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A meta-analytic review of psychodynamic therapies for anxiety disorders

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HIGHLIGHTS

- Anxiety disorders are mental-health burdens that are sometimes difficult to treat.
- Psychodynamic therapy is commonly used to treat anxiety.
- Psychodynamic therapies may not differ overall in efficacy from other treatments.
- For most disorders investigated, efficacy may continue over a year post-treatment.
- Research should identify who may uniquely benefit from psychodynamic therapy.

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ABSTRACT

Recent randomized controlled trials (RCTs) suggest that psychodynamic therapy (PDT) may be useful in the treatment of anxiety disorders. This paper presents the most comprehensive meta-analysis to date examining the controlled effects of PDT for anxiety disorders. 14 RCTs totaling 1073 patients were included. PDT was found to be significantly more effective than control conditions ($g = 0.64$). PDT did not differ significantly from alternative treatments at post-treatment ($g = 0.02$), follow-up (FU) up to a year ($g = -0.11$), and FU past a year ($g = -0.26$). Medium-to-high levels of heterogeneity were detected, indicating significant differences between studies. Nevertheless, our findings remained unchanged when heterogeneity outliers were removed (termination $g = -0.06$/short FU $g = -0.01$/long FU $g = -0.10$). Power analyses indicated that large or medium effect size differences between PDT and other active treatments could be detected even with high heterogeneity. Exploratory moderator analyses found few significant predictors of effect (e.g., relative risk of dropout). No differences were found examining remission rates or relative risk of dropout. Overall, PDT was shown to be as efficacious as other active treatments that have been studied for anxiety disorders.

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1. Introduction

Anxiety disorders are among the most prevalent psychiatric conditions, with combined lifetime prevalence near 17% (Somers, Goldner, Waraich, & Hsu, 2006). Anxiety disorders have high rates of comorbidity with other Axis I and II psychiatric disorders (Andrews, Slade, & Issakidis, 2002), and are associated with substantial physical and mental health liabilities that are further aggravated by comorbidity (Andrews, Henderson, & Hall, 2001; Bruce et al., 2005; Kroenke, Spitzer, Williams, Monahan, & Löwe, 2007).

Several well-established treatments for anxiety disorders exist, including cognitive-behavioral therapies (CBT; Olatunji, Cisler, & Deacon, 2010) and psychopharmacological treatments (Hoffman & Mathew, 2008; Koen & Stein, 2011). However, as current treatments have incomplete efficacy and tolerability, it is valuable to explore other treatment options such as the widely used psychodynamic therapies (PDTs) (Fonagy, Roth, & Higgitt, 2005; Goisman, Warshaw, & Keller, 1999). PDTs have been studied and found to be efficacious for other types of disorders (Abbass, Hancock, Henderson, & Kisley, 2006 for short-term PDTs; Driessen et al., 2010 for PDTs for depression; Leichsenring & Rabung, 2011b for long-term PDTs for complex conditions; for a review of different disorders including anxiety disorders, see Barber, Muran, McCarthy, & Keefe, 2013) and have a rich theoretical literature concerning the nature of anxiety symptoms and their resolution (e.g., Busch, Milrod, Singer, & Aron, 2011 for panic; Slavin-Mulford & Hilsenroth, 2012 for a general review). However, PDT awaits a meta-analytic validation of its efficacy for anxiety disorders.

Broadly speaking, PDT is distinguished from CBT on the basis of different theoretical assumptions about the psychological processes underlying anxiety disorders, which result in different approaches to treatment (e.g., Busch et al., 2011; Crits-Christoph, Wolf-Palacio, Ficher, & Rudick, 1995; Leichsenring, Beutel, & Leibing, 2007; for a review see Slavin-Mulford & Hilsenroth, 2012). In psychodynamic theory, anxiety symptoms are often assumed to originate from relationship experiences in which certain feelings or wishes were experienced by the patient as painful, dangerous, or unacceptable (e.g., feelings of loss or abandonment, a wish to express anger or assert oneself). The patient learns to disavow these intense, negative feelings and desires, avoids their experiences, and develops anxiety symptoms (e.g., having a panic attack when triggered by sensations of loss or anger; Busch et al., 2011). Psychodynamic therapists encourage the patient to discuss the contexts in which their symptoms arise in order to understand the experiences surrounding the occurrence of symptoms. Therapists help the patient make connections between the experience of their current symptoms and the prior interpersonal and intrapsychic events from which these anxiety-producing defenses and dynamics may have originated, with the aim of reaching emotional insight. This may be especially helpful when the anxiety symptoms emerge in the therapeutic setting. Making such connections helps the patient to become more aware of and tolerate their own affect and wishes (i.e., lowering experiential avoidance; Kashdan, Barrios, Forsyth, & Steger, 2006), less rigid in interpersonal perceptions and behaviors, and allows the patient to try new ways of getting their needs met without anxiety while using more adaptive psychological defenses (Summers & Barber, 2009). Other PDT theories of anxiety emphasize object-relations theory and ambivalent feelings about significant others, attachment, and self-psychology concepts of esteem-regulation.

Unlike CBTs, psychodynamic therapists do not usually give out homework exercises to be performed outside of the therapeutic hour (e.g., in vivo self-exposure) nor do they provide adjunctive sessions (e.g., additional hours of guided exposure). However, encouraging patients to try new behaviors, especially those relevant to their own fears, has been within the aims of psychodynamic therapy since its inception, and the feelings and conflicts evoked by exposure may be useful material for psychodynamic work (Barber & Luborsky, 1991; Freud, 1926/1990; Summers & Barber, 2009; Wachtel, 1977). Nevertheless, it is unclear how often these recommendations are implemented in PDT (see Leichsenring et al., 2007 for a prominent exception concerning supportive–expressive therapy for social phobia, which includes a recommendation for exposure framed psychodynamically). Even if PDT does sometimes entail exposure, there is reason to suspect that it is often performed in a less directive and systematic manner as a consequence of other therapeutic foci (e.g., intense exploration of emotionally charged issues). By contrast, a recent survey study of CBT practitioners treating anxiety disorders identified the directive nature of CBTs and issues with behavioral assignments (e.g., exposure) as substantial barriers to treatment success for some patients with diagnoses of GAD, panic, and social anxiety disorders (McAleavey, Castonguay, & Goldfried, 2014; Szkodny, Newman, & Goldfried, 2014; Wolf & Goldfried, 2014). Thus, the less directive PDTs could conceivably provide an efficacious treatment frame for these patients.

At present, no PDT for any anxiety disorder qualifies as a well-established "empirically supported therapy" (EST) as per American Psychological Association (APA) Division 12 criteria (Chambless & Hollon,