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THERAPIES DERIVED FROM PSYCHOANALYSIS AS EMPIRICALLY SUPPORTED TREATMENTS

Private practice

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psychodynamic therapy
empirically supported treatments

Summary

The article aims to answer the question of whether therapies derived from psychoanalysis, referred to as psychoanalytic and psychodynamic therapies, can be considered as so-called empirically supported treatments. The characteristics of therapies derived from psychoanalysis are first described, including common theoretical assumptions and characteristics of the therapeutic approach. Next, the criteria for empirically supported treatments, as outlined by the American Psychological Association (APA) in 1995 (the first evaluation system, requiring two experimental studies) and 2015 (the current system, based on analysis of systematic reviews involving multiple experimental studies), are discussed. The importance of randomized controlled trials (RCTs) in the process of evaluating the efficacy of psychological interventions is also described. Taking the current APA evaluation system as a frame of reference, the article presents recent research on the effectiveness of therapies derived from psychoanalysis. Evidence presented therein suggested that psychoanalytic and psychodynamic therapies can be considered as empirically supported treatments for adults suffering from common disorders: depressive, anxiety, personality and somatoform disorders. An evaluation of the available evidence provided the basis for the recommendation of psychoanalytic and psychodynamic therapies in the treatment of these disorders.

Introduction

The concept of evidence-based practice is becoming increasingly popular and relevant, impacting the evaluation of psychological therapies and decisions regarding their public funding. Scientific research is thus becoming not only a means of testing theories and advancing psychotherapy practice but also a source of information that shapes public awareness and determines the accessibility of specific psychological interventions within public healthcare. Consequently, many psychoanalytic and psychodynamic therapists highlight the need to conduct research and disseminate findings on the effectiveness of treatments derived from psychoanalysis [see e.g., 1–3].

Research on psychoanalysis and psychoanalytic therapies has a long history [4–6]. Interested readers can find extensive publications on this topic [see e.g., 3, 7], including works available in Polish [8]. This article does not aim to be an exhaustive review. The approach adopted here is defined by a specific purpose: to answer the question of whether therapies derived from psychoanalysis can be considered empirically supported treatments[1]. Such an assessment requires not merely discussing any available empirical studies but research that meets specific criteria [10].

Accordingly, the paper is divided into three sections. The first section describes the characteristics of therapies derived from psychoanalysis, i.e., psychodynamic and psychoanalytic therapies. Next, the criteria for empirically supported treatments, as defined by the American Psychological Association (APA), are discussed. These evaluation frameworks provide the basis for reviewing data on the efficacy of psychodynamic and psychoanalytic therapies in the treatment of specific mental disorders.

Therapies derived from psychoanalysis

Sigmund Freud developed psychoanalysis, the first method of "talking cure", at the turn of the 20th century. Since then, psychoanalytic theory has evolved and diversified, giving rise to a wide range of therapeutic approaches [see, for example, 11, 12]. Therapies derived from psychoanalysis, often referred to as psychoanalytic or psychodynamic therapies, despite differences in theoretical assumptions and clinical methods, share important common features that allow them to be classified as a single group of psychotherapeutic approaches. The shared theoretical premise is the assumption that human functioning is determined by unconscious mental processes and that every mental act has its origin and meaning [13, 14]. The common clinical characteristics, in turn, are the features of the therapeutic process. Seven such characteristics have been empirically identified: a focus on affect and expression of patient's emotions, analysis of attempts to avoid difficult emotions and thoughts, identification of recurring patterns in the patient's life, discussion of past experiences to understand current difficulties from a developmental perspective, focus on interpersonal relationships, attention to the therapeutic relationship (i.e., transference analysis) and exploration of the fantasy life [15, cf. 16–17].

Although psychodynamic and psychoanalytic therapists focus on the shared aspects of the patient's functioning outlined above, they may differ in terms of treatment characteristics such as the duration of therapy, the structure of the process, or the interventions employed. For instance, therapies derived from psychoanalysis can be either short-term or long-term and may follow an open structure or be conducted according to specific treat-

[1] Empirically supported treatments are also referred to as evidence-based treatments. However, it should be stressed that the movement promoting empirically supported treatments is not synonymous with so-called evidence-based practice (see detailed discussion, e.g., in [9]).

ment protocols [see e.g., 18–19]. Additionally, the interventions used by the therapist can be positioned along an interpretive-supportive continuum[2] [17, 20–24].

It is important to note that, despite existing controversies, the terms "psychodynamic psychotherapy" and "psychoanalytic psychotherapy" are generally used interchangeably in the international literature [16, 25, cf. 8, 26]. This is likely due to the shared characteristics outlined above, which — despite differences — allow therapies derived from psychoanalysis to be considered part of one "family of psychotherapeutic approaches" [17, p. 287]. This integrative perspective is reflected, among others, in the codification of therapeutic competencies and research procedures. For example, there is a description of the key competencies needed to conduct psychoanalytic and psychodynamic therapies [25]; the consensus on such competencies has also been established in Poland [26]. Moreover, in review studies, such as those conducted by Leichsenring and colleagues [17, 20–24], the keywords used to identify relevant studies included "psychodynamic psychotherapy", "dynamic psychotherapy" and "psychoanalytic psychotherapy". Therapies labeled as such were required to share common features so that, in line with current standards [27], researchers could be confident that meta-analytic evaluations of treatment efficacy were based on studies utilizing the same therapeutic approach.

In this review, consistent with the integrative approach outlined above, psychoanalytic and psychodynamic therapies, as therapies derived from psychoanalysis, will be treated as a single group of therapeutic approaches. This decision is made for the sake of clarity. Specifically, the clinical characteristics of psychoanalysis-based therapies outlined earlier serve as the foundation for operational definitions in review studies, which are the main source of evidence for empirically supported therapies.

Criteria for empirically supported treatments

To assess whether a therapy is an empirically supported treatment, it must be evaluated against specific criteria. Various classification systems exist [10], which, despite their differences, share a common principle: they prioritize data from randomized controlled trials. These systems either exclusively consider such studies [see e.g., 27–29], or rank them as high-quality evidence within a hierarchical framework for evaluating scientific data [see e.g., 30].

Given the variety of existing systems, this paper will refer to two evaluation approaches proposed by the American Psychological Association (APA). This choice was made because APA's systems are widely recognized in international scientific discussions and provide a key framework for evaluating psychotherapies, including those derived from psychoanalysis, which are discussed in this paper [17, 21].

[2] Interpretive interventions are designed to enhance the patient's insight into emotions, defense mechanisms and internal conflicts that underlie the difficulties they experience. In contrast, supportive interventions (such as giving advice) aim to strengthen the patient's ego functions that may be temporarily inaccessible.

As mentioned above, a randomized controlled trial (RCT) is considered the gold standard in efficacy research [see, e.g., 31]. Key features of this research model include strict participant selection and randomization, meaning patients are randomly assigned to either the experimental group (receiving the therapy the researchers intend to evaluate) or the control group (where they either wait for treatment or receive an alternative therapy with pre-established efficacy). Since, at the start of the study, patients experience "the same difficulties" (as defined by a nosological diagnosis) and are randomly assigned to research groups, any changes in the severity of these difficulties (measured as outcomes) after the treatment can be attributed to the interventions. Due to its precise control over potential confounding variables, the RCT is considered the most reliable research model for determining whether a therapy works – that is, based on the collected results, researchers can make causal inferences regarding the therapy's efficacy.

In 1995, the American Psychological Association (APA) established criteria for empirically supported treatments (ESTs) and published the first list of therapies that met these criteria [28]. According to the original evaluation system, psychological therapy was considered a well-established treatment if at least two experiments[3] conducted by independent research groups provided empirical support for manualized therapies (i.e., therapies guided by a standardized treatment manual) in a clearly defined patient group (i.e., patients with a specific nosological diagnosis)[4]. An outcome provided empirical support if it demonstrated that psychotherapy was either (a) superior to a placebo pill, psychological placebo or another psychotherapy, or (b) equivalent to an already established treatment.

If the therapy met the above criteria, it was considered a well-established treatment. If it met less stringent criteria (e.g., the waiting list as a comparison group), it was classified as a probably efficacious treatment. If the therapy did not meet the criteria for a well-established or probably efficacious treatment, it was considered an experimental treatment.

At this point, it is important to emphasize that just because a therapy meets the criteria for a well-established treatment for a specific disorder, this does not necessarily imply that a therapy based on a particular theory is universally efficacious. A precise description of the research group serves as a limitation on the generalizability of the findings concerning the therapy's efficacy across different disorders or patient populations. Consequently, even if a therapy is deemed efficacious for treating adult patients with depressive disorders according to APA criteria, this does not automatically imply that it is also efficacious for, for instance, adolescents or children with the same disorder.

The original classification system proposed by the APA faced significant criticism. Key concerns included the limited number of required studies, the focus on symptoms (neglecting psychosocial functioning), the difficulty of generalizing results (as findings often did not transfer into clinical practice) and the reliance on statistical significance (which

3) The empirical equivalent was considered to be data from at least nine single-case design experiments.
4) Cf. the Polish proposal, which also includes two experimental studies [29].

provided little insight into the relevance of observed changes for patients' functioning) (see detailed discussion in [27]).

In response to the noted limitations and the growing body of research on the efficacy of psychological therapies, a new criteria system was proposed in 2015 [27]. This approach requires that therapy evaluation draws on meta-analysis results, assesses the quality of evidence and, importantly, provides specific recommendations for therapy application, marking a practical shift. The evaluation process considers functional outcomes (not just symptom improvement), a long-term stability (i.e., sustained effects over time) and emphasizes practical and clinical significance rather than mere statistical significance. According to this framework, therapy assessment proceeds in two stages: (1) a systematic review of available RCT studies[5] (meta-analysis) and (2) an evidence quality rating (high, moderate or low), which then informs recommendations on therapy use, categorized as very strong, strong or weak.

Evidence is considered high quality if, based on the available data, we can be confident that the estimated results accurately reflect the true effect. For this to be possible, the following conditions must be met: the analysis includes a wide range of studies with no significant methodological limitations; differences between studies are minimal (i.e., results exhibit high homogeneity); and the average effect sizes have narrow confidence intervals. Evidence is classified as moderate quality when the true effect is likely close to the estimated effect based on research findings. This occurs when the available studies have some methodological weaknesses or when the confidence intervals for the average effect are wide. Evidence is considered low quality when there is a high probability that the true effect differs substantially from the estimated effect. This situation arises when studies have serious methodological flaws, there is significant variability in results and the confidence intervals are very wide.

The evidence quality assessment outlined above forms the basis for making therapy recommendations (see Table 1).

[5] It is worth noting that the original system permitted methodological equivalents to RCT studies, i.e., single-case design experiments (with a minimum of 9 cases). Currently, however, only RCT studies are recommended for inclusion [27, p. 11].

Table 1. **The APA's system for evaluating empirically supported treatments, based on systematic reviews [27]**

Recommendation	The conditions that must be met
Very strong recommendation	All of the following: There is high-quality evidence that the treatment produces a clinically meaningful effect on symptoms of the disorder being treated. There is high-quality evidence that the treatment produces a clinically meaningful effect on functional outcomes. There is high-quality evidence that the treatment produces a clinically meaningful effect on symptoms and/or functional outcomes at least three months after treatment discontinuation. At least one well-conducted study has demonstrated effectiveness in non-research settings.
Strong recommendation	At least one of the following: There is moderate- to high-quality evidence that the treatment produces a clinically meaningful effect on symptoms of the disorder being treated. There is moderate- to high-quality evidence that the treatment produces a clinically meaningful effect on functional outcomes.
Weak recommendation	Any of the following: There is only low- or very low-quality evidence that the treatment produces a clinically meaningful effect on symptoms of the disorder being treated. There is only low- or very low-quality evidence that the treatment produces a clinically meaningful effect on functional outcomes. There is moderate- to high-quality evidence that the effect of the treatment, although statistically significant, may not be of a magnitude that is clinically meaningful.

Effectiveness of psychotherapies derived from psychoanalysis

Research on psychoanalysis and psychoanalytical psychotherapies has a long history [4–6]. The International Psychoanalytic Association supports researchers by offering funding for scientific projects and collecting information on empirical studies focused on psychoanalytic theory and practice. A synthesis of this information is presented in a publicly available review document, the "An open-door review of outcome studies in psychoanalysis", with its third edition published in 2015 [7].

In the context of current methodological standards, an important question arises: are there RCT studies aimed at evaluating the efficacy of therapies derived from psychoanalysis? The answer is affirmative, as evidenced by numerous reviews, some of which will be discussed later in this article. As a starting point, however, it is useful to consider the review by Peter Lilliengren [32]. Lilliengren identified 298 RCT studies published between 1967 and 2022. Notably, likely due to evolving methodological requirements, the number of RCTs

increased over time, with 123 studies (41.2%) published in the past decade. The majority of the studies focused on short-term therapies (up to 40 sessions), though long-term therapies were also included in the analysis. The reviewed studies involved patients from a variety of age groups (primarily adults, around 85%) and with diverse diagnoses (mood, anxiety, personality and psychosomatic disorders predominated, accounting for 57%). The review's findings suggest that patients receiving psychoanalysis-based psychotherapies generally achieve better outcomes than those in inactive control groups (e.g., no therapy or waiting lists). Furthermore, no significant differences were observed between these patients and those in comparison groups receiving alternative forms of therapy.

Although there are RCT studies on the efficacy of psychoanalytic therapies, one might question whether they meet the criteria for empirically supported treatments. Lilliengren's review provides an initial positive answer. The analyses presented in the review are based on available RCT studies demonstrating the effectiveness of psychodynamic therapies; however, no selection was made according to methodological criteria. Therefore, in the following sections of the article, two of the most recent review works led by Falk Leichsenring [17, 21] will be discussed in detail, as they directly address the APA evaluation criteria.

The first review pertains to the first evaluation system [28]. Although a different evaluation framework is currently in use [27], the original APA criteria continue to serve as a reference framework in scientific discourse and several other classification systems are analogous to it [cf. e.g., 29]. Thus, it seems worthwhile to outline the findings of this initial review.

First and foremost, it is important to emphasize that Leichsenring and his team [21], in their review of the empirical literature, selected studies strictly following the APA criteria [28]: (1) a randomized controlled trial (RCT) as the research model; (2) the study included a control group: no interventions (no treatment or a waiting list), an active control group (e.g., placebo or standard treatment) or a control group with an active therapy with established efficacy (psychotherapy or pharmacotherapy); (3) diagnosis and outcome assessments were conducted using reliable and valid instruments; (4) treatment included adult patients with a specific type of disorder; (5) therapy was standardized through a precise description of the treatment.

Ultimately, 39[6] studies published between 1970 and 2014, meeting all of the aforementioned criteria, were included in the review. Based on a qualitative analysis of these studies, the authors concluded that – according to the criteria proposed by the APA – psy-

[6] Leichsenring and colleagues conducted similar reviews three times [22–24]. However, these analyses differed in the number of studies included: 27 [22], 42 [23] and 67 [24]. These differences may stem from the timing of study identification, but the substantial reduction to 39 RCT studies in the present review primarily results from the exclusion of studies in which psychodynamic therapy was compared with an established treatment but lacked sufficient sample size for equivalence testing (a criterion not applied in earlier reviews). For instance, the comparative study by Barkham et al. [33], involving a total of 36 patients (18 in each group), was included in the three prior reviews but excluded from the analyses described here due to insufficient statistical power (see Table 1 in: supplementary materials [21]).

chodynamic therapy meets the standards for efficacious treatment in cases of depression, social phobia, anorexia, borderline disorder and heterogeneous personality disorders. Additionally, data available as of 2015 indicated that psychodynamic therapy could be considered probably efficacious treatment in treating dysthymia, complicated grief, generalized social anxiety, panic disorder and substance abuse/dependence. The authors noted that their analyses were restricted to adult populations and for many disorders (e.g., obsessive-compulsive disorder), no data from studies meeting APA criteria were available. Furthermore, they highlighted that numerous studies could not be included due to insufficient sample sizes (see footnote 6).

The review outlined above – though a valuable source of information – now serves primarily as a historical reference. Currently, the most relevant benchmark is a recently published meta-review that employs the updated evaluation framework (i.e., the 2015 APA criteria). Leichsenring and colleagues [17] identified 11 recent meta-analyses on psychodynamic therapy for adult patients diagnosed with depressive disorders ($k = 27$ RCT studies), anxiety disorders ($k = 17$), personality disorders ($k = 16$) and somatic symptom disorders ($k = 17$). In line with the APA evaluation system, the authors assessed study quality using the GRADE system (Grading of Recommendations, Assessment, Development and Evaluations), ultimately appraising the quality of available evidence and formulating recommendations for the application of therapy in specific mental disorders. A summary of the review's findings is provided in Table 2.

Table 2. **Psychodynamic/psychoanalytic psychotherapy in the treatment of mental disorders. Quality of evidence assessment according to the criteria of the American Psychological Association (based on [17])**

Disorder	Control group	N	Effect size, g (95% CI)	Evidence quality
Depressive disorders	vs. all controls	1017	–0.58 (–0.83, –0.33)	high
	vs. active controls	945	–0.51 (–0.68, –0.35)	high
	vs. active therapies	2154	0.10 (–0.06, 0.26)	moderate
Anxiety disorders	vs. all controls	479	–0.72 (–1.06, –0.37)	moderate
	vs. active controls	86	–0.64 (–1.14, –0.14)	low
	vs. active therapies	1196	0.06 (–0.11, 0.23)	moderate
Personality disorders	vs. all controls	239	–0.63 (–0.87, –0.41)	moderate
	vs. active controls	200	–0.65 (–0.99, –0.32)	moderate
	vs. active therapies	473	–0.04 (–0.31, 0.22)	moderate
Somatic symptom disorders	vs. all controls	776	–0.47 (–0.70, –0.23)	high
	vs. active therapies	644	–0.41 (–0.74, –0.09)	high

A detailed discussion of Table 2 is presented below[7].

[7] The table and paper include the results of analyses in which the authors removed outliers.

Depressive disorders

Psychodynamic therapy was superior to interventions in all control groups ($g = -0.58$; 95% CI: – 0.33 to – 0.83; $k = 12$, $N = 1017$). This effect was also observed when compared with active control groups (g = – 0.51, 95% CI: – 0.68 to – 0.35; $k = 9$, $N = 945$). The largest difference was noted when comparing waiting list controls; patients undergoing psychodynamic therapy exhibited significantly lower levels of depressive symptoms ($g = -1.14$; 95% CI: – 1.66 to – 0.62; $k = 3$, $N = 115$). The observed differences can be considered medium effects; the confidence intervals suggest that the true effect is either large (-0.83 and – 0.68) if the upper bounds of the confidence intervals are considered, or small but still clinically significant if the lower bounds are taken into account (-0.33 and – 0.35).

In comparisons with other active therapies, no significant differences were observed ($g = 0.10$, 95% CI: – 0.06 to 0.26; $k = 19$, $N = 2154$). The sample size was sufficient to detect a clinically significant effect. Additionally, in follow-up measurements ranging from 2 to 55 months after treatment termination, no difference was found between psychodynamic therapy and other therapies ($g = 0.08$, 95% CI = – 0.14 to 0.30; $k = 9$, $N = 1096$).

The available evidence was rated as high or moderate quality[8], supporting a strong recommendation for the use of psychodynamic therapy in the treatment of depressive disorders.

Anxiety disorders

The meta-analysis included in the review considered 17 RCTs on the effectiveness of psychodynamic psychotherapy for individuals suffering from anxiety disorders: agoraphobia with or without panic attacks, panic disorder, social anxiety disorder, generalized anxiety disorder and PTSD. Psychodynamic therapy was superior to interventions in all control groups ($g = -0.72$, 95% CI: – 1.06 to – 0.37, $k = 6$, $N = 479$). A similar difference was observed when comparing the experimental group with active control groups; however, only three studies were available, which limited the precision of the estimate ($g = -0.64$, 95% CI: – 1.14 to – 0.14, $k = 3$, $N = 86$). This effect can be considered a medium-sized difference; the confidence intervals suggest that the true effect ranges from very large (-1.06), if the upper bound of the confidence interval is considered, to small but still clinically significant if the lower bound is taken into account (-0.37).

When comparing psychodynamic therapy to other active therapies, no clinically significant differences were observed ($g = 0.06$, 95% CI: – 0.11 to 0.23, $k = 14$, $N = 1196$). The effect was not dependent on the type of anxiety disorder. Clinically significant differences were also not observed in follow-up studies: those lasting up to one year after treatment completion ($g = -0.03$, 95% CI: – 0.25 to 0.19; $k = 9$, $N = 914$) and those conducted more than a year after treatment ($g = 0.00$, 95% CI: – 0.20 to 0.20; $k = 4$, $N = 617$).

8) In the case of analyses comparing psychodynamic therapy to other active therapies there were certain limitations concerning the procedure of group assignment, decreasing the strength of evidence.

The quality of the available evidence was rated as moderate, but as low when compared to active therapies in the analyses[9]. However, the overall data supported a strong recommendation for the use of psychodynamic therapy in the treatment of anxiety disorders.

Personality disorders

The meta-analysis included in the review encompassed 16 RCTs addressing borderline personality disorder or cluster C personality disorders. Psychodynamic therapy proved to be more effective in reducing personality disorder symptoms than interventions in all control groups ($g = -0.63$, 95% CI: – 0.87 to – 0.41, $k = 5$, $N = 239$), including active controls ($g = -0.65$, 95% CI: – 0.99 to – 0.32, $k = 4$, $N = 200$). The observed differences indicate a medium effect; the confidence intervals suggest that the effect size ranges from large (–0.87, –0.99) to medium. However, the relatively small sample size limits the precision of the estimate.

Comparisons of the effectiveness of psychodynamic psychotherapy to other active therapies revealed no significant differences ($g = -0.04$, 95% CI: – 0.31 to 0.22, $k = 6$, $N = 473$). No differences in effect sizes were observed based on the type of disorder (borderline vs. cluster C personality disorders). The lack of significant differences persisted in follow-up studies as well ($g = -0.18$, 95% CI: – 0.38 to 0.03, $k = 4$).

The available evidence was rated as moderate quality. Psychodynamic psychotherapy received a strong recommendation for use in the treatment of personality disorders.

Somatic symptom disorders

Psychodynamic therapies were effective in reducing somatic symptoms compared to all control groups ($g = -0.47$, 95% CI: – 0.70 to – 0.23, $k = 10$, $N = 776$) and active control groups ($g = -0.41$, 95% CI: – 0.74 to – 0.09, $k = 7$, $N = 644$). The observed difference in symptom reduction between psychodynamic therapies and control groups can be considered a medium-sized effect; the upper values of the confidence intervals indicate a large or medium effect, while the lower values are slightly below the accepted threshold (i.e., – 0.25). The difference in effectiveness was maintained in the follow-up study, conducted 3 to 6 months after treatment, compared to all control groups ($g = -0.45$, 95% CI: – 0.69 to – 0.20, $k = 4$, $N = 479$) and active control groups ($g = -0.45$, 95% CI: – 0.69 to – 0.20, k = *4*, $N = 479$). The meta-analysis did not include studies comparing the effectiveness of psychodynamic psychotherapy to other active therapies.

The available evidence was rated as high quality. A strong recommendation was made for the use of psychodynamic therapies in the treatment of somatic symptom disorders.

[9] Only three studies were available.

Summary

Based on the findings discussed above, it can be argued that psychodynamic therapies meet the current APA criteria for empirically supported treatments. The analyses presented include recently published systematic reviews, encompassing a wide range of RCT studies. Conceptual homogeneity was demonstrated in the methods used as psychodynamic therapies, as well as the appropriate quality of the included RCT studies and the conducted meta-analyses. For patients treated with psychodynamic therapy, compared to control groups, clinically significant symptomatic improvement was observed; these differences were noted both after the completion of treatment and in follow-up studies. Differences in the effectiveness of psychodynamic therapy compared to other active therapies were not significant, suggesting clinical equivalence. The analysis of study characteristics indicated that there is high-quality evidence (in depressive and somatic symptom disorders) or moderate-quality evidence (in anxiety and personality disorders). Therefore, strong recommendations can be made for the use of psychodynamic therapies in the treatment of depressive, anxiety, personality and somatic symptom disorders (cf. Table 1).

Discussion

Returning to the question posed at the outset: can treatments derived from psychoanalysis be considered empirically supported treatments? Answering this question requires precision. First, it should be emphasized that we adopt the perspective of the empirically supported treatments movement, which defines specific criteria for evidence, focusing exclusively on the results of RCTs [9]. It is equally important to note that in other contexts, "evidence" or "empirical support" may include findings from other types of research (see, for example, the definition of "best evidence" within evidence-based practice: [34, p. 274]).

Second, adopting this specific perspective, we can assert that, according to the current APA criteria, psychoanalytic and psychodynamic therapies are considered empirically supported treatments for adults suffering from depressive, anxiety, personality and somatic symptom disorders. For other disorders, there is currently either an insufficient number of RCTs available or the relevant expert panels have not yet conducted their evaluations. It can be expected that further research will continue and the findings will be disseminated.

Third, it is important to remember that, although therapies derived from psychoanalysis share common features [13–16], they differ in terms of theoretical assumptions and working techniques. The fact that certain therapies have achieved the status of empirically supported treatments for specific disorders does not imply that all psychoanalytically derived therapies would meet the required criteria. Representatives of specific therapeutic schools must monitor the current state of research and undertake empirical studies to address identified gaps if they wish to adhere to established scientific standards. In this context, it is also worth noting that the pluralism within the psychoanalytic tradition (sometimes referred to as fragmentation [35, p. 14]) creates a need for evaluation tools tailored to in-

dividual therapeutic schools. Effectiveness research could potentially serve as such a tool, complementing clinical methods.

Fourth, in the case of psychoanalytically derived therapies, it is often emphasized that therapeutic effects persist or even increase after the therapy has ended [16]. If this is the case, the current APA evaluation system [27] includes an important measure — from the perspective of psychoanalytic approaches — of long-term therapeutic effects. The stability of the therapeutic effect after treatment has concluded (at least three months) is, in fact, one of the necessary criteria for a therapy to receive a very strong recommendation (see Table 1). These current criteria are particularly relevant because the original evaluation system was criticized for favoring therapies that, among other things, do not result in significant, enduring change over time [36]. This argument requires revision, as the review by Leichsenring and colleagues demonstrated that while the effects of psychodynamic therapies do persist after treatment, this was equally true for other therapies with established efficacy [17].

As part of the discussion, it is also important to consider another perspective. One could argue that the effectiveness of therapies does not automatically validate the underlying theoretical assumptions. Since the 1930s, there has been ongoing debate about the role of common factors across different therapies, which — regardless of specific therapeutic methods — may contribute to the observed improvement in patients (e.g., therapist empathy, therapeutic alliance) [37]. For example, it is possible that two therapists using the same therapeutic approach may have different levels of effectiveness, while therapists from different schools of therapy may achieve comparable outcomes. In this view, it is not necessarily the method itself that drives therapeutic success, but rather the therapist delivering it. For instance, the therapeutic alliance is the factor most strongly correlated with treatment outcomes, yet studies have shown that therapists differ in their ability to establish this alliance with patients [38]. Recognizing the importance of therapist characteristics leads to the suggestion that, in addition to comparing therapeutic methods, effectiveness should also be evaluated based on therapists themselves — using the RCT model where applicable [see, for example, 31, p. 552].

Additionally, the fact that the effectiveness of therapy does not validate the underlying theory underscores the need for multi-level empirical research. Psychoanalytic theory continues to face criticism as unscientific and the existing pluralism — as previously mentioned — raises legitimate concerns [37]. Therefore, on one hand, there remains a need for research that facilitates the evaluation and further development of psychoanalytic theories, as well as potential modifications to therapeutic techniques (see, for example, a discussion of such research [39]). On the other hand, it is equally important to disseminate the extensive body of existing work that has been produced since the outset of psychoanalysis [5–7].

References

1. Martindale B. Changes in psychoanalytic therapy in Europe over three decades. Then and now. Psychoanal. Psychother. 2022; 36(4): 383–436.
2. Kernberg OF. The pressing need to increase research in and on psychoanalysis. Int. J. Psychoanal. 2006; 87(4): 919–936.
3. Leuzinger-Bohleber M, Arnold SE, Solms M, red. Outcome research and the future of psychoanalysis. London: Routledge; 2020.
4. Leuzinger-Bohleber M. Development of a plurality during the one-hundred-year-old history of research of psychoanalysis. In: Leuzinger-Bohleber M, Kächele H, eds. An open-door review of outcome studies in psychoanalysis. London: International Psychoanalytical Association; 2015: 18–32.
5. Wallerstein R. The generations of psychotherapy research: An overview. Psychoanal. Psychol. 2001; 18(2): 243.
6. Wallerstein R, Fonagy P. Psychoanalytic research and the IPA: History, present status and future potential. Int. J. Psychoanal. 1999; 80(1): 91–109.
7. Leuzinger-Bohleber M, Kächele H. An open-door review of outcome studies in psychoanalysis. Third Edition. London: International Psychoanalytical Association; 2015.
8. Kalita L, Chrzan-Dętkoś M. Skuteczność psychoterapii psychoanalitycznych. Psychoter. 2017; 4(183): 5–16.
9. Duncan BL, Reese RJ. Empirically supported treatments, evidence-based treatments, and evidence-based practice. In: Weiner IB, Stricker G, Widiger TA, eds. Handbook of psychology, vol 8. Clinical psychology, II. Psychotherapy. Hoboken, New Jersey: John Wiley & Sons, Inc.; 2013: 489–513.
10. Rakowska JM. Użyteczność kliniczna interwencji psychoterapeutycznych wspartych empirycznie. Rocz. Psychol. 2011; 14(1): 7–22.
11. Cierpiałkowska L, Gościniak J, eds. Współczesna psychoanaliza: teorie relacji z obiektem. Wydaw. Fundacji Humaniora; 2002.
12. Mitchell SA, Black MJ. Freud i inni. Historia współczesnej myśli psychoanalitycznej. Kraków: Wydawnictwo Uniwersytetu Jagiellońskiego; 1996/2016.
13. Musiał M. Psychoterapia psychoanalityczna jako metoda leczenia i poznawania umysłu. Psychiatr. Prakt. Klin. 2009; 2(2): 93–99.
14. Leźnicka-Łoś A. Podstawy terapii psychoanalitycznej. Teoria i praktyka. Gdańsk: Imago; 2012.
15. Blagys MD, Hilsenroth MJ. Distinctive features of short-term psychodynamic-interpersonal psychotherapy: A review of the comparative psychotherapy process literature. Clin. Psychol. Sci. Pract. 2000; 7(2): 167–188.
16. Shedler J. The efficacy of psychodynamic psychotherapy. Am. Psychol. 2010; 65(2): 98.
17. Leichsenring F, Abbass A, Heim N, Keefe JR, Kisely S, Luyten P et al. The status of psychodynamic psychotherapy as an empirically supported treatment for common mental disorders — an umbrella review based on updated criteria. World Psychiatry 2023; 22(2): 286–304.
18. Leichsenring F, Schauenburg H. Empirically supported methods of short-term psychodynamic therapy in depression — towards an evidence-based unified protocol. J. Affect. Disord. 2014; 169: 128–143.
19. Leichsenring F, Salzer S. A unified protocol for the transdiagnostic psychodynamic treatment of anxiety disorders: An evidence-based approach. Psychotherapy 2014; 51(2): 224.

20. Leichsenring F. Are psychodynamic and psychoanalytic therapies effective: A review of empirical data. Int. J. Psychoanal. 2005; 86(3): 841–868.
21. Leichsenring F, Leweke F, Klein S, Steinert C. The empirical status of psychodynamic psychotherapy — an update: Bambi's alive and kicking. Psychother. Psychosom. 2015; 84(3): 129–148.
22. Leichsenring F, Klein S. Evidence for psychodynamic psychotherapy in specific mental disorders: A systematic review. Psychoanal. Psychother. 2014; 28(1): 4–32.
23. Leichsenring F, Klein S, Salzer S. The efficacy of psychodynamic psychotherapy in specific mental disorders: A 2013 update of empirical evidence. Contemp. Psychoanal. 2014; 50(1–2): 89–130.
24. Leichsenring F, Luyten P, Hilsenroth MJ, Abbass A, Barber JP, Keefe JR et al. Psychodynamic therapy meets evidence-based medicine: A systematic review using updated criteria. Lancet Psychiatry 2015; 2(7): 648–660.
25. Lemma A, Roth A, Pilling S. The competences required to deliver effective psychoanalytic/psychodynamic therapy. https://www.ucl.ac.uk/pals/research/clinical-educational-and-healthpsychology/research-groups/core/competence-frameworks-6 [retrieved: 12.07.2024].
26. Kalita L, Bittner-Jakubowska A, Buzun E, Dworczyk P, Giza M, Henzel-Korzeniowska A et al. Competences needed to conduct psychoanalytical and psychodynamic therapies in Poland. Psychoter. 2021; 197(2): 51–66.
27. Tolin DF, McKay D, Forman EM, Klonsky ED, Thombs BD. Empirically supported treatment: Recommendations for a new model. Clin. Psychol. Sci. Pract. 2015; 22(4): 317.
28. APA Task Force on Promotion and Dissemination of Psychological Procedures. Training in and dissemination of empirically validated psychological treatments: Report and recommendations. Clin. Psychol. 1995; 48: 3–23.
29. Rakowska JM. Skuteczność zapobiegania zaburzeniom psychicznym i ich leczenia: Wnioski z badań dla praktyki klinicznej. Warszawa: Wydawnictwa Uniwersytetu Warszawskiego; 2021.
30. WHO. Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders. Geneva: World Health Organization; 2023.
31. Gold C. Quantitative psychotherapy outcome research: Methodological issues. In: Gelo O, Pritz A, Rieken B, eds. Psychotherapy research: Foundations, process, and outcome. London: Springer; 2014: 537–558.
32. Lilliengren P. A comprehensive overview of randomized controlled trials of psychodynamic psychotherapies. Psychoanal. Psychother. 2023; 37(2): 1–24.
33. Barkham M, Rees A, Shapiro DA, Stiles WB, Agnew RM, Halstead J et al. Outcomes of time-limited psychotherapy in applied settings: Replicating the Second Sheffield Psychotherapy Project. J. Consult. Clin. Psychol. 1996; 64(5): 1079.
34. APA Presidential Task Force on Evidence-Based Practice. Evidence-based practice in psychology. Am. Psychol. 2006; 61(4): 271–285.
35. Fonagy P. Some complexities in the relationship of psychoanalytic theory to technique. Psychoanal. Q. 2003; 72(1): 13–47.
36. Shedler J. Where is the evidence for "evidence-based" therapy. J. Psychol. Ther. Prim. Care 2015; 4(1): 47–59.
37. Rosenzweig S. Some implicit common factors in diverse methods of psychotherapy. Am. J. Orthopsychiatry 1936; 6(3): 412.
38. Baldwin SA, Wampold BE, Imel ZE. Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. J. Consult. Clin. Psychol. 2007; 75(6): 842.

39. Westen D. The scientific legacy of Sigmund Freud: Toward a psychodynamically informed psychological science. Psychol. Bull. 1998; 124(3): 333.

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Szanowni Państwo,

serdecznie zapraszamy na **Konferencję Trzech Sekcji**, kolejną z cyklu tzw. Trójkonferencji organizowanych przez trzy Sekcje Psychoterapii Polskiego Towarzystwa Psychiatrycznego i Polskiego Towarzystwa Psychologicznego. W tym roku organizacją wydarzenia zajmuje się **Sekcja Naukowa Psychoterapii Polskiego Towarzystwa Psychiatrycznego.**

Konferencja Trzech Sekcji odbędzie się w Międzynarodowym Centrum Kongresowym w Katowicach w terminie 25–27 października 2024 roku. Tematem tegorocznej konferencji jest „Ciało w psychoterapii".

Choć ciało jest w psychoterapii stale obecne fizycznie, to rzadko znajduje się w centrum uwagi. Dychotomia ciało — psychika skłania nas do odsuwania spraw ciała na bok. Staje się ono tłem, na którym wypatrujemy „istotniejszych" zjawisk psychicznych. Tym razem chcemy to odwrócić — postawić ciało w centrum uwagi psychoterapeutów i przypomnieć, że bez niego nie ma psychoterapii.

Zapraszamy do patrzenia na ciało z różnych stron z nadzieją na twórczą syntezę wielu spojrzeń. Liczymy na zobaczenie w nim ważnego partnera w przymierzu terapeutycznym. Z jednej strony ciało jawi się jako obszar kształtowania tożsamości i miejsce spotkania wewnętrznego świata psychiki z zewnętrznym światem społecznym. Z innej wygląda jak pryzmat określający nasz sposób percepcji i narzędzie umożliwiające nam działanie. Z jeszcze innej — widziane z pomocą urządzeń do neuroobrazowania — bezcenne źródło informacji, które pomaga weryfikować psychoterapeutyczne teorie.

Takich spojrzeń może być bardzo wiele i mamy nadzieję, że ten wielowymiarowy obraz cielesności pacjentów i terapeutów pozwoli nam lepiej współpracować z ciałem w szukaniu pomocy dla ducha.

Zachęcamy do śledzenia aktualności na naszej stronie trojkonferencja2024.pl oraz na Facebooku Sekcji facebook.com/SNPPTP.

Mamy nadzieję na Państwa obecność podczas tego ważnego dla środowiska psychoterapeutów wydarzenia.

Zarząd SNP PTP