Research Committee. However, this does not imply that PACFA or its Member Associations endorses any of the particular treatment approaches described. It demonstrates the effectiveness of psychodynamic psychotherapy, as described recently by the American Psychological Association:
http://www.apa.org/news/press/releases/2012/08/resolution-psychotherapy.aspx

The PACFA Research Committee recognises that it is important to counsellors and psychotherapists that they have access to recent research evidence that demonstrates the effectiveness of different therapeutic approaches, to assist them in their practice. This document is one of a series of reviews that has been commissioned by the PACFA Research Committee to support its Member Associations in their work.

The PACFA Research Committee endorses the American Psychological Association's definition of evidence-based practice as 'the integration of the best available research evidence with clinical expertise in the context of patient characteristics, culture and preferences', although we would prefer to use the word client or consumer rather than 'patient'.

The PACFA Research Committee recognises that there is overwhelming research evidence to indicate that, in general, counselling and psychotherapy are effective and that, furthermore, different methods and approaches show broadly equivalent effectiveness. The strength of evidence for effectiveness of any specific counselling and psychotherapy intervention or approach is a function of the number, independence and quality of available effectiveness studies, and the quality of these studies is a function of study design, measurements used and the ecological validity (i.e. its approximation to real life conditions) of the research.

The PACFA Research Committee acknowledges that an absence of evidence for a particular counselling or psychotherapy intervention does not mean that it is ineffective or inappropriate. Rather, the scientific evidence showing equivalence of effect for different counselling and psychotherapy interventions justifies a starting point assumption of effectiveness.

It should be noted that this review is limited in its scope and covers the more popular forms of psychodynamic psychotherapy including short-term psychotherapy, long-term psychotherapy, intensive short-term dynamic psychotherapy, short-term psychodynamic supportive psychotherapy, and supportive-expressive psychotherapy. It examines the types of mental health issues that psychodynamic psychotherapy is effective in treating.

The PACFA Research Committee is committed to supporting our Member Associations and Registrants to develop research protocols that will help the profession to build the evidence-base to support the known effectiveness of counselling and psychotherapy. We hope that you will find this document, and others in this series, useful. We would welcome your feedback.

Dr Sally Hunter
Chair of the PACFA Research Committee, 2012

Contents

Abstract

The purpose of this research was to determine the effectiveness of psychodynamic psychotherapy, both generally and in Australian settings. A systematic review of recent (last five years) and Australian (last 10 years) papers using MEDLINE Complete and PsycINFO was performed. For the review of recent literature, 59 papers (56 studies) met the inclusion criteria. The search for Australian literature identified four papers on one quasi-experimental study. Research 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). Improvements made through psychodynamic psychotherapy typically endure beyond the completion of treatment. Psychodynamic psychotherapy is generally superior to treatment as usual and equivalent to other psychotherapies.

Literature Review

Introduction

In Australia (Pelling, 2005; Schofield, 2008), as well as internationally (Aldridge & Pollard, 2005), it is common for counsellors and psychotherapists to use psychodynamic approaches in their work with clients. The findings from a survey of professional and clinical members of the 41 Psychotherapy and Counselling Federation of Australia member associations, for example, showed that 30% of respondents regarded psychodynamic approaches as being their primary theoretical orientation (Schofield, 2008). With the significant use of psychodynamic approaches, it is necessary to keep psychotherapists up to date with current evidence of the efficacy of these approaches.

Psychodynamic psychotherapy focuses on those aspects of self that may be unknown (i.e., unconscious processes), especially as they manifest in therapeutic relationships (Shedler, 2010). Distinguishing techniques and processes of psychodynamic psychotherapy include: (1) focusing on affect and the expression of the clients' emotions; (2) exploring clients' attempts to avoid topics or engage in activities that the obstruct therapeutic progress; (3) identifying patterns in actions, thoughts, feelings, experiences, and relationships; (4) emphasising past experiences; (5) focusing on interpersonal experiences; (6) placing an emphasis on the therapeutic relationship; and (7) exploring dreams, wishes, or fantasies (Blagys & Hilsenroth, 2000).

Psychodynamic psychotherapy refers to a range of treatments with similar theoretical underpinnings and methods. Specific treatments that have attracted the attention of researchers in recent years include: short-term psychodynamic psychotherapy (STPP; Malan, 1976; Malan & Osimo, 1992), long-term psychodynamic psychotherapy (LTPP; Gabbard, 2004), intensive short-term dynamic psychotherapy (Davanloo, 1990, 2000), short-term psychodynamic supportive psychotherapy (de Jonghe, 2005), and supportive-expressive psychotherapy (Barber & Crits-Christoph, 1995; Luborsky, 1984). In Australia, researchers have been especially interested in investigating the effectiveness of the conversational model (CM; Hobson, 1985; Meares, 2000, 2004) in the treatment of borderline personality disorder.

The purpose of this paper is to present the findings of a systematic review of recent and Australian research into the effectiveness of psychodynamic psychotherapy. With respect to each of the two bodies of literature (i.e., recent studies and Australian studies), the specific aims of this review were to determine:

(a) the effectiveness of psychodynamic psychotherapy,
(b) whether the effects of psychodynamic psychotherapy endure following the termination of treatment, and
(c) the effectiveness of psychodynamic psychotherapy in comparison to other treatments.

Method

The structure and contents of this paper is consistent with current guidance for reporting systematic reviews of studies that evaluate healthcare interventions (Liberati et al., 2009).

Information Sources

Studies were identified through searching the following electronic databases: MEDLINE Complete (1857-) and PsycINFO (1800-). The review of recent research focused on papers published in the last five years (i.e., 2007 onwards), whereas the review of Australian literature was concentrated on studies published during the last 10 years (i.e., 2002 onwards). Limits were applied to language (English only) and publication type (periodicals, peer reviewed). The terms used in the search for recent studies were *psychodynamic*, *insight-oriented therapy*, *self-psychology*, *conversational model*, *intersubjectivity*, *study*, *studies*, and *trial** . The terms used in the search for Australian studies were those used in the search for recent studies with the addition of the term *Australia*. These search strategies are presented in Appendix 7. The search was current as at 8 August 2012.

Eligibility Criteria

Inclusion criteria

Studies were included in this review if they reported the effect of psychodynamic psychotherapy on 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

Psychoanalysis and therapies described as being psychoanalytically-oriented were excluded from the review. Studies, or findings within studies, were also excluded if psychodynamic psychotherapy was initiated at the same time as other treatments (e.g., medications, other psychotherapeutic approaches). Papers in which findings pertinent to this review were duplicated from other publications included in the review were excluded. Narrative reviews and case studies were excluded from the review.

Study Selection and Data Extraction

The author performed the eligibility assessment of the studies in an unblinded, standardised manner. The following data were extracted from papers that met the eligibility criteria: study authors, year of publication, study design, intervention name, intervention duration, intervention characteristics, number of participants, participant characteristics, outcome measures, comparison conditions, intervention effectiveness, intervention effectiveness relative to comparison conditions, follow up length of time, number of participants at follow up, intervention effectiveness at follow up, intervention effectiveness relative to comparison conditions at follow up.

Data Analysis

Descriptive statistics pertaining to (where possible) the primary outcome measures of each study were extracted. In studies with more than one follow up point, the statistics for the final follow up point have been reported. Effect sizes for the differences between treatments and differences between time points are reported (e.g., Cohen's *d*, η^2). When these statistics were not reported in the original papers, they were calculated using the statistics available (e.g., *M*, *SD*, *t*, *n*). With respect to differences between time points, it is preferable to adjust Cohen's *d* values for the potentially large correlations between repeated measures (Dunlap, Cortina, Vaslow, & Burke, 1996). Given that researchers rarely report these correlations, however, an acceptable alternative is to use means and standard deviations provided to estimate effect sizes. In the social sciences, guidelines for small, medium, and large effect sizes for *d* are 0.2, 0.5, and 0.8, and for η^2 are .01, .06, and .14, respectively (Cohen, 1988). Whenever possible, levels of statistical significance were also extracted from the papers.

Findings

The findings from the reviews of recent and Australian literature are presented separately.

Review of Recent Literature

Of the 1,343 records retrieved from the two databases, 59 papers met the eligibility criteria to be included in this review (see Figure 1).

Systematic reviews and meta-analyses

During the search, four combined systematic reviews and meta-analyses, nine meta-analyses, and eight systematic reviews were found. Summaries of the papers with meta-analyses are presented separately (see Table 1) from those in which only systematic reviews are reported (see Table 2). Collectively, the findings from these reviews demonstrate that psychodynamic psychotherapy, in various forms, is effective in the treatment of mood disorders (mainly depressive disorders), some anxiety disorders (mainly generalised anxiety disorder), somatic symptoms and somatoform disorders, and some personality disorders (mainly borderline and Cluster C personality disorders). Cluster C includes obsessive-compulsive, avoidant, and dependent personality disorders (American Psychiatric Association, 2000). There is also evidence from a limited number of studies that psychodynamic psychotherapy can be effective in the treatment of eating disorders, post traumatic stress disorder, and some substance-related disorders (alcohol dependence**,** opiate dependence). Longer forms of psychodynamic psychotherapy may be more effective than short forms for the treatment of depression, anxiety, and general psychiatric symptoms.

The evidence suggests that the effects of psychodynamic psychotherapy may endure after the termination of treatment. When follow up measurements have been included in studies,

there have generally been minimal changes in depression, mood, general psychopathy, and interpersonal functioning scores between the conclusion of treatment and follow up.

Psychodynamic psychotherapy is superior to treatment as usual (TAU) and of equivalent effectiveness to other psychotherapies in the treatment of several conditions (depressive disorders, in particular). Some evidence, however, suggests that cognitive behavioural therapy (CBT) may be slightly more effective than psychodynamic psychotherapy for various conditions.

Randomised controlled trials

From the search, 20 papers reporting on 18 randomised controlled trials (RCTs) that met the eligibility criteria were retrieved (see Tables 3 and 4). In 17 of these studies, the efficacy of individual psychodynamic psychotherapy was investigated, with group therapy evaluated in the remaining study (Sandahl et al., 2011). Collectively, these studies included 1,845 participants in treatment and comparison conditions. STPP was the most common form of psychodynamic psychotherapy investigated, being included in six studies.

Over half the studies (*n* = 11) included participants with anxiety or depressive disorders, with the findings suggesting that psychodynamic psychotherapy is effective in reducing the symptoms related to these conditions. A small number of studies have demonstrated that psychodynamic psychotherapy is beneficial in the treatment of hypochondriasis**,** borderline and other personality disorders, and alcohol-related disorders.

The effects of psychodynamic psychotherapy beyond the termination of treatment are equivocal. The findings of most studies suggest that the effects are at least maintained at follow up.

The evidence for the effectiveness of psychodynamic psychotherapy in comparison with other treatments is equivocal. Psychodynamic psychotherapy appears to be superior to TAU for anxiety and depressive disorders, and equivalent to TAU for borderline personality disorder and hypochondriasis. Psychodynamic psychotherapy seems equivalent to antidepressant medications and CBT in the treatment of depression.

Quasi-experimental studies

During the search of recent literature, 18 papers on 17 quasi-experimental studies were found (see Tables 5 and 6). These designs used in these studies were: non-randomised controlled trials (*n* = 4), non-equivalent groups controlled trials (*n* = 3), a time series design (*n* = 1), and single condition, pre-treatment/post-treatment (*n* = 9).

Most of the studies (*n* = 13) included participants with broad ranges of disorders or psychosocial issues. In general, psychodynamic psychotherapy appeared effective in the treatment of the problems presented in therapy. For those studies in which people with specific disorders were treated, psychodynamic psychotherapy was associated with the reduction of symptoms relating to depressive disorders, anxiety disorders, and borderline personality disorder.

Review of Australian Literature

Of the 75 records retrieved from the databases, four met the eligibility criteria for this review (see Figure 2).

Systematic reviews and meta-analyses
No systematic reviews or meta-analyses of Australian literature were found.

Randomised controlled trials
No randomised controlled trials were found.

Quasi-experimental studies
Four papers were found, each describing different aspects of the same study (Gerull, Meares, Stevenson, Korner, & Newman, 2008; Korner, Gerull, Meares, & Stevenson, 2006; Meares, Gerull, Stevenson, & Korner, 2011; Stevenson, Meares, & D'Angelo, 2005). The participants in this study were 60 patients (the number of patients differed slightly between some of the papers) with borderline personality disorder. Patients received psychotherapy based on the CM, which was provided twice weekly over 12 months. Patients on a waiting list for psychotherapy received TAU and served as the control condition. CM was superior to TAU in facilitating changes in self (η^2 = .14, *p* = .004) and affect deregulation (η^2 = .10, *p* = .02), but equivalent to TAU in terms of impulse changes (η^2 = .05, *p* = .11; Meares et al., 2011). With regard to social adjustment, CM was superior to TAU with respect to partners (η^2 = .26, p = .001) and children (η^2 = .18, p = .004), but the two conditions were equivalent in terms of the family unit (η^2 = .07, p = .06; Gerull et al., 2008). CM was superior to TAU in producing changes in global function (η^2 = .10, p = .001), but the conditions were equivalent using an alternative measure of symptom severity (η^2 = .01, p = .57; Korner et al., 2006). Between post-treatment and five year follow up, there were significant reductions in time off work (*p* = .03), time as inpatients (*p* = .04), and symptoms (*p* = .01; Stevenson et al., 2005).

Discussion

The reviewed evidence suggests that psychodynamic psychotherapy is effective in treating a broad range of mental health conditions, particularly 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). In a limited number of studies, psychodynamic psychotherapy has also been effective in the treatment of eating disorders, post traumatic stress disorder, and some substance-related disorders (alcohol dependence, opiate dependence). In reviews and studies on the effectiveness of psychodynamic psychotherapy, meta-analysts and researchers have routinely reported medium, large, and very large (exceeding two standard deviations) effect sizes for improvement on primary outcome measures. Such improvements are typically retained beyond the termination of therapy.

The findings on the effectiveness of psychodynamic psychotherapy in comparison to other treatments are equivocal. Generally, psychodynamic psychotherapy has been found to be superior to TAU (e.g., Abbass, Town, & Driessen, 2012) and equivalent to other psychotherapies (e.g., Cuijpers, van Straten, Andersson, & van Oppen, 2008; Leichsenring & Leibing, 2007). This finding replicates that of a recent quality-based review of RCTs of psychodynamic psychotherapy (Gerber et al., 2011). In this review, psychodynamic psychotherapy was found to be superior to inactive comparators (e.g., TAU, waiting list) in 18 of the 24 comparisons. Psychodynamic psychotherapy was also found to be equivalent to active treatments (e.g., CBT) in 28 of 39 comparisons (although studies were typically underpowered for equivalence), superior in six of 39 comparisons, and inferior in five of 39 comparisons. Although these results are sufficient to consider psychodynamic psychotherapy to be empirically validated (as per American Psychological Association Division 12 standards), more research needs to be conducted to replicate and extend these findings to specific disorders (Gerber et al., 2011). The collective findings from the present review should encourage researchers to conduct head-to-head trials to compare various therapies for specific disorders, which would enable more definitive conclusions to be drawn about the relative effectiveness of different psychotherapies for the treatment of specific conditions.

Although some meta-analysts have concluded that LTPP is superior to shorter forms of psychotherapy (Leichsenring & Rabung, 2008, 2011), these claims have been strongly disputed (e.g., Bhar et al., 2010; Pignotti & Albright, 2011). Among the criticisms of Leichsenring and Rabung's (2008) meta-analysis were that (a) the effect sizes for key comparisons were miscalculated, (b) the meta-analysis was performed on a small number of underpowered studies that differed markedly with respect to the patients treated, comparison conditions, interventions used, and outcome measures; and (c) the studies included in the meta-analysis had poor internal validity (Bhar et al., 2010). Higher quality trials of long-term versus short-term psychodynamic psychotherapy need to be conducted before firmer conclusions can be drawn.

This review has highlighted the substantial work that has occurred to evaluate the effectiveness of psychodynamic psychotherapy, especially in adults with depressive disorders and some anxiety disorders. More research is clearly needed in areas where initial studies have yielded positive findings, such as somatoform disorders, eating disorders, substance-related disorders, and other anxiety disorders. In addition, more work is needed to investigate the efficacy of psychodynamic therapy with children and adolescents. One meta-analysis on children and adolescents who had been sexually abused, for example, produced mixed findings on the effectiveness of psychodynamic psychotherapy (Sánchez-Meca, Rosa-Alcázar, & López-Soler, 2011). These findings were based on only two studies, however. Clearly, a stronger evidence base for the use of psychodynamic psychotherapy in the treatment of some issues needs to be developed.

The findings of this review suggest that Australian researchers have not been particularly active in publishing the results of research on the effectiveness of psychodynamic

psychotherapy, except at the level of case studies. Only four papers (representing one study) were sourced during the search for Australian literature. The limited work in this area highlights a possible avenue for research to support clinicians in Australia.

Conclusion

The conclusion reached in this review is that there is strong support for the use of psychodynamic psychotherapy in the treatment of a broad range of psychological conditions. Moreover, the improvements gained through psychodynamic psychotherapy are typically maintained beyond the termination of treatment. Psychodynamic psychotherapy appears to be as effective as other psychotherapies, but more comparative trials are needed before firmer conclusions can be drawn.

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Appendices

Appendix 1

Figure 1 - ***Identification and selection of studies for the systematic review***

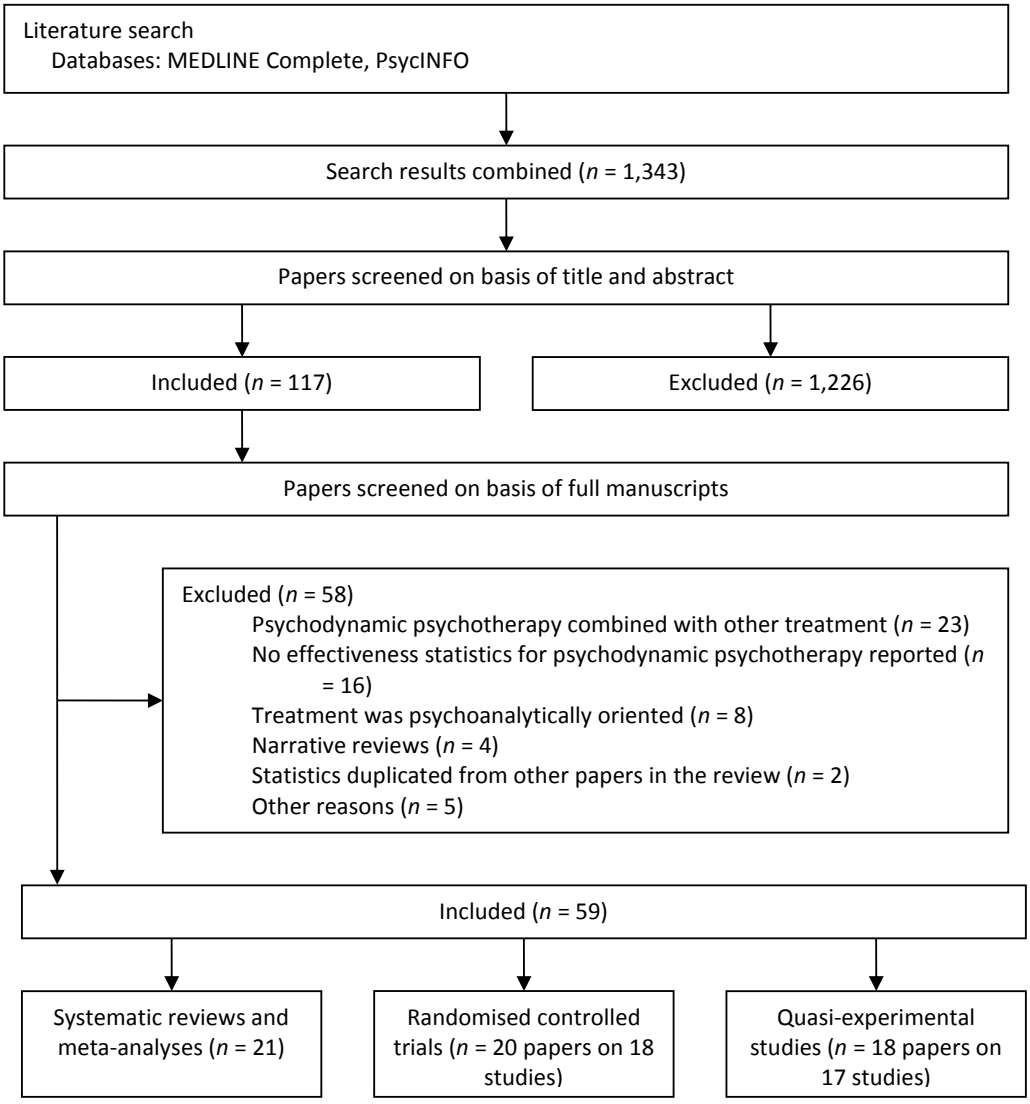
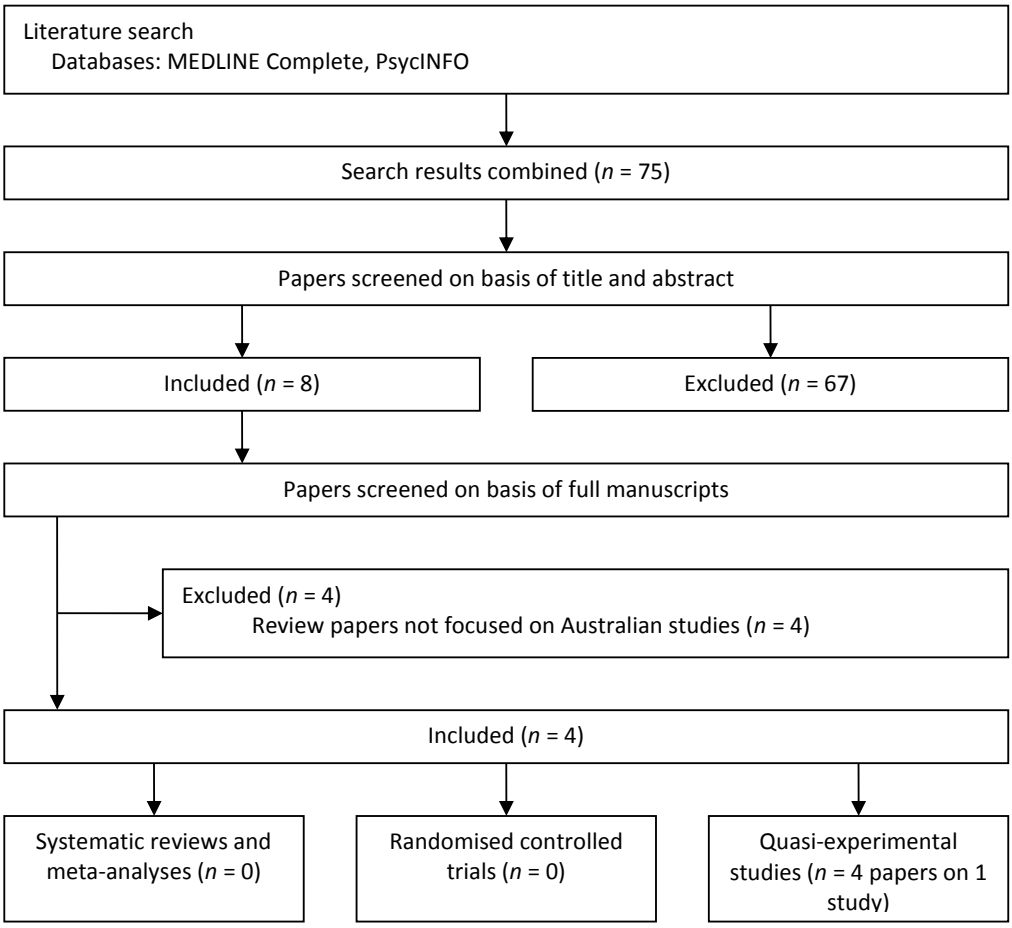


Figure 2 - ***Identification and selection of studies for the systematic review***



Appendix 2

Table 1: ***The findings of meta-analyses and systematic reviews with meta-analyses on the effectiveness of psychodynamic psychotherapy***

Study	Intervention	Study characteristics	Participants	Participant characteristics	Effect of psychodynamic psychotherapy	Psychodynamic psychotherapy versus other interventions
Abbass et al. (2009)	Short-Term Psychodynamic Psychotherapy (STPP)	13 RCTs, 10 case serious with pre-post data	1,870 (intervention) and 535 (control) in systematic review	People with somatic disorders	Pre-post – effective for general psychiatric symptoms (short-term outcomes [up to 3 months]: ES = -0.69, 95% CI: –0.86, –0.52]; long-term outcomes [over 9 months]: ES = –0.70, [95% CI –0.91, –0.48]), depression (short-term: ES = -0.97 [95% CI –1.19, –0.74]; long-term: ES = –2.26, [95% CI: –2.75, –1.77), anxiety (short-term: ES = -0.74, 95% CI: –0.96, –0.52; long-term: ES = –2.28, 95% CI: –2.76, –1.80), and somatic symptoms (short-term: ES = -0.59, 95% CI: –0.78, –0.40; long-term: ES = –0.49, 95% CI: –0.77, –0.21).	
Abbass et al. (2011)	STPP	8 RCTs	166	People with comorbid depressive and personality disorders	Pre-post – effective for depression (ES = -1.13, 95% CI: -0.87, -1.39), general psychopathology (ES = -1.00, 95% CI: -0.67, 1.33), and interpersonal functioning (ES = 1.27, 95% CI: 0.76, 1.79). Post-follow up - no change for depression (ES = 0.1, 95% CI: -0.15, 0.35), general psychopathology (ES = 0.00, 95% CI: -0.17, 0.34), and interpersonal functioning (ES = 0.24, 95% CI: -0.23, 0.72).	STPP equivalent to other psychotherapies (ES = -0.04, 95% CI: -0.44, 0.36).
Abbass et al. (2012)	Intensive short-term dynamic psychotherapy (ISTDP)	6 RCTs, 4 nonrandomized, controlled trials, and 11 studies with no control groups	664 in meta-analysis	People with mood, anxiety, personality, and somatic disorders	Pre-post – effective for general psychopathology (*d* = -1.16, 95% CI: -0.82, -1.50), interpersonal functioning (*d* = 0.84, 95% CI: 0.50, 1.18), depression (*d* = -1.51, 95% CI: -1.16, -1.87), anxiety (*d* = -0.98, 95% CI: 0.47, 1.49). Post-follow up –no change for general psychopathology (*d* = 0.01, 95% CI: -0.51, 0.53), interpersonal functioning (*d* = 0.12, 95% CI = -0.27, 0.51).	ISTDP superior to control conditions (active controls, *n* = 3; waiting list controls, *n* = 2) post-treatment - general psychopathology (*d* = 1.18, 95% CI: 0.61, 1.75)
Cuijpers et al. (2008)	Various psychological treatments	53 studies	2757 in meta-analysis	Adults with mild to moderate depression		Psychodynamic psychotherapy (PP) equivalent to other psychotherapies (*d* = -0.07, 95% CI: -0.21, 0.08).
Driessen et al. (2010)	STPP	13 RCTs, 3 non-random comparative design, 7 naturalistic design without controls	1365 (713 in STPP, 551 in alternative psychotherapy, 101 in control)	Adults with major depressive disorder, mood disorder, or depressed mood	Pre-post – effective for depressive and mood disorders (*d* = 1.34, 95% CI: 1.13, 1.55) Post-follow up (1 year): negligible differences (*d*=–0.04; 95% CI: –0.21, 0.12).	STPP superior to controls at post treatment (*d* = 0.69, 95% CI: 0.30, 1.08). STPP inferior to other psychotherapies (*d* = 0.30, 95% CI: 0.06, 0.54).

Jakobsen et al. (2011)	Interpersonal psychotherapy (5 trials) and short psychodynamic supportive psychotherapy (1 trial)	6 RCTs	648	Adults with major depressive disorder		PP superior to treatment as usual (M_{diff} = 3.12, 95% CI: 2.03, 3.98 on the HAM-D; M_{diff} = 3.09, 95% CI: 0.83, 5.35 on the BDI).
Leichsenring and Rabung (2008)	Long-term psychodynamic psychotherapy (LTPP; at least 1 yr or 50 sessions)	11 RCTs, 12 observational studies	1,053 (intervention), 257 (comparison conditions)	Adults with various mental disorders	Pre-post – effective across various mental disorders (*d* = 1.03, 95% CI: 0.84, 1.22) and, specifically, with target problems (*d* = -1.98, 95% CI: -1.37, -2.59), psychiatric symptoms (*d* = -0.91, 95% CI: -0.72, -1.11), personality functioning (*d* = 0.78, 95% CI: 0.30, 1.26), and social functioning (*d* = 0.81, 95% CI: 0.60, 1.03)	LTPP superior to other psychotherapy methods for overall effectiveness (*d* = 0.96 vs 0.47), target problems (*d* = -1.16 vs -0.61), and personality functioning (*d* = 0.90 vs 0.19).
Leichsenring and Rabung (2011)	LTPP (at least 1 yr or 50 sessions)	9 RCTs, 1 non-randomised, controlled trial	446 (intervention), 505 (comparison treatments)	Adults with various mental disorders		LTPP superior to other psychotherapy methods for overall effectiveness (*d* = 0.54, 95% CI: 0.26, 0.83), target problems (*d* = -0.49, 95% CI: -0.27, -0.71), psychiatric symptoms (*d* = -0.44, 95% CI: -0.15, -0.73), personality functioning (*d* = 0.68, 95% CI: 0.31, 1.04), and social functioning (*d* = 0.62, 95% CI: 0.18, 1.06).
Pinquart et al. (2007)	Various psychotherapies and other behavioural interventions	57 studies		Older adults (average age 60+) with depression	Pre-post – effective in reducing depression (3 studies, *d* = -0.76, 95% CI: -0.31, -1.21).	PP equivalent to other psychotherapies.
Saini (2009)	Various psychological treatments	73 RCTs, 19 non-random comparative design, 4 designs without comparison conditions	7440	Adults with anger issues	Pre-post – effective in reducing anger (2 studies - *d* = -1.40, 95% CI: -1.14, -1.72).	PP may be superior to other psychotherapies (only based on 2 studies with PP, however).
Samad et al. (2011)	Behaviour therapy vs other psychotherapies	4 RCTs	256 (total), 34 received PP	Older adults (55+) with depression		PP equivalent to behaviour therapy (SMD = 0.37, 95% CI: 0.84, -0.11).
Sánchez-Mecca et al. (2011)	Psychological treatment of sexual abuse	33 studies	1,037 (intervention), 104 (control)	Children and adolescents who had been sexually abused	Pre-post – effective in reducing sexualised behaviours (2 studies - *d* = -0.62, 95% CI: -0.27, -0.97) and behaviour problems (3 studies - *d* = -0.89, 95% CI: -0.48, -1.30), but not anxiety (1 study - *d* = 0.41, 95% CI: -0.99, 1.81) and depressed mood (1 study - *d* = 0.89, 95% CI: -0.80, 2.58).	Global measures: PP (*d* = 0.76, 95% CI: 0.40, 1.11) inferior to CBT + supportive therapy (*d* = 1.74, 95% CI: 0.72, 2.76) and CBT + play therapy + supportive therapy (*d* = 1.34, 95% CI: 0.85, 1.84). Sexualised behaviours: PP (*d* = 0.62, 95% CI: 0.27, 0.97) inferior to CBT + play therapy + supportive therapy (*d* = 1.92, 95% CI: 1.03, 2.81). Behaviour problems: PP (*d* = 0.89, 95% CI: 0.48, 1.30) inferior to CBT + supportive therapy (*d* = 1.74, 95% CI: 0.69, 2.79).
Tolin (2010)	Various psychological treatments	26 RCTs	1981	People with various mental disorders		PP less effective than CBT (24 studies; *d* = 0.28, 95% CI: 0.12, 0.44).

Note. BDI = Beck's Depression Inventory, CBT = cognitive behavioural therapy, HAM-D = Hamilton Depression Rating Scale.

Appendix 3

Table 2: ***The findings of systematic reviews without meta-analyses on the effectiveness of psychodynamic psychotherapy: Recent literature***

Study	Intervention	Study characteristics	Participant characteristics	Effect of psychodynamic psychotherapy	Psychodynamic psychotherapy versus other interventions
Leichsenring and Leibing (2007)	Psychodynamic psychotherapy (PP)	23 RCTs	People with various mental disorders	Short-term PP (STPP) effective for major depressive disorder, minor depressive disorder, borderline personality disorder, bulimia nervosa, anorexia nervosa, somatoform disorders, post-traumatic stress disorder, alcohol dependence, and opiate dependence. Long-term PP (LTPP) effective for social phobia, bulimia nervosa, anorexia nervosa, borderline personality disorder, Cluster C personality disorders, somatoform pain disorder, and opiate dependence.	PP superior to treatment-as-usual or waiting list in the treatment of specific psychiatric disorders. Psychodynamic therapy as effective as other therapies (e.g., CBT) in the treatment of specific psychiatric disorders.
Leis et al. (2009)	Home-based interventions	6 studies	Women with postpartum depression	Only one study included PP. Evidence suggests it may be effective in treating postpartum depression.	
Lewis et al. (2008)	STPP	15 studies with outcome measures	Adults with various mental disorders	STPP effective for depression, generalised anxiety disorder, panic disorder, and some personality disorders.	STPP equivalent to other psychotherapies in the treatment of depression.
Midgley & Kennedy (2011)	Individual psychodynamic or psychoanalytic psychotherapeutic treatment	9 experimental, 3 quasi-experimental, 8 controlled observational, 14 non-controlled observational	Children, mostly aged 3 to 18 with broad range of diagnoses	Limited evidence on PP for children and adolescents.	
Nevo & Manassis (2009)	Various psychological treatments	2 RCTs, 1 non-randomised, controlled trial, 5 cohort studies	Children previously treated for anxiety	Limited evidence (one study) suggests PP may be effective in treating anxiety in children as measured at 2 years follow up.	
Ponniah & Hollon (2009)	Various psychological treatments	57 RCTs	Adults with ASD or PTSD	Limited evidence (one study) suggests PP may be effective in treating PTSD in adults.	
Town et al. (2011)	STPP	8 RCTs	People with (mainly Cluster C) PD	STPP effective in improving symptomatic (d = 0.92), interpersonal (d = 0.86), and functional pathology (d = 1.47).	STPP appears comparable to other PP and CBT in the treatment of PD.
Wethington et al. (2008)	Interventions to reduce psychological harm from traumatic events	7 studies	Children and adolescents who had experienced trauma	Limited evidence (one study) suggests PP may be effective in treating PTSD in children aged 3-5 years.	

Note., ASD = Acute Stress Disorder, CBT = cognitive behavioural therapy, PD = Personality Disorder, PTSD = Post-Traumatic Stress Disorder.

Appendix 4

Table 3: ***The findings of randomised controlled trials on the effectiveness of psychodynamic psychotherapy***

Study	Intervention	Intervention duration	Participants	Participant characteristics	Outcome measures	Effect of psychodynamic psychotherapy	Follow up period	Follow up participants	Change between post-treatment and follow up
Abbass et al. (2008)	Intensive short-term dynamic psychotherapy (ISTDP)	Weekly, 1hr sessions , *M* = 27 sessions, *SD* = 20	27	Patients with PD	BSI, IIP	Symptoms: ↓ (*d*= 1.84, *p* < .001). Interpersonal problems: ↓ (*d* = 1.44, *p* > .001).	2.1 years (average)	27	Symptoms: ↑ (*d* = .09). Interpersonal problems: no change (*d* = .00).
Amianto et al. (2011)	Sequential brief Adlerian psychodynamic psychotherapy (SB-APP)	40 weekly sessions for 10-11months	35	Outpatients with BPD	SCI-90, STAXI, CGI, GAF	12mths - Symptoms: ↓ (*d* = .72, *p* < .001).State anger: no change (*d* = -0.18). Trait anger: no change (*d* = 0.01). Anger inward: ↓ (*d* = 0.47). Anger outward: ↓ (*d* = 0.34).Anger control: ↑ (*d* = 1.11). Anger expression: ↓ (*d* = 0.57). Global impression: ↓ (*d* = 0.98). Global function: ↑ (*d* = 0.57).	12 months	35	Global impression: ↓ (*d* = 0.10). Global function: ↓ (*d* = .02).
Bressi et al. (2010)	Short-term psychodynamic psychotherapy (STPP)	40 weekly sessions, 45mins each	60	Patients with depressive or anxiety disorders	IIP, SCL-90	Global severity of symptoms: ↓ (*d* = 5.79). Interpersonal problems: ↓ (*d* = 3.03).			
Dekker et al. (2008)	Short-term psychodynamic supportive psychotherapy (SPSP)	8 weekly sessions	141	Patients with a depressive episode	HAM-D	Depression: ↓ (*d* = 0.38).			
Gregory et al. (2008)	Dynamic deconstructive psychotherapy	Weekly sessions for 12 to 18months	30	Individuals with BPD and alcohol use disorder	ASI, LPC, THI	Baseline to 12mths - individuals with parasuicide (73% to 30%), alcohol misuse (67% to 30%), and institutional care (67% to 10%).			
Hyphantis et al. (2009)	Psychodynamic interpersonal therapy	One long (≈2hrs) and 7 shorter (45 min) individual sessions over 3 months	257	Patients with irritable bowel syndrome	IIP, SF-36 (PCS), SCL-90 (GSI), VAS (pain today)	Visual inspection of graphs - Interpersonal problems: stable. Physical health: stable. Global severity of symptoms: slight improvement. Pain today: slight improvement.	12 months	257	Visual inspection of graphs - Interpersonal problems: slight improvement. Physical health: slight improvement. Global severity of symptoms: stable. Pain today: stable.
Johansson et al. (2010)	PP with transference interpretation or PP without transference interpretation	Weekly sessions for 1 year	100	Outpatients with depression, anxiety, personality disorders, and interpersonal problems.	Psychodynamic Functioning Scales (Interpersonal Functioning)	PP with transference interpretation – Low quality of object relations (QOR) condition: ↑ (*d* = 1.25). High QOR condition: ↑ (*d* = 0.99). PP without transference interpretation – Low QOR condition: ↑ (*d* = 0.59). High QOR condition: ↑ (*d* = 1.07).	3 years	100	PP with transference interpretation – Low QOR condition: ↑ (*d* = 0.67). High QOR condition: ↑ (*d* = 0.29). PP without transference interpretation – Low QOR condition: ↑ (*d* = 0.71). High QOR condition: ↑ (*d* = 0.14).

Knekt et al. (2010; 2008; 2008)	LTPP or STPP	LTPP: 2-3 sessions per week for up to 3 years. STPP: 20 weekly sessions over 5-6mths	326	Outpatients with depressive or anxiety disorder	WAI, Perceived Psychological Functioning Scale, BDI, SCL-90 (Anx), alcohol consumption, smoking, body mass index (BMI), leisure time exercise	STPP (baseline – 7months) – Work ability: ↑ (d = 5.78). Psychological functioning: ↑ (d = 7.60). Depression: ↓ (d = 9.13). Anxiety: ↓ (d = 5.34). Alcohol consumption: ↓ (d = 2.03, p < .05). Smoking: ↑ (19.4% to 21.3%, p = ns). BMI: ↑ (d = 0.49, p < .05). Leisure time exercise: ↑ (36.7% to 42.7%, p = ns). LTPP (baseline - 7mths) – Work ability: ↑ (d = 4.42). Psychological functioning: ↑ (d = 5.08). Depression: ↓ (d = 6.06). Anxiety: ↓ (d = 2.77). Alcohol consumption: ↓ (d = 0.94, p = ns). Smoking: ↓ (23.3% to 21.0%, p = ns). BMI: ↑ (d = 0.54, p < .05). Leisure time exercise: ↓ (46.4% to 36.3%, p < .05).	STPP: 29mths. LTPP: potentially 0mths	326	STPP (7mths-36mths) – Work ability: ↓ (d = 0.41). Psychological functioning: ↓ (d = 0.67). Depression: unchanged (d = 0.00). Anxiety: ↓ (d = 0.53). Alcohol consumption: ↑(d = .07). Smoking: ↑ (21.3% to 22.3%). BMI: ↑ (d = 0.68). Leisure time exercise: ↓ (42.7% to 28.9%). LTPP (baseline - 7mths) – Work ability: ↑ (d = 5.22). Psychological functioning: ↑ (d = 6.98). Depression: ↑ (d = 8.54). Anxiety: ↓ (d = 6.62). Alcohol consumption: ↓ (d = 0.06). Smoking: ↑ (21.0% to 22.4%, p = ns). BMI: ↑ (d = 1.00). Leisure time exercise: ↑ (36.3% to 40.8%).
Leichsenring et al. (2009)	Supportive-expressive psychotherapy (SEP)	Up to 30 sessions, 50min each	57	Patients with GAD	HAM-A	Anxiety: ↓ (d = 2.01).	6 months	57	Anxiety: ↑ (d = 0.09).
Salminen et al. (2008)	STPP	16 weekly sessions	51	Patients with major depressive disorder	HAM-D	Depression: ↓ (d = 8.46, p < .0001).			
Salzer et al. (2011)	STPP	M = 29 sessions (SD = 3)	57	Patients with GAD	HAM-A		12 months	41	Pre-treatment to follow up – Anxiety: ↑ (d = 2.20).
Sandahl et al. (2011)	Focused psychodynamic group therapy (FPGT)	3 pre-therapy interviews and 18 group sessions (twice weekly for first 10, and once per week for last 8), 90mins each	117	Patients on long-term sick-leave (> 90 days) from white collar work, with a diagnosis of work-related depression, dysthymia, or maladaptive stress reaction	CPRS-S-A, SCL-90, OLBI	6 months from baseline - Depression: ↓ (d = 0.58). Anxiety: ↓ (d = 0.21). Global severity of symptoms: ↓ (d = 0.58). Exhaustion: ↓ (d = 0.49). Disengagement: ↓ (d = 0.3).	12 months from baseline	117	6 months to 12 months - Depression: ↓ (d = 1.40). Anxiety: ↓ (d = 1.09). Global severity of symptoms: ↓ (d = 0.67). Exhaustion: ↓ (d = 0.79). Disengagement: ↓ (d = 0.76).
Sørensen et al. (2011)	STPP	16 weekly sessions, 50mins each	80	Patients with hypochondriasis	HAI, HAM-A	Health anxiety: ↓ (d = 1.15). Anxiety: ↓ (d = 0.13)	12 months	72	Health anxiety: ↓ (d = 0.13). Anxiety: ↓ (d = 0.38).
Thyme et al. (2007)	Psychodynamic art psychotherapy	10 sessions, 60mins each	37	Women with dysthymic disorder	BDI, SCL-90, IES, HAM-D	Depression: ↓ (BDI: d = 1.05; SCL-90: d = 0.84). Global severity of symptoms: ↓ (d = 0.67). Intrusion: ↓ (d = 0.32). Avoidance: ↓ (d = 1.01).	3 months	39	Depression: ↓ (BDI: d = 0.18; SCL-90: d = 0.06). Global severity of symptoms: ↓ (d = 0.18). Intrusion: ↓ (d = 0.15). Avoidance: ↑ (d = 0.03).
Trowell et al. (2007)	PP	16-30 sessions over 9 months, 50min each, plus parent sessions	72	9-15 year olds with major depressive disorder and/or dysthymia	Kiddie-SADS	74.3% no longer diagnosed with depression (p < .001)	6 months	68	100% no longer diagnosed with depression (p < .001)

Van et al. (2008)	SPSP	16 sessions over 6 months	190	Patients with mild to moderate depression	HAM-D	33% of patients achieved remission.			
Vinnars et al. (2009)	SEP	40 sessions over 1 year	156	Patients with PD	KAPP, KSP, PMS	Psychological mindedness: ↑ (*d* = .06). Interpersonal problems: ↓ (*d* = 0.21). Neuroticism: ↓ (*d* = 0.34). Agreeableness: ↓ (*d* = 0.25). Impulsiveness: ↑ (*d* = .02).	1 year	89	No significant differences for psychological mindedness, interpersonal problems, neuroticism, agreeableness, or impulsiveness.

Note. Participant characteristics abbreviations: BPD = Borderline Personality Disorder, PD = Personality Disorder. Outcome measure abbreviations: ASI = Addiction Severity Index, BDI = Beck Depression Inventory, BSI = Brief Symptom Inventory, CGI = Clinical Global Impression scale, CPRS-S-A = Comprehensive Psychopathological Rating Scale-Self-Affective, GAF = Global Assessment of Function, HAI = Health Anxiety Inventory, HAM-A = Hamilton Anxiety Rating Scale, HAM-D = Hamilton Depression Rating Scale, IES = Impact Event Scale, IIP = Inventory of Interpersonal Problems, KAPP = Karolinska Psychodynamic Profile, Kiddie-SADS = Schedule for Affective Disorders and Schizophrenia for School-Age Children, KSP = Karolinska Scale of Personality, LPC = Lifetime Parasuicide Count, OLBI = Oldenburg Burnout Inventory, PFS = Psychodynamic Functioning Scales, PMS = Psychological Mindedness Scale, SCL-90 (Anx, GSI) = Symptom Checklist-90 (Anxiety, Global Severity Index), SF-36 (PCS) = Short Form-36 (Physical Component Summary), STAXI = State-Trait Anger Expression Inventory, THI = Treatment History Interview, VAS = visual analogue scales taken from the McGill Pain Questionnaire, WAI = Work Ability Index.

Appendix 5

Table 4: ***Comparison between the effectiveness of psychodynamic psychotherapy and other interventions in randomised controlled trials***

Study	Intervention	Intervention duration	Participants	Participant characteristics	Outcome measures	Comparison condition	Comparison effect size (post-treatment)	Follow up period	Follow up participants	Comparison effect size (follow up)
Abbass et al. (2008)	Intensive short-term dynamic psychotherapy (ISTDP)	Weekly, 1hr sessions , *M* = 27 sessions, *SD* = 20	27	Patients with PD	BSI, IIP	Waiting list control	Symptoms: ISTDP > Control (*d* = 1.08). Interpersonal problems: ISTDP > Control (*d* = 0.83).			
Amianto et al. (2011)	Sequential brief Adlerian psychodynamic psychotherapy (SB-APP)	40 weekly sessions for 10-11months	35	Outpatients with BPD	SCI-90, STAXI, CGI, GAF	Treatment as usual (TAU; supervised team management)	No significant differences between conditions for any of the measures.	12 months	35	No significant differences between conditions for any of the measures.
Bressi et al. (2010)	Short-term psychodynamic psychotherapy (STPP)	40 weekly sessions, 45mins each	60	Patients with depressive or anxiety disorders	IIP, SCL-90	TAU (drug treatment, clinical interviews)	Global impression: STPP > TAU (*d* = 0.98, *p* = .002). Global severity of symptoms: STPP ≈ TAU (*d* = 0.47, *p* = .124). Interpersonal problems: STPP > TAU (*d* = 0.69, *p* = .025).			
Dekker et al. (2008)	Short-term psychodynamic supportive psychotherapy (SPSP)	8 weekly sessions	141	Patients with a depressive episode	HAM-D	Antidepressants	Antidepressants > SPSP (*d* = .44).			
Gregory et al. (2008)	Dynamic deconstructive psychotherapy	Weekly sessions for 12 to 18months	30	Individuals with BPD and alcohol use disorder	ASI, LPC, THI	TAU (individual psychotherapy and medication management)	No significant differences between conditions for any of the measures.			
Hyphantis et al. (2009)	Psychodynamic interpersonal therapy	One long (≈2hrs) and 7 shorter (45 min) individual sessions over 3 months	257	Patients with irritable bowel syndrome	IIP, SF-36 (PCS), SCL-90 (GSI), VAS (pain today)	Daily SSRI antidepressants for 3 months	Visual inspection of graphs - psychotherapy ≈ antidepressants.	12 months	257	Visual inspection of graphs - psychotherapy ≈ antidepressants.

Johansson et al. (2010)	PP with transference interpretation	Weekly sessions for 1 year	100	Outpatients with depression, anxiety, personality disorders, and interpersonal problems.	Psychodynamic Functioning Scales (Interpersonal Functioning)	PP without transference interpretation	Low quality of object relations (QOR) condition: PP with transference > PP without transference (d = 0.41). High QOR condition: PP without transference > PP with transference (d = 0.23).	3yrs	100	Low QOR condition: PP with transference > PP without transference (d = 0.23). High QOR condition: PP without transference > PP with transference (d = 0.08).
Knekt et al. (2010; 2008; 2008)	LTPP or STPP	LTPP: 2-3 sessions per week for up to 3 years. STPP: 20 weekly sessions over 5-6mths	326	Outpatients with depressive or anxiety disorder	WAI, Perceived Psychological Functioning Scale, BDI, SCL-90 (Anx), alcohol consumption, smoking, body mass index (BMI), leisure time exercise)	Solution-focused therapy (SFT)	7 months – Work ability: STPP ≈ LTPP ≈ SFT (p = ns). Psychological functioning: SFT > LTPP (d = 2.38), STPP > LTPP (d = 3.07), SFT ≈ STPP (p = ns). Depression: STPP > LTPP (d = 3.44, p < .05), SFT > LTPP (d = 3.16, p < .05), STPP ≈ SFT (p = ns). Anxiety: STPP > LTPP (d = 2.11), STPP and LTPP ≈ SFT (p = ns). Alcohol consumption: LTPP > STPP (d = 2.33, p < .05), STPP and LTPP ≈ SFT. Smoking, BMI, leisure time exercise: STPP ≈ LTPP ≈ SFT (p = ns).	STPP: 29mths. LTPP: potentially 0mths	326	Work ability: STPP > LTPP (d = 2.38), LTPP and STPP ≈ SFT (p = ns). Psychological functioning: SFT ≈ STPP ≈ LTPP (p = ns). Depression: LTPP > STPP (d = 2.27, p < .05), LTPP > SFT (d = 3.16, p < .05), STPP ≈ SFT (p = ns). Anxiety: LTPP > STPP (d = 2.00, p < .05), LTPP > SFT (d = 2.22, p < .05), STPP ≈ SFT (p = ns). Smoking: SFT > STPP (OR = 5.03, p < .05). LTPP ≈ STPP and SFT (p = ns) Alcohol consumption, BMI, leisure time exercise: STPP ≈ LTPP ≈ SFT (p = ns).
Koppers et al. (2011)	SPSP	16 sessions	52	Patients with major depressive disorder		SPSP plus pharmacotherapy		5 years	52	Recurrence(s) of depressive episodes: SPSP ≈ SPSP plus pharmacotherapy (φ = .07, p = .609).
Leichsenring et al. (2009)	Supportive-expressive psychotherapy (SEP)	Up to 30 50min sessions	57	Patients with GAD	HAM-A	CBT		6 months	57	Anxiety: STPP ≈ CBT (d = .06).
Salminen et al. (2008)	STPP	16 weekly sessions	51	Patients with major depressive disorder	HAM-D	Fluoxetine treatment	STPP ≈ fluoxetine (difference between mean change d = 0.16, p = .87).			
Salzer et al. (2011)	STPP	M = 29 sessions (SD = 3)	57	Patients with GAD	HAM-A	CBT		12 months	41	Anxiety: STPP < CBT (d = 0.50)

Sandahl et al. (2011)	Focused psychodynamic group therapy (FPGT)	3 pre-therapy interviews and 18 group sessions (twice weekly for first 10, and once per week for last 8), 90mins each	117	Patients on long-term sick-leave (> 90 days) from white collar work, with a diagnosis of work-related depression, dysthymia, or maladaptive stress reaction	CPRS-S-A, SCL-90, OLBI	(1) cognitive group therapy (CGT), (2) TAU (medication and rest; 85% organised their own individual therapy, however)	No significant differences between conditions for any of the measures.	12 months from baseline	117	No significant differences between conditions for any of the measures.
Sørensen et al. (2011)	STPP	16 weekly sessions, 50mins each	80	Patients with hypochondriasis	HAI, HAM-A	(1) CBT, (2) waiting list control	Health anxiety: STPP ≈ Control (d = 0.20, p = .785), STPP < CBT (d = 1.36, p < .0001). Anxiety: STPP ≈ control (d = 0.39, p < .30), STPP ≈ CBT (d = 0.69, p = .06).	12mths	72	Group × Time (0, 6, 12 months follow up: Health anxiety: STPP > CBT (η = .04, p = .045). Anxiety: STPP > CBT (η = .04, p = .045).
Thyme et al. (2007)	Psychodynamic art psychotherapy	10 sessions, 60mins each	37	Women with dysthymic disorder	BDI, SCL-90, IES, HAM-D	Psychodynamic verbal psychotherapy (10 sessions, 45min each)	No significant differences between conditions for any of the measures.	3months	39	No significant differences between conditions for any of the measures.
Trowell et al. (2007)	PP	16-30 sessions over 9 months, 50min each, plus parent sessions	72	9-15 year olds with major depressive disorder and/or dysthymia	Kiddie-SADS	Family therapy	PP ≈ family therapy (p = ns).	6 months	68	PP ≈ family therapy (p = ns).
Van et al. (2008)	SPSP	16 sessions over 6months	190	Patients with mild to moderate depression	HAM-D	SPSP with antidepressants	SPSP ≈ SPSP with antidepressants (φ = .12, p = .11).			
Vinnars et al. (2009)	SEP	40 sessions over 1 year	156	Patients with personality disorders	KAPP, KSP, PMS	Treatment as usual (CDPT)	SEP ≈ Control on all measures (p = ns)	1 year	89	Quality of object relations and ego functions: SEP = Control (p = ns). Psychological mindedness: SEP = Control (p = ns). Neuroticism: SEP improved more than Control (p < .05). Agreeableness: SEP = Control (p = ns). Impulsiveness: SEP = Control (p = ns).

Note. < and > symbols indicate which treatment is superior. Participant characteristics abbreviations: BPD = Borderline Personality Disorder, PD = Personality Disorder. Outcome measure abbreviations: ASI = Addiction Severity Index, BDI = Beck Depression Inventory, BSI = Brief Symptom Inventory, CGI = Clinical Global Impression scale, CPRS-S-A = Comprehensive Psychopathological Rating Scale-Self-Affective, GAF = Global Assessment of Function, HAI = Health Anxiety Inventory, HAM-A = Hamilton Anxiety Rating Scale, HAM-D = Hamilton Depression Rating Scale, IES = Impact Event Scale, IIP = Inventory of Interpersonal Problems, KAPP = Karolinska Psychodynamic Profile, Kiddie-SADS = Schedule for Affective Disorders and Schizophrenia for School-Age Children, KSP = Karolinska Scale of Personality, LPC = Lifetime Parasuicide Count, OLBI = Oldenburg Burnout Inventory, PFS = Psychodynamic Functioning Scales, PMS = Psychological Mindedness Scale, SCL-90 (Anx, GSI) = Symptom Checklist-90 (Anxiety, Global Severity Index), SF-36 (PCS) = Short Form-36 (Physical Component Summary), STAXI = State-Trait Anger Expression Inventory, THI = Treatment History Interview, VAS = visual analogue scales taken from the McGill Pain Questionnaire, WAI = Work Ability Index. Treatment abbreviations: CBT = Cognitive Behavioural Therapy.

Appendix 6

Table 5: ***The findings of quasi-experimental studies on the effectiveness of psychodynamic psychotherapy***

Study	Intervention	Intervention duration	Participants	Participant characteristics	Outcome measures	Effect of psychodynamic psychotherapy	Follow up period	Change between post-treatment and follow up
Non-randomised controlled trials								
Ferrero et al. (2007)	Brief Adlerian psychodynamic psychotherapy	10 weekly sessions, plus sessions at 3months and 1year, 45min each	87 (76 at follow up)	Patient with GAD	HAM-A, HAM-D, CGI, SOFAS	Anxiety: ↓ (d = 1.58). Depression: ↓ (d = 1.26). Global impression: ↓ (d = 1.73). Social and occupational functioning: ↑ (d = 0.99).	12 months	6-12mths - Anxiety: ↑ (d = 0.02). Depression: ↓ (d = .02). Global impression: ↓ (d = 0.05). Social and occupational functioning: ↑ (d = 0.03).
Gerull et al. (2008) and Meares et al. (2011)	Conversational Model	12 months	60	Parents with BPD	SAS, WSS	Partner: ↓ (d = 0.76, p < .001). Children: ↓ (d = 0.45, p = .009). Family-unit: ↓ (d = 0.57, p unreported). Significant improvement on the self (η^2 = .30, p = .002), affect deregulation (η^2 = .50, p = .001), and impulse (statistics unreported) subscales.		
Puschner et al. (2007)	Psychodynamic psychotherapy (PP)	~50 weekly sessions	616	People with private health insurance who applied for outpatient psychodynamic psychotherapy	SCL-90-R (GSI)	Monthly reduction of 0.0091 GSI (global severity of symptoms) points over 27 months (d = 0.33, p < .0001).		
Simpkins & Simpkins (2008)	Brief Dynamic Therapy (BDT) or Ericksonian Therapy (ET)	1 session per week, 1hr each	27	No specific class of problems. Each participant chose some problem or difficulty to focus on as the target complaint	CPSAS, HSCL	BDT - Personal and social adjustment: ↑ (d = 0.46). Symptoms: ↓ (d = 0.13). ET - Personal and social adjustment: ↑ (d = 0.65). Symptoms: ↓ (d = 1.85).		
Non-equivalent groups controlled trials								
Beutel et al. (2010)	Panic-focused PP	4 weeks intensive treatment	9 (PP treatment condition)	People with panic disorder	ACQ	Agoraphobic cognitions: ↓ (d = 0.68, p = .015)		
Buchheim et al. (2012)	Long-term psychodynamic psychotherapy (LTPP)	2-4 hours of weekly therapy for 15 months	16 (PP treatment condition)	Outpatients with recurrent depression	BDI, SCL-90-R (GSI)	Depression: ↓ (d = 1.82, p < .001). Global severity of symptoms: ↓ (d = 2.19).		
Slonim et al. (2011)	PP (based on object relations, self psychology, and relational theories)	Weekly 45-50min sessions for 12 months	30 (PP treatment condition)	Adolescents (aged 15-18) in treatment, mostly (88%) with symptoms of emotional distress	Y-OQ, TCS	Psychosocial distress: ↓ (d = 0.60). Target complaints: ↓ (d = 2.52).		

Time series design								
Roseborough et al. (2012)	PP	Median of 9 sessions	1050	Adults attending an outpatient mental health clinic	OQ	Psychosocial functioning: imp at 1 yr (*d* = .34).		
Single condition, pre-treatment/post-treatment								
Abbass et al. (2008)	Intensive Short-Term Dynamic Psychotherapy	1 session of 60-180mins (*M* = 84mins)	30	People with anxiety, depressive, adjustment, personality, or somatoform disorders	BSI (GSI), IIP	Global severity of symptoms: ↓ (*d* = 0.71, p < .0001). Interpersonal problems: ↓ (*d* = 0.33, p = .06).		
Barry et al. (2008)	Psychodynamically-oriented group therapy	1 group session per week for 32 weeks, 90min each	7	Women with psychogenic non-epileptic seizures	BDI, SCL-90 (GSI)	Depression: ↓ (*d* = 1.54, p < .01). Global severity of symptoms: ↓ (*d* = 0.47).		
Beail et al. (2007)	PP	8, 16, or 24 weekly sessions, 50min each	20 (20 at follow up)	People with intellectual disability and co-morbid psychological problems	SCL-90-R (GSI), IIP-32, Rosenberg	8 sessions - Global severity of symptoms: ↓ (*d* = 0.73). Interpersonal problems: ↓ (*d* = 1.00). Self-esteem: ↑ (*d* = 1.22). 16 sessions - Global severity of symptoms: ↓ (*d* = 0.57). Interpersonal problems: ↑ (*d* = 0.13). Self-esteem: ↑ (*d* = 0.56). 24 sessions - Global severity of symptoms: ↓ (*d* = 0.49). Interpersonal problems: (*d* = 0.45). Self-esteem: ↑ (*d* = 0.68).	3 months	8 sessions - Global severity of symptoms: ↓ (*d* = 0.42). Interpersonal problems: (*d* = 0.60). Self-esteem: ↓ (*d* = 0.23). 16 sessions - Global severity of symptoms: ↓ (*d* = 0.59). Interpersonal problems: ↓ (*d* = 0.65). Self-esteem: ↑ (*d* = 0.55). 24 sessions - Global severity of symptoms: ↓ (*d* = 0.02). Interpersonal problems: ↓ (*d* = 0.65). Self-esteem: ↓ (*d* = 0.10).
Bradshaw et al. (2009)	PP	2 to 109 sessions	78	Clients with DSM-IV Axis I disorders	OQ	Psychosocial functioning: ↑ (*d* = 0.90, p < .001).		
Kirchmann et al. (2009)	Interpersonal-psychodynamic group psychotherapy	12 weeks of group therapy	289	Inpatients with a range of psychiatric disorders	SCL-90-R (GSI), IIP	Global severity of symptoms: ↓ (*d* = 0.73). Interpersonal problems: ↓ (*d* = 0.42).		
Odhammar et al. (2011)	PP and parallel work with parents	1 or 2 sessions per week for 6 months to 2.5 years	33	Children aged 5-10, 29 of whom had at least one DSM-IV diagnosis (attention disorder and disruptive behaviour most common)	CGAS, HCAM	General functioning: ↑ (*d* = 1.80, p < .001). Adaptation: ↑ (*d* = 1.98, p < .001).		
Paley et al. (2008)	Psychodynamic-interpersonal therapy	16 to 25 sessions, 50mins each	62	People referred by either their general practitioner or psychiatrist	BDI-II, IIP-32, CORE-OM	Depression: ↓ (*d* = 0.76). Interpersonal problems: ↓ (*d* = 0.56). Clinical outcomes: ↓ (*d* = 0.76).		
Pobuda et al. (2008)	Time-limited dynamic psychotherapy	Weekly sessions for 20 weeks	79	Men who have sex with men who are also living with HIV and AIDS	OQ-45.2	Psychosocial functioning: ↑ (*d* = 0.82, p < .001).		

Slavin-Mulford et al. (2011)	Short-term psychodynamic psychotherapy	1 or 2 sessions per week (*Mdn* = 24 sessions, maximum = 64 sessions)	21	Patients consecutively admitted for individual psychotherapy to the psychodynamic psychotherapy treatment team at a community outpatient psychological clinic	BSI (Anx, GSI, Dep, Interpersonal Sensitivity), GAF, GARF, SOFAS, SAS (Global)	Anxiety: ↓ (*d* = 0.89, p = .0001). Global symptom distress - GAF: ↑ (*d* = 1.44, p = .001). BDI (GSI): ↓ (*d* = 0.92, p = .0001). BDI (Dep): ↓ (*d* = 0.83, p = .0006). Interpersonal distress - GARF: ↑ (*d* = 1.23, p = .0008). BDI (Interpersonal Sensitivity): ↓ (*d* = 0.33, p = .04). Social/occupational functioning - SOFAS: ↑ (*d* = .84, p = .004). SAS (Global): ↓ (*d* = 0.53, p = .04).		

Note. Participant characteristics abbreviations: BPD = Borderline Personality Disorder, GAD = generalised anxiety disorder. Outcome measure abbreviations: ACQ = Agoraphobic Cognitions Questionnaire, BDI = Beck Depression Inventory, BSI (Anx, Dep, GSI) = Brief Symptom Inventory (Anxiety, Depression, Global Severity Index), CGAS = Children's Global Assessment Scale, CGI = Clinical Global Impression scale, CORE-OM = Clinical Outcomes in Routine Evaluation-Outcome Measure, CPAS = Clark Personal and Social Adjustment Scale, GAF = Global Assessment of Function, GARF = Global Assessment of Relational Functioning scale, GI = Global Improvement, HAM-A = Hamilton Anxiety Rating Scale, HAM-D = Hamilton Depression Rating Scale, HCAM = Hampstead Child Adaption Measure, HSCL = Hopkins Symptom Checklist, IIP = Inventory of Interpersonal Problems, OQ - Outcome Questionnaire, PBI = Parental Bonding Instrument, Rosenberg = Rosenberg Self-Esteem Inventory, SAS (Global) = Social Adjustment Scale (Global Adjustment Score), SCL-90 (GSI) = Symptom Checklist-90 (Global Severity Index), SOFAS = Social and Occupational Functioning Assessment Scale, TCS = Target Complaints Scale, WSS = Westmead Severity Scale, Y-OQ = Youth-Outcome Questionnaire.

Appendix 7

Table 6: ***Comparison between the effectiveness of psychodynamic psychotherapy and other interventions in quasi-experimental studies***

Study	Intervention	Intervention duration	Participants	Participant characteristics	Comparison condition	Outcome Measures	Comparison effect size (post-treatment)	Follow up period	Comparison effect size (follow up)
Non-randomised controlled trials									
Ferrero et al. (2007)	Brief Adlerian psychodynamic psychotherapy (B-APP)	10 weekly sessions, and single sessions at 3mths and 1yr, 45min each	87 (76 at follow up)	Patient with GAD	(1) medication (MED), (2) B-APP and medication combined (COM)	HAM-A, HAM-D, CGI, SOFAS	No significant time (baseline, 3mths, 6mths) by treatment (B-APP, MED, COM) effects - HAM-A (η_p^2 = .03, p = .31), HAM-D (η_p^2 = .04, p = .24), CGI (η_p^2 = .35, p = .21), and SOFAS (η_p^2 = .05, p = .12).	12 months	No significant time (6mths, 12mths) by treatment (B-APP, MED, COM) effects - HAM-A (η_p^2 = .05, p = .17), HAM-D (η_p^2 = .03, p = .40), CGI (η_p^2 = .04, p = .27), and SOFAS (η_p^2 = .02, p = .44).
Gerull et al. (2008) and Meares et al. (2011)	Conversational Model	12 months	60	Parents with BPD	Treatment as usual (TAU; waiting list control)	SAS, WSS	Time × group - Partner: CM > TAU (η^2 = .26, p = .001). Children: CM > TAU (η^2 = .18, p = .004). Family-unit: CM ≈ TAU (η^2 = .07, p = .06). Self: CM > TAU (η^2 = .14, p = .004). Affect deregulation: CM > TAU (η^2 = .10, p = .02). Impulse: CM ≈ TAU (η^2 = .05, p = .11).		
Puschner et al. (2007)	PP	~50 weekly sessions	616	People with private health insurance who applied for outpatient PP	Psychoanalytic psychotherapy (~80 sessions, typically 2-4 sessions/week)	SCL-90-R (GSI)	No significant difference in progress made between the two conditions.		
Simpkins & Simpkins (2008)	Brief Dynamic Therapy (BDT) or Ericksonian Therapy (ET)	1 session per week, 1hr each	27	No specific class of problems. Each participant chose some problem or difficulty to focus on as the target complaint		CPSAS, HSCL, TCS, GI	Post-treatment - Personal and social adjustment: BDT ~ ET (*d* = 0.13, *p* = ns). Symptoms: ET > BDT (d = 0.80, p < .05). Target complaints: BDT ~ ET (d = .13, p = ns). Global improvement: BDT ~ ET (d = 1.12, p = ns).		

Non-equivalent groups controlled trials									
Buchheim et al. (2012)	Long-term psychodynamic psychotherapy (LTPP)	2-4hrs of weekly therapy for 15 months	(1) 16 (2) 17	(1) Outpatients with recurrent depression (2) Non-depressed controls	None	BDI, SCL-90-R (GSI)	Depression: larger difference between conditions at pre-treatment (d = 3.35) than post- treatment (d = 1.90). Global severity of symptoms: larger difference between conditions at pre-treatment (d = 2.96) than post- treatment (d = 2.20).		
Slonim et al. (2011)	PP (based on object relations, self psychology, and relational theories)	Weekly 45-50min sessions for 12 months	(1) 30 (2) 42	(1) Adolescents (aged 15-18) in treatment, mostly (88%) with symptoms of emotional distress (2) Adolescents (aged 15-18) in the community	None	Y-OQ, TCS	Psychosocial distress: larger difference between conditions at pre-treatment (d = 1.54) than post-treatment (d = 1.14). Target complaints: minimal difference between conditions at pre-treatment (d = 0.63) than post- treatment (d = 0.67).		

Note. Participant characteristics abbreviations: BPD = Borderline Personality Disorder, GAD = generalised anxiety disorder. Outcome measure abbreviations: BDI = Beck Depression Inventory, CGI = Clinical Global Impression scale, CPAS = Clark Personal and Social Adjustment Scale, GI = Global Improvement, HAM-A = Hamilton Anxiety Rating Scale, HAM-D = Hamilton Depression Rating Scale, HSCL = Hopkins Symptom Checklist, SAS = Social Adjustment Scale, SCL-90 (GSI) = Symptom Checklist-90 (Global Severity Index), SOFAS = Social and Occupational Functioning Assessment Scale, TCS = Target Complaints Scale, WSS = Westmead Severity Scale, Y-OQ = Youth-Outcome Questionnaire.

Appendix 8

Search strategy for recent studies: MEDLINE Complete (EBSCOhost) and PsychINFO (EBSCOhost)
01. psychodynamic

02. insight-oriented therapy

03. self-psychology

04. conversational model

05. intersubjectivity

06. study

07. studies

08. trial*

09. 1 or 2 or 3 or 4 or 5

10. 6 or 7 or 8

11. 9 and 10

Search strategy for Australian studies: MEDLINE Complete (EBSCOhost) and PsychINFO (EBSCOhost)
01. psychodynamic

02. insight-oriented therapy

03. self-psychology

04. conversational model

05. intersubjectivity

06. study

07. studies

08. trial*

09. Australia

10. 1 or 2 or 3 or 4 or 5

11. 6 or 7 or 8

12. 9 and 10 and 11