Different forms of Psychoanalytical Treatment:

A Continuüm, and the available Evidence

Doses in Psychoanalytical Forms of Treatment:

Differences and similarities /continuüm between Psychoanalysis Proper and Psychoanalytic Psychotherapy and their Effectivity

PSYCHOANALYSIS AND PSYCHOANALYTIC PSYCHOTHERAPY

INTRODUCTORY REMARKS

Psychoanalytical Treatments 1

- **Broad spectrum of psychopathological conditions**
  - From symptomatic neuroses or representational disorders: Conflictual pathology
  - To severe Personality Disorders or Mental Process Disorders: Developmental pathology
- **From long term to short term; from high frequency to low frequency**
  - Short and less intensive when it is possible. Long-term and intensive when necessary.
  - From classical psychoanalysis, to open ended psychoanalytic psychotherapy and focal, short term psychoanalytic psychotherapy

Psychoanalytical Treatments 2

- **From insight giving (expressive) to supportive**.
  - Sometimes working on the couch with a frequency of 4/5 times a week results into a supportive process focusing on the **creation** of inner structures/representations: **structuring**
  - Sometimes working with a chair and a lower frequency results in an insight giving process which was called in earlier times a psychoanalytic process, focusing on **restructuring** of inner mental representtions
  - Sometimes supportive forms af psychoanalytical forms of treatment, focusing on complaints creates structural changes in the personality

- **Stepped versus Matched Care**

Psychoanalytical Treatments 3

- Couch or chair
- Frequency
- Duration

- They all are instruments to provoke and revise or facilitate the development of the inner working model
- They are no aims in it self

Psychoanalytical Treatments 4

The analyst or therapist should:

- Manage regression
- Regulate emotions
- Make use of the psychotherapeutic relation
- Use interpretations
- Manage dependency /independency
- Managing the dose of relation: autonomy/relatedness

- By varying the frequency, intensity, duration, by focusing the material, by making use of the couch or not.
- Differences between the psychoanalytical treatments are about the process and not primarely about the content, the setting or the frequency
- **It is the session where change is happening**

TWO FORMS OF PATHOLOGY

Two Forms of Pathology

- **Mental process disorders**

- Somatic Self
- Dyadic relations
- No sharing
- No mentalizing ability
- Building new Structures
- The Relation as vehicle of change
- Failing S/O diff.
- Doing

- **Developmental pathology**

- **Conflicting mental representations**
- Psychological Self
- Triadic forms of relation
- Sharing
- Mentalizing ability
- Restructuring
- Interpretion as vehicle of change
- Adequate S/O diff.
- Feeling

- **Conflictual pathology**

Mental Process Disorders

- **Anxiety neurosis**
- Externally Regulated / Motivated
- Building Structures
- The area of Developmental Pathology
- Personality Disorders, Somatization, Somatoform disorder, Panic disorder, Conversion, Dissociative disorder and PTSD.
- Facilitating development by working “in” the transference : focusing upon the relation

- **MBT and TFP**

Conflicting mental representations

- **Psycho-neurosis**
- Intrapsychic Conflicts : conflictual pathology
- Internally regulated / Motivated
- Restructuring
- Neurotic pathology and mild personality disorders
- Open for interpretation of the conflicting mental representations by working through the transference.

- **Classical Psychoanalysis and Psychoanalytical Psychotherapy**
- **Short- Term forms of psychoanalytical psychotherapy**

PSYCHOANALYTIC TREATMENTS

Psychoanalytical Treatments

First Step

- Supportive Psychotherapy
- Short Term Psychoanalytic Psychotherapy

Second Step

- Psychoanalysis
- Psychoanalytical Psychotherapy
- A.F.T.
- T.F.P. or M.B.T.

Differences

Differences 1

Conflict Pathology: Conflicting mental representations

- Inducing a regressive transference neurosis: heatening up
- Working **through** the transference in a neutral way
- By using the instrument of **interpretation**
- It is about conflicting mental representations, or revision of the IWM
- Change by insight

Differences 2

Developmental Pathology: Mental Process disorders

- Facilitating development
- Inhibition of regression
- By working **in** the transference: cooling down
- Through adequate mirroring (sensitivity and responsivity)
- It is about the creation of the mentalizing process, or developing the IWM.
- Change by growth

Differences 3

- **In both cases -** process and representational disorders - we are trying to **detect, provoke** and **revise** the IWM
  - Revision of the IWM: by restructuring (conflict)
  - Development of the IWM: by structuring (deficit)

- **Different kind of patiënts**
  - High level mental functioning: neurotics
  - Middle level mental functioning: high/low level borderlines
  - Low level mental functioning: psychotics.

- Working with **different** aspects of the psychotherapeutic relation

Psychoanalytical treatments

- Are related to **personality** pathology, neurotic as well as structural.
- Improve the quality of the mental functioning,
  - either on the level of the neurotic personality organization
  - or on the level of the borderline personality organization.
- Focus on the working through of conflictual mental representations or the improvement of the mental process itself.
- Create a (better) balance between **autonomy** and **relatedness** or self-agency and interpersonal functioning

Psychoanalytical treatments

- **Neurotic Personality Organization: conflictual pathology**
  - Psychoanalysis: intrapsychic conflicts throughout personality
  - Psychoanalytic Psychotherapy: intrapsychic conflicts throughout personality
  - Short-Term: complaints/circumscribed conflicts within the person

- **Bordeline Personality Organization: more developmental pathology**
  - Psychanalysis, Psan Psth. + Mentalisation based interventions (high levellers)
  - Affect Phobia
  - The more developmental pathology is at stake the more TFP and MBT are indicated (middle and low levellers)

- **In bothe cases: Supportive Psychoanalytical Psychotherapy**

PSYCHOANALYTIC FORMS OF TREATMENT & ATTACHMENT

Psychoanalytical Treatments and Attachment 1

- **Safe attachment:**
  - Regression inducing approach.
  - Psychoanalysis and Psychoanalytical Psychotherapy or Short Term
  - AFT
  - High or low frequency, long or short in time, alternating on interpretation or relation
  - Therapeutic attitude: a balance between being more reserved and being expressive, focusing on the balance between **autonomy and relatedness**
  - Adequate affect regulation
  - He is able to balance between being on his own or being related

Psychoanalytical Treatments and Attachment 2

Avoidant attachment: Blatt 2008

- High frequency and long during.
- Psychoanalysis: on demand of the process
- At the start more focus on interpretation than on relation
- The therapist is more expressive and focusing more on the **relatedness**

- The patient is over-regulating his feelings
- No memories
- The patient is focusing on **autonomy**
- “I can do it on my own”

Psychoanalytical Treatments and Attachment 3

Preoccupied attachment: Blatt 2008

- Low frequency but long during
- Psychoanalytical Psychotherapy
- At the start more focus on relation than on interpretation
- Therapeutic attitude more reserved, focusing on **autonomy**

- Patient is under-regulating his feelings
- Feelings of loss are always on the foreground
- The patient is focusing on **relatedness**
- "I am not able to function on my own"

Psychoanalytical Treatments and Attachment 4

- **Disorganized attachment:**
  - Developmental approach,
  - Frequency and intensity depends on low/high level BPO
  - Patient is not able to regulate his emotions.
  - The patient is unable to create and keep boundaries
  - MBT or TFP

  - Therapeutic attitude is alternating between reluctance and being expressive and focusing both on **autonomy** and **relatedness**

Summary

1. It is not only about mental representations but also about the mentalizing process itself
2. It is about creating mental representations and solving conflicts between them
3. It is not only about interpreting but also about constructing/exploration of the mental state
4. It is not only about conflicts but also about deficits or inhibitions
5. **Developmental** and/or **conflictual** pathology

EVIDENCE

Research 1

1. F. Leichsenring; P. Luyten; M. Hilsenroth; A. Abbass; J. Barber; J. Keefe; F. Leweke; S. Rabung; C. Steinert: **Psychodynamic therapy meets evidence based medicine: a systematic review using updated criteria.** Lancet Psychiatry 2015; 2: 648 – 660P.
2. P. Fonagy: **The Effectiveness of Psychodynamic Psychotherapies: an update.** World Psychiatry 2015; 14: 137 – 150

Research 2

1. S. de Maat; Fr. De Jonghe; R.Schoevers; J.Dekker: **The effectivity of long-term psychoanalytic therapy: a systematic review of emperical studies.** Harvard Review of Psychiatry; 2009; 17:1 – 23
2. S. de Maat; Fr. De Jonghe; R .de Kraker; F. Leichsenring; A. Abbass; P. Luyten; J. Barber; R. Van; J. Dekker**: The Current State of the Empirical Evidence for Psychoanalysis: A Meta-analytic Approach**. Harvard Review of Psychiatry; 2013; 21: 3, 107 -137
3. M.de Wolf: **Psychoanalytische Behandelingen.** 2011 Bussum Coutinho

Different types of studies

Non Inferiority Trial

- Treatment A is as good or better as B
- Small sample
- To compare a new intervention with a proven old one

Superiority Trial

- Treatment A is better than B
- To compare an intervention with an inactive control for example placebo

Equivalency Trial

- Treatment A is as efficacious as B
- For example A is on a specific outcome measure α better than B
- Big sample

LEICHSENRING 2015

F. Leichsenring 1

- 64 RCT's
- Most of them were Short to medium term PDT (8-40 sessions)
- A few of them included also long-term (12 – 36 month)
- Maximising internal validity and minimises external validity
- Difference between efficacy and effectivity
- Most of the studies were superiority trials, equivalency trials were missing

- Psycho Dynamic Therapy (PDT)
  - Short Term
  - Long term Psychoanalytical Psychotherapy (LPPT)
    - Psychoanalysis (PA)

F. Leichsenring 2

Depressive disorders

- PDT superior to waiting list and alternative treatments for the improvement of depression
- PDT superior to TAU in case of maternal depression and patiënt with breast cancer
- Internet guided PDT superior to internet guided structured support
- PDT plus medication superior to medication alone or combined with suportive psychotherapy in major depressive disorders
- No significant differences in outcome in comparison with CBT
- No significant differences in outcome in comparison with other treatments of known efficacy
- Complicated grief: PDT superior to a waiting list or supportive psychotherapy

F. Leichsenring 3

Anxiety Disorders

- PDT evidence for the efficacy in the treatment of anxiety disorders
- PDT superior to applied relaxation
- No significant differences with CBT in treatment of panic disorders and social anxiety disorders, no significant differences in remission rate
- No differences between internet guided PDT or CBT
- For a mixed sample of anxiety disorders Short term PDT was superior to Long term PDT
- In case of either depressive or anxiety or both PDT was superior to TAU
- In case of social anxiety disorders or panic disorders PDT + medication was superior to medication alone

F. Leichsenring 4

PTSS

- No significant differences between PDT,CBT and Hypno therapy

Somatoform and somatic disorders

- PDT (short term) superior to TAU and supportive psychotherapy

Eating disorders

- PDT was in 1 RCT superior to CBT in cases of boulimia, in 2 others there was no difference and in 1, CBT was superior
- In case of anorexia there was more or less the same mixed results

F. Leichsenring 5

Personality disorders

- Results from 2 meta analyses showed PDT to be efficacious in the treatment of personality disorders

Cluster C

- In 2 RCT's no differences between PDT (AFT) and CBT
- 1 RCT showed CBT superior to a waiting list and PDT to the treatment of avoidant personlity disorders

Cluster B

- Several RCT's show that PDT is effective in the treatment of BPS
- Fonagy/Bateman: MBT is superior to a day treatment and to structural clinical management
- Clarkin: TFP is superior to supportive treatment and DBT in RF and Attachment, improvement of anger and inpulsivity.
- The comparison of TFP with SFT is not completely clear because of methodological reasons

F. Leichsenring 6

Heterogeneous samples of PD

- In 2 RCT's PDT was superior to a waiting list or minimal contact conditions

Substance related disorders

- Opiates:No differences between PDT and CBT, both were superior to drug counselling
- Cocaïne: Both PDT and CBT were inferior compared to individual drug counselling

Obsessive Compulsive disorder

- Only 1 RCT in which PDT + medication was not superior to medication alone
- High users of psychiatric services
- PDT was superior to TAU

Marital Treatment

- No differences were found between PDT and Behavioral Therapy

F. Leichsenring 7

Complex mental disorders

(chronic mental disorders; P.D. or multiple comorbid disorders)

- In several meta analyses LTPP (at least 50 sessions) was superior to Short Term Treatment

Discussion

- RCT makes use of treatment manual. Fonagy, Bateman (2009), Clarkin (2007) and Vinnars (2005) proved that manuals are no cookbooks and PDT can be manualized without loosing flexibility in the behavior of the therapists
- Treatment integrity: adherence seems to be very important
- Future research should focus not only on symptoms but also on more psychoanalytically relevant issues

FONAGY 2015

Fonagy 1

Depression

Short Term PDT: results are mixed: some studies are favouring PDT superior to waitinglist, placebo or TAU and some not

- 1 RCT about women with depressive disorders or breast cancer: PDT was superior
- 1 RCT of a mixed anxiety and depression group reported: superiority of PDT
- Unreplicated findings suggest that PDT may be particularly indicated if depression is accompanied by personality disorder or childhood trauma
- CBT was superior for the radomly rather than systematically assigned group of patiënts. PDT only those who were specifically selected for that treatment.

Long term PDT: very few studies

- The Helsinki study (2008/9/10/11) showed inferiority to short term in the beginning but superiority after 3 years follow-up. Psychoanalysis was initially inferior to other forms of therapy but more effective after 5 years follow-up

Fonagy 2

Long term PDT

- Huber (2012/2013) with major depressive disorder; randomized to or PA or LPPT:
  - no differences after 1 or 2 years follow-up, superiority of PA after 3 years follow-up
  - PA superior to CBT, LPPT was not

Meta-analyses

- High absolute effect sizes,medium compared with inactive controls, no difference to alternative interventions
- Discussion
- PDT is effective in the treatment of depression although their effectivity is moderate instead of large
- The effects are maintained in Long and Short term
- PDT is an alternative for medication and iadds to the effectivity of mdication
- The difference between PDT and CBT is neither large nor reliable

Fonagy 3

Anxiety

Short term PDT: few studies

- Superior to waiting list for social anxiety, social phobia
- No studies against inactive controls for generalized anxiety disorders
- No evidence that PDT is helpful for obsessive compulsive disorder
- Insufficient evidence for PDT in relation to PTSD

Meta-analyses

- PDT is more effective than inactive control conditions (medium effect sizes)

Discussion

- There is emerging evidence for PDT in cases of:social anxiety, perhaps generalized anxiety disorder and panic disorder
- Absence of evidence for PTSD and Obsessive compulsive disorder

Fonagy 4

Eating disorders

- There is strong evidence that PDT is effective in the treatment of anorexia nervosa
- There is uncertainty about the effectivity of PDT in the treatment of bulimia nervosa

Somatic problems

- A number of studies showed the usefulness of interpersonal PDT for patients presenting a range of pain symptoms. Medium effect sizes compared to TAU, with longduring effects.
- PDT is reducing long term health care costs.
- There are no recent relevant meta-analyses available
- The evidence base for PDT in somatoform disorders compared to control treatments is robust especially in patients with a history of sexual abuse
- No comparison with CBT

Fonagy 5

Drug dependence

- It is not clear whether PDT is effective in the treatment of drug dependency

Psychosis

- There is increasing optimism about the value of psychotherapy for psychosis.
- Supporting evidence is missing for both PDT and CBT

Fonagy 6

Personality Disorders

- Short term does less well against active controls
- TFP is superior to DBT and Supportive Therapy but less effective than SFT (there are doubts about the quality of the RCT) because of early drop outs in TFP
- MBT is superior to structured clinical management

Meta-analysis

- A number of meta-analyses shows that PDT is an effective form of treatment for personality disorders
- Discussion
- A review of the treatment of personality disorders shows that an effective form of treatment of PD should be: structured, focusing on self agency, the integration of feelings and actions, active and validating and it should incorporate supervision

Fonagy 7

Conclusions

- The conclusions of reviews and studies are often reflecting the theoretical orientation of the authors
- The current PDT approaches are (too) deeply rooted in the technical preferences of the professionals (expressive/supportive; deficit/conflict; PDT/CBT and Psychoanalysis or Psychoanalytic Psychotherapy)
- There is little evidence that PDT is superior to other therapeutic approaches
- The speed of recovery and cost-effectiveness is a crucial parameter

DE MAAT 2009/2013

De Maat 1 2009

Comparison psychoanalysis and psychoanalytic psychotherapy

- Only 19 studies including 1 RCT, the rest are cohort studies
- The quality of the design is variable, great heterogenity and the measurement of outcome
- No systematic use of diagnostic categories, mostly a combination of mood and personality disorders
- Differentiation between PA and LPPT
- Differentiation between mild and severe pathology
  - Mild pathology: regular indications for PA and LPPT
  - Severe pathology: personality disorders

De Maat 2 2009

LPPT: effect sizes mild pathology

- High effect sizes pre/post and at follow up
- For symptom reduction and personality change
- Effect sizes for symptom reduction is better than for personality change

LPPT: effect sizes severe pathology

- The same picture as with mild pathology
- Indications for growing effectivity after ending treatment

PA: effect sizes

- With mild pathology: the same picture as LPPT
- With severe pathology: no studies

ESs: 0.2-0.5 small; 0.5-0.8 moderate; ≥ 0.8 big

De Maat 1 2013

Current State of the emperical evidence for Psychoanalysis

- 14 studies (N 603)
- 13 cohort studies
- 1 RCT : Huber (2006/2012) with a frequency of twice a week
- 2-5 times a week, on the couch
- Mostly completers
- Complex mental disorders; anxiety and depressive disorders yes or no combined with a personality disorder
- Lack of control treatments
- Quality of the design is variable
- No manuals

De Maat 2 2013

- At termination there was a substantial pre/post change
  - mean effect size was 1.27
  - 1.52 for symptom instruments
  - 1.08 for personality and social functioning outcome
- At follow-up the effect was stable.
  - The effect sizes were: 1.46; 1.65; 1.31
- The majority of patients (62- 76%) were no longer clinical cases

- Findings are based upon pre/post studies the effect of psychoanalysis cannot be compared to the effects of alternative forms of treatment.

  → So firm conclusions about effectiveness are not possible

De Maat 3 2013

- Drop out rate of 3 – 33%, comparable with drop out in short term psychotherapies
- Although definite conclusions cannot be drawn there are indications that the presence of personality disorders is reducing the effect of treatment outcome for depression
- There was a moderate heterogenity in the analyses (duration, frequency, outcome measures) which can influence the results
- Huber(2006/12) Randomized patients to PA (2x7) or to LPPT (1x7). They found that PA performed better than LPPT
- Therapist ratings were the lowest, observer ratings the highest and patient ratings were in between

CONCLUSIONS

Conclusions

- PDT seems effective in the treatment of severe and complex pathology
  - Comparison with **inactive** control (waitinglist; TAU and Placebo) show effectivity for depresion some anxiety disorders, eating disorders and somatic or somatoform disorders
  - There is little evidence for the effectivity of PTSD, OCD, Bulimia nervosa, cocaine dependency or psychosis
  - The strongest evidence is in the area of personality disorders especially the Borderline Personality Disorder
  - Comparison with **active** treatments show that PDT is as effective as the alternative treatment
  - Most studies are superiority trials only a few eguivalency trials
  - There are some indications for growing effectivity LPPT after ending treatment
- Efficacy research for PDT is growing and the evidence is beginning to accumulate
- Efficacy research for PA is lacking

THE END

We are there for our patients and the patients are not there for our theoretical orientations

- **Dr. M.de Wolf**
- mhmdewolf@gmail.com