DYNAMIC THERAPIES FOR PSYCHIATRIC DISORDERS

Introduction: Why We Should Develop *Psychodynamic* Treatments for Specific Psychiatric *Disorders*

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Introduction:
Why We Should Develop Psychodynamic Treatments for Specific Psychiatric Disorders

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This chapter presents briefly the background and rationale for what the book intends to achieve. Developments in psychotherapy research and practice as well as changes in the patterns of delivery and reimbursement for mental health care have led us to conclude, along with many others, that psychodynamic psychotherapy is in a precarious situation. What follows are the recent developments responsible for our concerns.

SOCIAL AND POLITICAL DEVELOPMENTS

With the emergence of managed health care, such as health maintenance organizations (HMOs), and caps on reimbursement for inpatient and outpatient care, psychotherapists have become more aware of the importance of being recognized by the health alliances as providing a worthwhile, cost-effective service. In general, HMOs and similar managed care organizations provide their patients with a small number of low-fee therapy sessions. The aims of the treatment are mostly targeted at alleviating

symptomatic discomfort. It seems more than likely that the emphasis on specific disorders or on specific symptoms will continue and that therapists will be encouraged to use treatments that have been shown empirically to be effective for those disorders and symptoms.

EMPHASIS ON EMPIRICALLY DEMONSTRATED EFFECTIVE TREATMENT

There is consensus that psychotherapy in general appears to be effective (e.g., Smith & Glass, 1977); thus, the general question of effectiveness is no longer seen as relevant. Instead, the question has become, "What treatments are effective for what types of patients?" Along these lines, researchers on cognitive and behavioral treatments have shown that brief therapies can be effective for specific disorders. As an example, cognitive therapy (CT) (Beck, Rush, Shaw, & Emery, 1979) has been repeatedly shown to be effective for depression (Dobson, 1989), panic disorders (Clark, Salkovskis, Hackmann, Middleton, Anastasiades, & Gelder, 1991), and opiate addiction (Woody et al., 1983). In fact, CT is as effective as pharmacotherapy in treating depression (see, e.g., Beck, 1993, and Dobson, 1989, for reviews) and may be better than medication at preventing relapse (Barber & DeRubeis, 1989). Such efficacy research has already resulted in key organizations recommending that treatments whose effectiveness has been empirically demonstrated be the treatments of choice. However, the interpretation of the research literature by such organizations may be open to question. For

example, despite the demonstrated efficacy of CT for depression (Dobson, 1989), the American Psychiatric Association (1993) recommends the use of CT for mild to moderate depression only. Although empirical evidence may not always be sufficient to convince different policy-making groups of the efficacy of any form of psychotherapy, we cannot envision convincing those groups without such evidence.

PAUCITY OF EVIDENCE FOR THE EFFICACY OF DYNAMIC PSYCHOTHERAPY

If cognitive therapy is barely recommended for depression by the American Psychiatric Association, what would be the recommendations regarding dynamic psychotherapy? Besides being ignored in some circles, dynamic psychotherapy is increasingly believed to be not as effective as other forms of psychosocial treatment. This widespread belief in the field is not necessarily based on facts but rather seems to emerge from the vacuum created by the paucity of adequate studies examining the efficacy of dynamic psychotherapy, especially in comparison with other forms of psychotherapy. For example, no study has ever compared a manualized dynamic therapy with other treatments for anxiety or panic disorders (Barber, 1994a; Crits-Christoph, 1992). Furthermore, the few studies that have compared dynamic psychotherapy with other treatments did not find dynamic therapy to be less effective than other forms of psychotherapy. In particular, Paul Crits-Christoph (1992) has recently shown in a metaanalysis summarizing 11 high-

quality clinical trials that brief dynamic psychotherapy is more effective than waiting list controls and as effective as other psychotherapies. Thompson, Gallagher, and Breckendridge (1987) showed that brief dynamic therapy was as effective as cognitive therapy and behavior therapy in a sample of depressed elders. It is important to note that the studies Crits-Christoph (1992) selected had to follow a treatment manual, include experienced therapists in brief dynamic psychotherapy, and have carefully screened patients.

PSYCHOTHERAPY RESEARCH TRENDS

With the appearance of the third edition of the *Diagnostic and Statistical Manual (DSM-III)* in 1980, research addressing the efficacy of psychotherapy went through a quiet paradigm shift. Before 1980, researchers had looked at groups of neurotic outpatients and administered a "treatment" to them. Neither the patient population nor the treatment was specified in great detail. Since the beginning of the 1980s, researchers have adapted their treatments to groups of patients with specific diagnoses. In addition, researchers have begun using more specific treatment guidelines (Luborsky & DeRubeis, 1984). These guidelines, often called treatment manuals, include an explicit exposition of the strategies and techniques to be used in treatment.

It is quite possible that the use of the term *treatment manual* was a poor

choice. Clinicians often have strong negative reactions when they hear the term for the first time. As our colleague Robert Weinryb has pointed out, the term *manual* is often associated with the operation of programming a VCR; it could be that the term *treatment guidelines* will be more acceptable. Nevertheless, another way of addressing dynamic therapists' reluctance to consider treatment manuals is to explain what dynamic manuals are about. Examples of psychodynamic manuals are Luborsky's *Principles of Psychoanalytic Psychotherapy: A Manual for Supportive-Expressive (SE) Treatment* (1984); Strupp and Binder's *Psychotherapy in a New Key: A Guide to Time-Limited Dynamic Psychotherapy* (1984); and Kernberg et al., *Psychodynamic Psychotherapy of Borderline Patients* (1989). Each of these books presents the reader with a detailed list of things to do and guidelines on how to do them, what to avoid, and so on.

None of the aforementioned authors provides therapists with a list of interventions for each minute of each session. Like many other dynamic therapists, we do not believe that manuals for psychodynamic psychotherapy need to provide a minute-by-minute or hour-by-hour narration of therapists' actions; rather, they should provide a set of specific guidelines or principles about treatment goals and how to achieve them (Barber, 1994b).

We are aware, however, of an increasing trend, among behavior therapists in particular (e.g., Barlow, Craske, Cemy, & Klosko, 1989), to write

very specific and detailed treatment manuals for circumscribed problems (e.g., panic attacks without agoraphobia) and sometimes to disseminate these treatment manuals to paraprofessionals. Although such a "cookbook" approach has been shown to be effective with well-circumscribed psychological problems, it is unclear whether such an approach would be appropriate for patients suffering from more complex co-morbid disorders and concurrent pervasive interpersonal problems. Thus the cookbook approaches used by paraprofessionals are not likely, in our view, to be useful for the treatment of many outpatients.

In addition to treatment manuals, state-of-the-art psychotherapy research includes criteria for specific training requirements and supervision as well as checks on therapists' behavior during actual treatments.

DYNAMIC PSYCHOTHERAPY'S DIMINISHING ROLE IN PSYCHOLOGY AND PSYCHIATRY TRAINING PROGRAMS

In training programs, especially in clinical psychology, we have witnessed a reduction in the number of teaching faculty interested in psychodynamic thinking, along with an increase in interest in cognitive behavioral approaches. In psychiatry residency programs, interest also seems to have decreased in psychotherapy in general and in dynamic psychotherapy in particular. There are various reasons for these trends. Most important, however, is the decreasing interest in treatments that have not been

empirically supported. Thus, in the long term there will be a reduction in the number of therapists actually practicing dynamic psychotherapy unless its effectiveness is demonstrated.

CONCLUSION

The conclusion we draw is that well-designed studies comparing dynamic psychotherapy with other psychotherapies for specific disorders are the best means to provide some of the data required to support the effectiveness of this approach. Studies examining the efficacy of any psychosocial treatment need to include a very specific description of the treatment targeting a specific patient population. Therefore, the obvious first step is to make available treatment manuals that could be used for such clinical trials. In those areas in which treatment manuals are not available, the first step is to encourage experts in the treatment of various disorders to write in detail about the techniques and rationale they use. We narrowed our focus to those psychiatric problems for which we could find treatment experts willing to write a chapter for this book. We also focused on those psychiatric problems that we think respond to dynamic psychotherapy. We have not, therefore, attempted to cover all Axis I disorders. For example, we felt it was not worthwhile developing a treatment manual for *DSM-III* or *IV* obsessive compulsive disorders, although developing treatment manuals for anxiety and mood disorders, for example, should be of the utmost priority.

(We are currently editing a volume similar to this one for personality disorders.)

The emphasis on specific psychiatric disorders is not new in psychodynamic therapy. If we look at the historical development of treatment manuals, we discern a pattern of increased specificity (Barber, 1994b) and increased rejection of metapsychology. Following Freud (1912/1958a, 1912/1958b, 1913/1958, 1914/1958) and Fenichel (1945), books describing psychodynamic psychotherapy in nonanalytic settings began to appear. Langs (1973), for example, described in detail how a treatment manual for dynamic psychotherapy might look. Malan (1963, 1976), Mann (1973, 1991), and Sifneos (1972) came out with books detailing the application of psychodynamic techniques to short-term dynamic psychotherapy. Following their work, Horowitz (1976/1986) developed a 12-session treatment for a group of related disorders. In the late 1970s, Luborsky, Woody, Hole, & Velleco (1977) developed a treatment manual for opiate addicts for the Veterans' Administration-University of Pennsylvania psychotherapy study (Woody et al., 1983). More recently, Kernberg et al. (1989) wrote a manual, intended specifically for patients diagnosed with borderline personality disorder, from a long-term psychoanalytic psychotherapy perspective. Further specification is provided by Yeomans, Selzer, and Clarkin (1992), who address in depth an important aspect of Kernberg's treatment for borderline personality disorders, namely, how to make a safety contract with them in

treatment.

In summary, the goal of this book is to examine the efficacy of dynamic psychotherapy for specific disorders and to provide dynamic therapists with a set of heuristics that they can adopt and modify in their inpidual practices to treat patients with a specific diagnosis. The chapters in this book, in themselves, should not be taken as final treatment manuals. As a matter of fact, many of them are only the first steps in the much-needed development of complex, sophisticated, and clinically realistic treatment manuals. We hope that one day the chapters will be further developed and turned into more comprehensive treatment manuals that will be used for both clinical and research evaluations of the efficacy of dynamic psychotherapy for different disorders.

The authors of these chapters have accumulated a wealth of clinical experience with the treatment they present, and they believe those treatments have helped their patients. Most of the treatments described in this book have not yet been used in controlled research to examine their efficacy; one exception is the supportive-expressive therapy for opiate addiction (Chapter 5), which was used successfully in the clinical trial comparing cognitive therapy, supportive-expressive dynamic therapy, and inpidual drug counseling (Woody et al., 1983). At this point, we are interested in stimulating research using those treatments in order to be able one day to

make some statements about their efficacy compared with other forms of treatment. When dynamic therapy proves to be an efficacious treatment, these treatment manuals can then be used to disseminate the treatment methods through training programs and workshops. We want to emphasize, however, that dynamic psychotherapy treatment manuals are simply an aid in the learning process and that there is no substitute for supervision by an experienced expert in the method.

We also want to emphasize that the time is ripe for such an enterprise; it is certainly not too late to "board the plane." Our hope is that it is not too late for such research to get off the ground, because the field seems already to have decided, lacking evidence to the contrary, that dynamic treatments are not effective.

Some of our readers may not sympathize with our pragmatic stance regarding the issue of treatment manuals and our choice of specific disorders; instead, they may argue that such an approach is antithetical to psychodynamic thinking. An often-heard argument is that each patient is different and thus treatment needs to be tailored to each patient's needs; developing treatments for a group of patients defined by an approach as empirical as the *DSM* is not feasible. We agree and disagree with this argument. We certainly agree that each patient is different, and that in principle each patient has her or his specific dynamics that need to be

addressed during treatment; however, we also disagree in that we wonder whether there is a way to generalize across a group of patients. It is certainly worth looking for an underlying organization in many of the existing disorders. Although we were interested in including chapters on *DSM-IV* diagnoses, we instructed contributors that they did not have to follow the *DSM* classification but that they did need to describe the patient group they were addressing.

Another response to the above criticism is that many psychodynamic clinicians—even analysts, including Freud—have written about many forms of symptomatology and their underlying dynamics. That is, not only is it not antithetical to psychodynamic thinking to try to find underlying order in the varied forms of presentation that patients employ to express their problems, but looking for such order is of its essence.

We should also note that, although this volume endorses a pragmatic approach to research on dynamic psychotherapy and emphasizes the public health significance of treatment research through its focus on disorders, at the same time we fully endorse theory-guided research on dynamic psychotherapy (e.g., Luborsky, Barber, & Crits-Christoph, 1990). We believe the two approaches are not mutually exclusive. Researching the process of dynamic psychotherapy, developing measures of key clinical constructs, and studying patient-treatment matching are of equal importance in considering

the public health significance of a treatment. In fact, these different goals can sometimes be combined in the same study.

BRIEF OVERVIEW OF THE CHAPTERS

Many prominent schools of thought coexist under the umbrella of psychoanalytically or psychodynamically oriented psychotherapy, such as the Freudian, interpersonal, object relations, and self-psychology schools. In choosing contributors to this volume, we did not attempt to cover each school. Because we set a limit of one chapter per disorder, the reader will find no comprehensive survey of how different psychodynamic schools tackle patients with specific psychiatric disorders. Furthermore, we recognize that the treatments surveyed in this book are not the only ones.

The chapters differ in many ways. Three of the most important differences are *degree of eclecticism, length of treatment,* and *research background.* Although the general framework of treatment for many of the authors is dynamic psychotherapy, some have moved away from traditional dynamic psychotherapy and include components from other forms of treatment. For example, educational components are included in Katherine Shear, Marylene Cloitre, and Leora Heckelman's chapter presenting a brief, manualized psychodynamic treatment for panic disorder, in Jerome David Levin's chapter on psychodynamic treatment of alcohol abuse, and in Randy

Sansone and Craig Johnson's chapter on psychodynamic therapy for eating disorders. With substance abuse disorders, dynamic therapy is seen as complementary to 12-step programs.

From a research perspective, we would have preferred to include only chapters that describe a form of time-limited psychotherapy because it is still difficult to examine the efficacy of long-term or time-unlimited psychotherapies, both scientifically and pragmatically. We included, however, chapters from contributors who are not committed to time-limited psychotherapy because we recognized that treatment of some disorders (e.g., multiple personality disorders) may be less amenable to a time-limited approach, while other disorders (e.g., panic disorder, generalized anxiety disorder) could be helped in a preset time frame.

Some of the chapters come from a more research-oriented perspective (e.g., the chapters by Crits-Christoph et al.; Eells; Shear, Cloitre, & Heckelman; Luborsky, Woody, Hole, & Velleco; Luborsky, Mark, Hole, Popp, Goldsmith, & Cacciola; and Mark & Faude), while others have little involvement with treatment research (DeRoche). Some of the characteristics of the research-oriented chapters are more stringent and specific inclusion and exclusion criteria and more detailed specification of therapists' training. Some of the authors of these chapters have also paid closer attention to therapists' adherence to the treatment manual. No adherence rating scales, however, are

included in the chapters.

OUTLINE OF THE CHAPTERS

So that we would have a relatively uniform presentation of the treatments, each contributor was asked to address the following topics: (1) history and development of the method; (2) selection criteria used for treatment; (3) specific dynamic issues; (4) treatment goals; (5) theory of change; (6) techniques; (7) case examples; (8) training; and (9) empirical evidence for the approach.

History and Development

A brief review of how analysts and psychodynamically oriented psychotherapists have conceptualized and treated patients with the specific disorder, and how the authors have developed their own approach.

Inclusion/Exclusion Criteria

Description of the phenomenological and dynamic criteria used for defining the specific disorders. Any discrepancy with the *DSM* is discussed and explained. If relevant, a description of the diagnostic process is included.

Dynamic Issues

A detailed psychodynamic description of the specific features of the patients (e.g., etiology, developmental history, major conflicts, identifications, and specific defenses).

Treatment Goals

Description of the therapist's and the patient's goals, including any changes in goals during treatment.

Theory of Change

An account of the changes during treatment and the clinical factors responsible for them.

Techniques

A detailed description of the techniques used and the principles that guide the selection and implementation of interventions. If relevant, this section addresses the issues of time limits and termination.

Case Examples

A detailed and concrete presentation of how the approach is actually applied to a patient.

Training

A description of any experience in training therapists in the above method, and any thoughts on that process.

Empirical Evidence for the Approach

If available, a presentation of empirical data that address the issue of the efficacy of the treatment.

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