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The role of therapy duration in interpreting change and treatment outcomes in psychodynamic psychotherapy: a systematic review

Rola czasu trwania terapii w interpretacji zmiany i wyników leczenia w psychoterapii psychodynamicznej: przegląd systematyczny

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Abstract

Introduction and objective: Mental disorders are a major global health concern, with psychodynamic psychotherapy recognised as an important treatment option. The optimal duration of psychodynamic therapy – short-term (≤6 months) vs. long-term (>6 months) – remains a subject of debate, with implications for clinical practice, treatment outcomes, and healthcare resource allocation. **Materials and methods:** This systematic review was conducted in accordance with the PRISMA 2020 guidelines, synthesising randomised controlled trials published between 2000 and 2025 that directly compared short-term and long-term psychodynamic psychotherapy in adults with mental disorders. Two studies involving 493 participants met the inclusion criteria. Outcomes included symptom severity, interpersonal and psychosocial functioning, remission rates, and treatment dropout. **Results:** Both short-term and long-term psychodynamic psychotherapy resulted in significant symptom reduction. Short-term therapy led to faster initial improvement (15–27% greater reduction during the first year), whereas after three years, long-term therapy demonstrated superior outcomes (14–37% greater reduction; higher remission rates at ten-year follow-up). The presence of a personality disorder moderated treatment efficacy: patients with personality disorders benefited more from long-term therapy, whereas those without personality disorders achieved similar outcomes with either treatment duration. High levels of social support were associated with better long-term outcomes; low social support favoured short-term therapy. Long-term therapy was associated with higher dropout rates (33% vs. 9%). **Conclusions:** Comparative efficacy of psychodynamic psychotherapy depends on patient characteristics and the timing of outcome assessment. Long-term therapy is recommended for patients with personality disorders; short-term therapy may be sufficient for other patients. Personalised treatment selection and strategies to support treatment continuation are essential for optimising outcomes and healthcare resource use.

Keywords: psychodynamic psychotherapy, systematic review, duration, mental disorders, efficacy

Streszczenie

Wprowadzenie i cel: Zaburzenia psychiczne stanowią poważny problem zdrowia publicznego na świecie, a psychodynamiczna psychoterapia jest uznawana za istotną opcję terapeutyczną. Optymalny czas trwania terapii psychodynamicznej – krótkoterminowej (≤6 miesięcy) *vs* długoterminowej (>6 miesięcy) – pozostaje przedmiotem dyskusji, mając istotne znaczenie dla praktyki klinicznej, wyników leczenia i alokacji zasobów. **Materiał i metody:** Przegląd systematyczny przeprowadzono zgodnie z wytycznymi PRISMA 2020, analizując randomizowane badania kontrolowane opublikowane w latach 2000–2025, które bezpośrednio porównywały krótkoterminową i długoterminową psychoterapię psychodynamiczną u dorosłych z zaburzeniami psychicznymi. Do analizy włączono dwa badania obejmujące 493 uczestników. Oceniano

nasilenie objawów, funkcjonowanie interpersonalne i psychospołeczne, wskaźniki remisji oraz odsetek rezygnacji z leczenia. **Wyniki:** Obie formy terapii prowadziły do istotnej redukcji objawów. Krótkoterminowa terapia dawała szybszą poprawę (o 15–27% większa redukcja w pierwszym roku), lecz po trzech latach długoterminowa terapia wykazywała lepsze efekty (o 14–37% większa redukcja; wyższy odsetek remisji po dziesięciu latach). Status zaburzenia osobowości moderował skuteczność: osoby z zaburzeniami osobowości korzystały bardziej z terapii długoterminowej, a pozostali osiągali podobne wyniki w obu formatach. Wysokie wsparcie społeczne sprzyjało lepszym efektom terapii długoterminowej; niskie wsparcie społeczne promowało terapię krótkoterminową. Terapia długoterminowa wiązała się z wyższym odsetkiem rezygnacji (33% *vs* 9%). **Wnioski:** Skuteczność terapii psychodynamicznej zależy od cech pacjenta i czasu oceny. Terapia długoterminowa zalecana jest przy zaburzeniach osobowości; krótkoterminowa może wystarczać w pozostałych przypadkach. Personalizacja leczenia i strategie wspierania kontynuacji terapii są kluczowe dla optymalizacji wyników i wykorzystania zasobów.

Słowa kluczowe: psychoterapia psychodynamiczna, przegląd systematyczny, czas trwania, zaburzenia psychiczne, skuteczność

INTRODUCTION

Mental disorders represent a substantial global health burden, affecting approximately one in four individuals during their lifetime (World Health Organization, 2022). Depression, anxiety disorders, and personality disorders are among the most prevalent conditions, contributing significantly to disability, reduced quality of life, and substantial economic costs. Psychotherapy remains a cornerstone of treatment, with various therapeutic modalities demonstrating efficacy across diverse populations and settings. Psychodynamic psychotherapy, rooted in psychoanalytic theory, focuses on unconscious processes, interpersonal relationships, and the exploration of past experiences to understand and resolve current psychological difficulties (Shedler, 2010). In contrast to cognitive-behavioural or solution-focused approaches that emphasise symptom reduction through structured techniques, psychodynamic therapy aims to facilitate lasting personality change and improved self-understanding by exploring the therapeutic relationship and interpreting unconscious conflicts (Leichsenring et al., 2015). A central question in psychodynamic practice concerns optimal treatment duration. Traditional psychoanalysis involved intensive, long-term treatment extending over several years. However, contemporary practice includes both short-term psychodynamic psychotherapy (STP), typically delivered over weeks to months, and long-term psychodynamic psychotherapy (LTP), extending beyond six months to several years (Leichsenring et al., 2004). Proponents of short-term approaches argue that focused, time-limited interventions can produce meaningful symptom relief while being more cost-effective and accessible (Messer and Warren, 2004). Conversely, advocates for long-term treatment contend that deeper personality change and sustained improvement require extended therapeutic work, particularly for complex or chronic conditions (Fonagy, 2015). Despite decades of clinical practice and research, the comparative efficacy of short-term vs. long-term psychodynamic psychotherapy remains insufficiently synthesised. Previous systematic reviews have examined psychodynamic therapy broadly, but they often combine different treatment durations or compare psychodynamic approaches to other modalities rather than directly contrasting short-term vs. long-term psychodynamic interventions (Abbass et al., 2014). Understanding the relative benefits of different treatment durations has important implications for clinical decision-making, as it helps clinicians match treatment intensity to patient needs. It also affects resource allocation by guiding healthcare policy on optimal service provision. Additionally, it supports patient choice by enabling informed decisions about treatment commitment and influences cost-efficacy by balancing clinical outcomes with economic considerations.

This systematic review aims to identify and synthesise randomised controlled trials that directly compare short-term vs. long-term psychodynamic psychotherapy for mental disorders, evaluate the comparative efficacy of these approaches across multiple outcome domains – including symptomatic, interpersonal, and functional outcomes – assess the methodological quality of the included studies, and identify gaps in the evidence base with recommendations for future research. To address the aims, the central focus was to determine how the efficacy of short-term psychodynamic psychotherapy compares with that of long-term psychodynamic psychotherapy in the treatment of mental disorders. This evaluation is grounded in evidence drawn from randomised clinical trials, enabling a direct comparison of both treatment approaches across a range of clinical outcomes.

METHODS

This systematic review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines (Page et al., 2021).

Protocol and registration

This review was not registered in the PROSPERO database because the work commenced before protocol registration was considered. The authors nonetheless adhered to the

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PRISMA 2020 guidelines and standard practices for systematic reviews in psychiatric research to maintain methodological rigour.

Eligibility criteria

Studies were selected according to the following PICOS (Population, Intervention, Comparison, Outcomes, Study design) framework. The population included adults aged 18 years or older who were diagnosed with mental disorders according to DSM-5 or ICD-10 criteria, and comprised clinical samples from outpatient or inpatient settings. The intervention focused on short-term psychodynamic psychotherapy, defined as a treatment duration of six months or less, and long-term psychodynamic psychotherapy, defined as a treatment duration of more than six months, with a clearly described psychodynamic approach such as psychoanalytic psychotherapy, mentalisation-based therapy, or transference-focused therapy. For the comparison, only studies that directly compared short-term and long-term psychodynamic psychotherapy within the same study were included, while studies comparing psychodynamic therapy with non-psychodynamic modalities were excluded. The primary outcomes assessed were symptomatic improvement (including depression and anxiety symptoms), interpersonal functioning, and global functioning and quality of life. Secondary outcomes included work ability and occupational functioning, treatment retention and dropout rates, and adverse events. Finally, eligible study designs were randomised controlled trials (RCTs) or clinical trials with random allocation, published in English between January 2000 and November 2025.

Exclusion criteria

Studies were excluded if they were systematic reviews, meta-analyses, case reports, or observational studies; included children or adolescents under 18 years exclusively; examined non-clinical or healthy volunteer samples; did not clearly distinguish between short-term and long-term psychodynamic approaches; compared psychodynamic therapy only with non-psychodynamic interventions; or were conference abstracts, dissertations, or unpublished manuscripts. The inclusion and exclusion criteria are described in detail in the Supplementary Material (Appendix A).

Information sources and search strategy

Databases searched

Systematic searches were conducted in November 2025 across Scopus, PubMed/MEDLINE, and Semantic Scholar.

Search terms

The search strategy incorporated a combination of terms related to psychodynamic therapy, including "psychodynamic psychotherapy", "psychodynamic therapy", and "psychoanalytic therapy". To capture treatment duration, the search included terms such as "short-term", "long-term", "duration", and "brief". Study design was represented by terms like "randomized controlled trial", "RCT", "clinical trial", and "randomized". Finally, the population of interest was described using terms including "mental disorders", "psychiatric disorders", "depression", "anxiety", and "personality disorders". The search strategy is described in detail in the Supplementary Material (Appendix B).

Study selection process

Screening phases

Study selection followed a two-stage process. In the first stage, title and abstract screening, all retrieved records were screened against the eligibility criteria using a liberal inclusion approach, meaning that studies were retained if they were potentially relevant. This screening was performed using a structured, criteria-based evaluation. In the second stage, full-text screening, the full texts of potentially eligible studies were retrieved and subjected to a detailed assessment against all inclusion and exclusion criteria. This stage involved a rigorous evaluation of study design, intervention comparisons, and outcomes, as well as documentation of exclusion reasons for rejected studies.

Deduplication

Duplicate records identified across databases were removed during the merging and reranking process, which combined results from all four databases into a single relevance-ranked dataset.

Data collection process

Data extraction

A standardised data extraction protocol was developed to ensure comprehensive and consistent data collection. The protocol covered study characteristics (authors, year, country, and setting), participant characteristics (sample size, demographics, and diagnoses), intervention details (duration, number of sessions, frequency, and therapeutic approach), comparison conditions, outcome measures and assessment time points, results (means, standard deviations, effect sizes, *p*-values, and confidence intervals), and risk-of-bias indicators. Data were extracted manually from full-text articles using a structured extraction process to ensure completeness and accuracy.

Risk-of-bias assessment

Study quality was evaluated using the Cochrane Risk of Bias 2 (RoB 2) tool (Sterne et al., 2019), which assesses the randomisation process and allocation concealment, deviations from intended interventions, missing outcome data and attrition, measurement of outcomes and blinding, and selection of reported results. Each domain was rated as low risk, some concerns, or high risk of bias.

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Data synthesis

Given the small number of included studies (n = 2) and the heterogeneity in outcome measures, a narrative synthesis approach was employed rather than a meta-analysis. The synthesis systematically described study characteristics, summarised intervention details and treatment parameters, compared efficacy findings across outcome domains, evaluated patterns and consistency of results, and identified methodological limitations and reporting gaps. Effect direction and statistical significance were reported where available, but the absence of standardised effect sizes in most included studies precluded quantitative pooling.

RESULTS

Study selection

The systematic search conducted across three databases initially identified 617 records. Following automatic deduplication during the merging process, 98 unique records remained for screening. During the title and abstract screening phase, 98 records were reviewed, of which 11 studies were considered potentially eligible and advanced to full-text review. The remaining 87 records were excluded primarily for being systematic reviews or meta-analyses (34 records), lacking a comparison of short-term vs. long-term psychodynamic therapy (28 records), not being randomised controlled trials (15 records), or focusing on non-psychodynamic interventions (10 records). In the full-text screening stage, 11 full-text articles were assessed, and two studies ultimately met all inclusion criteria and were included in the qualitative synthesis. Nine studies were excluded at this stage because they did not directly compare short-term vs. long-term psychodynamic therapy (3 studies), included mixed therapy modalities without distinct psychodynamic arms (2 studies), were observational in design without randomisation (1 study), reported results from the same cohorts (2 studies); or involved a paediatric population under 18 years of age (1 study). The process of study selection is shown in Fig. 1.

Study characteristics

Two studies were included in this review, each accompanied by several associated reports providing additional analyses and long-term outcomes.

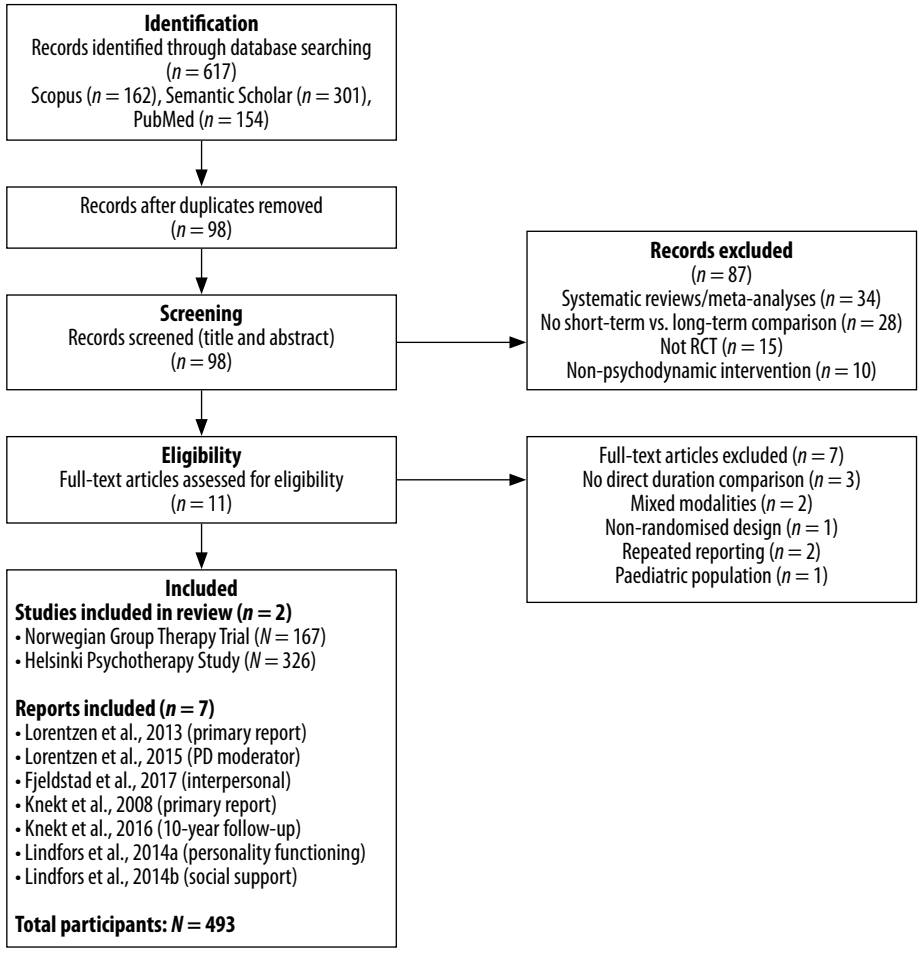

Fig. 1. PRISMA 2020 flow diagram of the study selection process

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The first study, the **Norwegian Group Psychodynamic Therapy Trial**, was primarily reported by Lorentzen et al. (2013)167 out-patients with mood, anxiety and personality disorders were randomised to short- or long-term group therapy (20 or 80 weekly, 90 min sessions. This randomised controlled trial was conducted in public mental health outpatient clinics across Norway and involved 167 patients. Participants had a mean age of 38.4 years, and 63% were female. Diagnoses among the sample included mood disorders, anxiety disorders, and personality disorders; notably, 45% of participants had comorbid personality disorders, and the mean duration of illness was 15 years. Baseline assessments indicated that patients were moderately disturbed but exhibited relatively low symptom severity.

The interventions compared were short-term and long-term group psychodynamic therapy. Short-term therapy consisted of 20 weekly sessions over approximately five months, whereas long-term therapy comprised 80 weekly sessions over roughly 18 months. Therapy was delivered in groups of five to eight patients and conducted by a team of nine therapists, including psychiatrists, psychologists, psychiatric nurses, and a social worker. To ensure consistency and quality, the treatment was manualised and therapists received ongoing supervision.

Outcomes were measured using the Symptom Checklist-90-Revised Global Severity Index (SCL-90-R GSI) for psychiatric symptoms, the Inventory of Interpersonal Problems-Circumplex version (IIP-C) for interpersonal functioning, and the Global Assessment of Functioning-Split version (GAF-S for symptoms, GAF-F for functioning). Assessments were conducted at baseline, at the end of treatment, and at one, two, and three years following the start of therapy, with extended analyses for interpersonal problems available up to seven years. Attrition rates varied between groups, with 8.6% of participants in the short-term group and 33.3% in the long-term group terminating treatment prematurely.

Additional reports from this study included a personality disorder moderator analysis ((Lorentzen et al., 2015) and an interpersonal change trajectory analysis (Fjeldstad et al., 2017).

The second study included in this review was the **Helsinki Psychotherapy Study**, primarily reported by Knekt et al. (2008). This randomised controlled trial evaluated the efficacy of both long- and short-term psychodynamic psychotherapy, as well as solution-focused therapy for psychiatric symptoms, over a three-year follow-up period. Additional analyses from this study were later published, including a ten-year follow-up report (Knekt et al., 2016) and two reports on the moderating role of social support (Lindfors et al., 2014b) and personality functioning (Lindfors et al., 2014a).

The trial was conducted within outpatient psychiatric services in Helsinki, Finland, and randomised a total of 326 patients. Participants ranged in age from 20 to 46 years, with a mean age of 32 years, and approximately three-quarters were female. Most participants were diagnosed with depressive disorders (84.7%), and a substantial proportion had anxiety disorders (43.6%). Chronicity was notable, with 38.9% experiencing disorders lasting more than five years. Patients with severe personality disorders were excluded.

Three treatment arms were compared: short-term psychodynamic psychotherapy (SPP), solution-focused therapy (SFT), and long-term psychodynamic psychotherapy (LPP). The SPP arm provided 20 sessions over a period of five to six months, while the SFT arm offered 12 sessions across eight months. The LPP intervention involved two to three sessions per week for up to three years. All therapies were delivered individually by qualified therapists, with those providing long-term therapy generally having greater clinical experience.

A range of outcome measures was employed to assess treatment effects, including the Symptom Checklist-90 Global Severity Index (SCL-90-GSI) for general psychiatric symptoms, the Beck Depression Inventory (BDI) and the Hamilton Depression Rating Scale (HAMD) for depressive symptoms, the Symptom Checklist 90 Anxiety subscale (SCL-90-ANX) and the Hamilton Anxiety Rating Scale (HAMA) for anxiety symptoms, and several measures of work ability and functional capacity.

Assessments were conducted at baseline, throughout treatment, at the end of treatment, and at one, two, and three year post-treatment. A subset of participants also underwent extended follow-up at ten years. Attrition was notable, with 33 patients declining participation after randomisation and 42 discontinuing treatment prematurely. However, the reports did not consistently detail dropout rates by treatment condition. In addition, a substantial proportion of patients in each group received auxiliary treatments during the study period: 47% in the solution-focused therapy arm, 58% in the short-term psychodynamic psychotherapy arm, and 33% in the long-term psychodynamic psychotherapy arm. Characteristics of the included studies are presented in Tab. 1.

Risk of bias in studies

In the **Norwegian Group Psychodynamic Therapy Trial** by Lorentzen et al. (2013), risk of bias was carefully evaluated across several domains. The risk arising from randomisation was considered low, as the study described an adequate randomisation procedure and implemented appropriate methods to conceal allocation. However, there were some concerns regarding deviations from intended interventions. Specifically, dropout rates differed substantially between groups – with 33.3% in the long-term therapy group discontinuing treatment prematurely compared with only 8.6% in the short-term group. Although reasons for dropout were documented, they may have differed systematically between groups. Additionally, it was not clearly specified whether intention-to-treat analyses were applied consistently across all outcomes.

Regarding missing outcome data, concerns remained due to the nearly four-fold difference in attrition rates between

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Study	Design	Setting	*N*	Population	Interventions	Outcomes	Follow-up	Attrition
Norwegian Group Psychodynamic Therapy Trial (Fjeldstad et al., 2017; Lorentzen et al., 2013, 2015)	RCT	Public mental health clinics, Norway	167	Mean age 38.4 years; 63% female; mood, anxiety, and personality disorders (45% with PD); mean illness duration 15 years	STP: 20 weekly group sessions (5 months) LTP: 80 weekly group sessions (18 months)	SCL-90-R GSI, IIP-C, GAF-S, GAF-F	3 years (extended to 7 years for interpersonal outcomes)	STP: 8.6% LTP: 33.3%
Helsinki Psychotherapy Study (Knekt et al., 2008, 2016; Lindfors et al., 2014a, 2014b)	RCT (3 arms)	Outpatient psychiatric services, Finland	326	Age 20–46 years (mean 32); 75% female; depressive (84.7%) and anxiety disorders (43.6%); 38.9% with illness >5 years; severe PD excluded	STP: 20 sessions (5–6 months) or SFT 12 sessions (8 months) LTP: 2–3 sessions/week for up to 3 years	BDI, HAMD, SCL-90-GSI, SCL-90-ANX, HAMA, work ability	3 years (10-year follow-up for subset)	33 declined post-randomisation; 42 discontinued treatment

Note: The characteristics of the included studies are summarised in Tab. 1. The Norwegian Group Psychodynamic Therapy Trial (Fjeldstad et al., 2017; Lorentzen et al., 2013, 2015) and the Helsinki Psychotherapy Study (Knekt et al., 2008, 2016; Lindfors et al., 2014a, 2014b) both employed randomised controlled trial designs in public mental health settings in Norway and Finland, respectively. Each study enrolled adult participants presenting with mood, anxiety, and (in the Norwegian sample) personality disorders, with varying proportions of female participants and differing illness duration. Interventions compared short-term and long-term group-based (Norwegian Study) or individual psychodynamic therapies (Helsinki Psychotherapy Study), with session frequency and duration differing significantly between conditions. Primary outcomes included validated measures of psychological distress, interpersonal functioning, global assessment, and work ability. Follow-up periods extended over several years, and both studies reported notable attrition rates, particularly within the long-term intervention arms.
BDI – Beck Depression Inventory; **HAMA** – Hamilton Anxiety Rating Scale; **HAMD** – Hamilton Depression Rating Scale; **LTP** – long-term psychodynamic psychotherapy; **PD** – personality disorder; **RCT** – randomised controlled trial; **SCL-90-ANX** – Symptom Checklist-90 Anxiety subscale; **SCL-90-GSI** – Symptom Checklist-90 Global Severity Index; **SFT** – solution-focused psychotherapy.

Tab. 1. Characteristics of included studies

groups. Procedures for handling missing data were not fully described, increasing the possibility that attrition may have influenced the results. By contrast, the risk of bias in the measurement of outcomes was judged to be low. The study used validated outcome measures, including the Symptom Checklist-90-Revised (SCL-90-R), IIP-C, and Global Assessment of Functioning (GAF), which comprised both self-report and clinician-rated instruments. However, it was not clearly stated whether outcome assessors were blinded to group allocation.

Finally, the risk of bias in the selection of reported results was considered low. The study reported on pre-specified outcomes and assessed them at multiple time points, with no evidence of selective reporting. Overall, the risk of bias for this study was judged to be of some concern, chiefly due to the differential attrition observed between treatment groups.

The Helsinki Psychotherapy Study, as reported by Knekt et al. (2008), was assessed for risk of bias across several domains. The risk associated with randomisation was considered low, as the study implemented an adequate method for randomising participants into the three treatment arms and used appropriate procedures to conceal allocation. However, there were some concerns regarding deviations from intended interventions. The three arms – short-term psychodynamic psychotherapy (STP), solution-focused therapy (SFT), and long-term psychodynamic psychotherapy (LTP) – followed different theoretical orientations, and therapist experience varied between conditions, introducing a potential confounding variable. Additionally, auxiliary treatment use was substantial and varied across groups, ranging from 33% to 58%. The study conducted intention-to-treat analyses, which helps address some of these concerns.

With respect to missing outcome data, further concerns were noted. Thirty-three patients declined to participate after randomisation, and forty-two discontinued treatment prematurely. Although the study described its procedures for handling attrition, these losses may still have influenced the results. Furthermore, the ten-year follow-up analyses were based only on a subset of the original sample, introducing the possibility of selection bias.

The risk of bias in the measurement of outcomes was judged to be low. The researchers utilised multiple validated outcome measures – including BDI, HAMD, the Symptom Checklist-90 (SCL-90), and HAMA – and employed both self-report and clinician-rated instruments. The assessment schedule was consistent across time points.

Finally, the risk of bias in the selection of reported results was also considered low. The study reported comprehensively on outcomes across multiple domains and at several follow-up time points, with no evidence of selective reporting. Overall, the Helsinki Psychotherapy Study was rated as presenting some concerns regarding risk of bias, primarily due to therapist experience confounds and differences in auxiliary treatment use across groups. Tab. 2 presents the risk-of-bias assessment for the included studies.

RESULTS

Overall treatment efficacy

Both the Norwegian Group Psychodynamic Therapy Trial and the Helsinki Psychotherapy Study provided evidence that both short-term and long-term psychodynamic psychotherapy led to substantial reductions in symptoms within each treatment group. In the Norwegian Group Psychodynamic Therapy Trial, participants in the short-term therapy group showed within-group effect sizes ranging from 0.3 [as measured by the Global Severity Index (GSI)]

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Domain	Norwegian Group Psychodynamic Therapy Trial (Lorentzen et al., 2013)	Helsinki Psychotherapy Study (Knekt et al., 2008)
Bias arising from the randomisation process	**Low risk:** Adequate randomisation and allocation concealment described	**Low risk:** Adequate randomisation and allocation concealment described
Bias due to deviations from intended interventions	**Some concerns:** Differential dropout rate (33.3% long-term vs. 8.6% short-term); reasons for dropout may differ between groups; unclear application of intention-to-treat analyses for all outcomes	**Some concerns:** Therapist experience varied between arms; notable and variable auxiliary treatment use (33–58%); intention-to-treat analyses conducted
Bias due to missing outcome data	**Some concerns:** Substantial difference in attrition rates; procedures for handling missing data not fully described	**Some concerns:** Attrition from non-participation and premature dropout; 10-year follow-up based on a subset, indicating possible selection bias
Bias in measurement of outcomes	**Low risk:** Validated outcome measures (SCL-90-R, IIP-C, GAF); both self-report and clinician-rated instruments; unclear blinding of outcome assessors	**Low risk:** Validated outcome measures (BDI, HAMD, SCL-90, HAMA); both self-report and clinician-rated instruments; consistent assessment schedule
Bias in selection of the reported result	**Low risk:** Pre-specified outcomes reported at multiple time points; no evidence of selective reporting	**Low risk:** Comprehensive reporting across domains and follow-up periods; no evidence of selective reporting
Overall risk of bias	**Some concerns** (mainly due to differential attrition)	**Some concerns** (mainly due to therapist experience confounds and differences in auxiliary treatment use)
Note: The assessment of risk of bias revealed that most domains were rated as low risk, particularly regarding the use of validated outcome measures and comprehensive reporting practices. However, both studies were judged to have some concerns overall, primarily due to issues such as differential attrition and potential confounding related to therapist experience and auxiliary treatments. These findings highlight the importance of participant retention and treatment fidelity when interpreting results from comparative studies of psychodynamic psychotherapy. **BDI** – Beck Depression Inventory; **HAMA** – Hamilton Anxiety Rating Scale; **HAMD** – Hamilton Depression Rating Scale; **LTP** – long-term psychodynamic psychotherapy; **PD** – personality disorder; **RCT** – randomised controlled trial; **SCL-90-ANX** – Symptom Checklist-90 Anxiety subscale; **SCL-90-GSI** – Symptom Checklist-90 Global Severity Index; **SFT** – solution-focused therapy; **STP** – short-term psychodynamic psychotherapy.		

Tab. 2. Risk of bias assessment according to Cochrane Risk of Bias 2 (RoB 2)

to 0.9 (as measured by GAF-S over a three-year period. Those in the long-term therapy group showed even greater improvements, with effect sizes ranging from 0.5 (GSI) to 1.3 (GAF-S) across the same timeframe. Importantly, both treatment groups demonstrated significant progress across all evaluated outcome measures.

Similarly, findings from the Helsinki Psychotherapy Study indicated statistically significant symptom reductions across all measured domains during the three-year follow-up. Specifically, patients experienced a 51% reduction in BDI scores, a 36% reduction on HAMD, a 41% decrease on SCL-90-ANX, and a 38% reduction on HAMA.

Temporal patterns of comparative efficacy

The comparative efficacy of short-term vs. long-term therapy revealed distinct temporal patterns. During the first year, results from the Helsinki Psychotherapy Study showed that patients receiving short-term therapies experienced faster symptom reduction, with symptom scores 15–27% lower than those in long-term therapy. These differences were statistically significant and favoured short-term approaches in the early phase of treatment.

By the second year, outcomes between short-term and long-term therapy converged, as patients in long-term therapy continued to improve and those in short-term therapy maintained their initial gains. During this intermediate phase, no significant differences were observed between treatment durations.

In the extended follow-up period spanning years three to ten, the pattern shifted. At the three-year mark, the Helsinki Psychotherapy Study found that long-term therapy resulted in 14–37% lower symptom scores compared with short-term therapy. Consistent with this, the Norwegian Group Psychodynamic Therapy Trial reported that long-term therapy led to markedly greater symptomatic change, with a between-group effect size of $d = 0.3$ in favour of long-term treatment. By the ten-year follow-up in the Helsinki study, 74% of patients overall were free from clinically elevated symptoms. The remission rate was higher among those who had received long-term therapy (62%) compared with those in short-term therapy (45%). Furthermore, long-term therapy was associated with greater improvements in work ability over the extended follow-up period.

Symptom outcomes

At the three-year follow-up in the Norwegian Group Psychodynamic Therapy Trial, long-term therapy demonstrated a modest advantage over short-term therapy, with a between-group effect size of $d = 0.3$ favouring the long-term approach based on SCL-90-R GSI. The number needed to treat (NNT) was calculated at five, indicating that for every five patients treated with long-term therapy, one additional patient achieved a clinically significant improvement compared with short-term therapy. Regarding recovery rates, 33.3% of participants in the short-term therapy group attained clinically significant change, whereas the rate was slightly higher (36.6%) among those receiving long-term therapy.

Similarly, findings from the Helsinki Psychotherapy Study at the three-year mark reinforced the benefits of longer therapy duration. Patients receiving long-term therapy showed symptom scores that were 14–37% lower across

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assessment measures compared with those in short-term therapy. These differences were statistically significant, further supporting the superiority of long-term therapy by the third year of follow-up.

Interpersonal functioning

In the Norwegian Group Psychodynamic Therapy Trial, short-term therapy produced significantly greater early improvements on the IIP-C "cold" interpersonal problems subscale during the treatment phase, with a similar trend observed for the "socially avoidant" subscale. However, by the three-year follow-up, no significant differences were observed between the short-term and long-term therapy groups across any of the interpersonal problem domains assessed ("cold", "socially avoidant", "non-assertive", "exploitable", and "overly nurturant"). Notably, the gains achieved in short-term therapy were maintained after the conclusion of treatment. Over the seven-year follow-up period, both treatment groups demonstrated small to moderate within-group effect sizes, indicating sustained improvements in interpersonal functioning.

Psychosocial functioning

In the Norwegian Group Psychodynamic Therapy Trial, measures of psychosocial functioning revealed improvements in both short-term and long-term therapy, although gains were more pronounced among those receiving long-term therapy. Specifically, for symptom functioning (GAF-S), the within-group effect size was $d = 0.9$ for the short-term group and $d = 1.3$ for the long-term group, indicating a greater degree of improvement with extended therapy. Similarly, for social functioning (GAF-F), the effect sizes were $d = 0.8$ for short-term therapy and $d = 1.0$ for long-term therapy, again demonstrating a numerical advantage for long-term treatment.

Findings from the Helsinki Psychotherapy Study at the ten-year follow-up further supported the benefits of longer therapy duration. Patients who received long-term therapy exhibited greater improvements in work ability and overall functional capacity compared with those who underwent short-term therapy.

Treatment acceptability

In the Norwegian Group Psychodynamic Therapy Trial, rates of premature termination differed significantly between the two treatment approaches. Specifically, 8.6% of participants in short-term therapy ended treatment early, whereas the rate was considerably higher at 33.3% among those in long-term therapy. This difference reached statistical significance ($p < 0.001$). Reported reasons for dropping out included dissatisfaction with the group or therapist, feeling that the therapy was not helpful, achieving the desired level of improvement, and external life events.

In the Helsinki Psychotherapy Study, 33 patients declined to participate after randomisation, and a further 42 discontinued treatment prematurely. However, the specific dropout rates for each treatment condition were not fully differentiated in the available data.

RESULTS OF SYNTHESES

Synthesis 1: main effects of treatment duration

Both studies revealed a clear temporal pattern in the comparative efficacy of short-term vs. long-term therapy. During the first year, short-term therapy provided notable advantages, with participants experiencing faster initial reductions in symptoms – demonstrated by scores that were 15–27% lower compared with long-term therapy. By the second year, these differences diminished, and outcomes between the two groups converged, showing no significant distinctions. However, from years three through ten, long-term therapy demonstrated superior benefits, with participants achieving 14–37% lower scores and higher remission rates (62% compared with 45%) than those who received short-term therapy. This trajectory was observed consistently across various measures, including depression, anxiety, general psychiatric symptoms, and functional capacity. The certainty of these findings is rated as moderate, with some concerns noted – such as potential risk of bias due to differential attrition and therapist experience confounds (see the Supplementary Material – Appendix C). Nonetheless, the results are strengthened by their consistency across two independent trials, the large combined sample size ($N = 493$), and the extended follow-up periods, all of which enhance confidence in these conclusions.

Synthesis 2: moderator effects – personality disorder status

The Norwegian Group Psychodynamic Therapy Trial provided the most comprehensive investigation into how personality disorder status moderates treatment outcomes. Among patients diagnosed with personality disorders, long-term therapy was significantly more effective than short-term therapy across all measured domains. Specifically, effect sizes between groups favoured long-term therapy for both symptom reduction ($d = 0.6$) and improvements in interpersonal problems ($d = 0.5$). The moderator effect reached statistical significance for symptom improvement ($p = 0.03$), with a trend towards significance for interpersonal issues ($p = 0.07$). Notably, the benefits of long-term therapy for this group appeared to develop gradually, with continued improvement after treatment had ended. These gains were particularly evident in enhanced autonomy and reductions in self-sacrificing behaviours.

In contrast, patients without personality disorders showed similar outcomes in both short-term and long-term

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therapy conditions over the three-year follow-up period. Those in short-term therapy experienced a higher rate of change during the first six months, but no further improvements were observed in either group thereafter. Extended therapy duration did not confer additional benefits for these individuals.

The certainty of evidence for these findings is rated as moderate, as the conclusions are based primarily on a single, well-designed Norwegian Group Psychodynamic Therapy Trial that conducted a pre-specified analysis of personality disorder as a moderator (see the Supplementary Material – Appendix C). The study demonstrated a statistically significant interaction effect and clinically meaningful effect sizes, and the results align with theoretical predictions. However, it is important to note that the Helsinki Psychotherapy Study excluded participants with severe personality disorders, which limits the generalisability of these findings to broader clinical populations.

Synthesis 3: moderator effects – social support

The Helsinki Psychotherapy Study evaluated social support as a moderator of therapy outcomes. For patients with high levels of social support, long-term therapy provided greater benefits at the three-year follow-up. Although short-term therapy initially led to faster symptom reduction, the advantages of long-term therapy became evident by the third year, resulting in a statistically significant interaction ($p < 0.05$). Conversely, patients with low social support experienced more rapid symptom improvement with short-term therapy during the first year, achieving a 40.0% reduction in SCL-90-GSI scores at 12 months, compared with a 26.3% reduction in the long-term therapy group. This difference was statistically significant. However, over extended follow-up, long-term therapy did not provide additional benefits for individuals with low social support, a finding that contradicts prior theoretical expectations. The certainty of this evidence is rated as moderate, as it is based on a single study with a pre-planned moderator analysis, demonstrated a statistically significant interaction, and presents a counterintuitive result that requires replication (see the Supplementary Material – Appendix C). The underlying mechanism remains unclear.

Synthesis 4: auxiliary treatment effects

In the Helsinki Psychotherapy Study, the interpretation of results was complicated by differential use of auxiliary treatments. Nearly half (47%) of participants in the solution-focused therapy group received some form of auxiliary treatment, and an even larger proportion (58%) of those in short-term psychodynamic therapy group did so. In contrast, only 33% of participants assigned to long-term psychodynamic therapy received auxiliary treatment. The higher rates of auxiliary treatment in the short-term therapy conditions suggest that some patients required additional support after completing the brief therapy protocols. As a result, the actual duration of treatment for these individuals may have been more similar across groups during the naturalistic follow-up period than initially intended. This circumstance may mean that observed differences between treatment groups underestimate the true effects of the assigned therapies. Additionally, it highlights that real-world efficacy might differ from the efficacy observed in controlled trial settings. However, the certainty of this evidence is low. Given that the data on auxiliary treatment are observational in nature, it is unclear whether these additional interventions were psychotherapeutic or of another type, and there is potential for confounding when attributing effects to the originally assigned treatments.

CERTAINTY OF EVIDENCE

Certainty of evidence was assessed using GRADE guidelines proposed by Guyatt et al. (2008). By the third year, long-term therapy results in substantially greater symptom reduction, with improvements ranging from 14% to 37% beyond those achieved by short-term therapy. The certainty of this evidence is rated as moderate: it begins at high because of the randomised controlled trial design, but is downgraded due to concerns about differential attrition and potential confounding related to therapist experience. However, consistency, directness, and precision of the results were maintained across studies.

Regarding remission rates after a decade, long-term therapy also demonstrated a notable advantage, with 62% of patients achieving remission compared with 45% in the short-term therapy group. This finding is drawn from a single study and a subset of participants, leading to moderate certainty due to imprecision; however, risk of bias is low and the comparison is highly direct.

Personality disorder status emerged as a key moderator of treatment efficacy. Patients diagnosed with a personality disorder benefited significantly more from long-term therapy, with effect sizes ranging from 0.5 to 0.6. The evidence for this moderator effect is of moderate certainty, beginning at high due to the use of a pre-specified moderator in a randomised controlled trial, but is downgraded for indirectness because the study was conducted in a group-therapy format and excluded individuals with severe personality disorders. There were no concerns regarding risk of bias, consistency, or precision.

Social support also plays a moderating role, with high levels of social support predicting better outcomes from long-term therapy, whereas individuals with low social support tended to improve more quickly with short-term therapy. This evidence is rated as moderate certainty, starting high but downgraded for indirectness, as it derives from a single study and presents a counterintuitive finding that requires replication. There were no major concerns about bias or precision for this outcome.

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Short-term therapy stands out for producing greater symptom reduction during the first year of treatment, with improvements 15% to 27% greater than those seen in the long-term therapy group. This evidence is also of moderate certainty: the high initial rating was downgraded due to possible confounding from therapist experience and differences in auxiliary treatments, although consistency, directness, and precision were not in question.

Finally, when considering dropout rates, long-term therapy was associated with a significantly higher rate of treatment discontinuation – 33% compared with just 9% for short-term therapy. The evidence supporting this finding is of high certainty, with no downgrades necessary due to low risk of bias, consistent findings, direct measurement, and precise estimates. The Supplementary Material – Appendix C presents GRADE certainty-of-evidence ratings for key outcomes.

DISCUSSION

Principal findings

This systematic review brings together evidence from two major randomised controlled trials, reported across seven publications and involving a total of 493 participants. These studies directly compared short-term psychodynamic psychotherapy – defined as lasting less than six months – with long-term psychodynamic psychotherapy, which extends beyond six months, in the treatment of mental disorders. The findings show that both approaches lead to significant reductions in symptoms, but their relative efficacy varies according to the timing of assessment and the specific characteristics of patients.

The first key observation is the clear temporal pattern in treatment effects. Patients receiving short-term psychodynamic psychotherapy tend to experience quicker improvements, with symptom scores 15% to 27% lower than those in long-term therapy during the first year of treatment. However, this early advantage diminishes over time. By the second year, outcomes for both groups converge, and from the third year onwards, long-term therapy begins to demonstrate greater benefits, with symptom scores 14% to 37% lower than those seen in the short-term group. This superiority is also evident in long-term remission rates: 62% of patients treated with long-term therapy achieve remission at a ten-year follow-up, compared with 45% of those who underwent short-term therapy. These patterns suggest that short-term therapy may rapidly activate accessible psychological resources to address specific issues, whereas long-term therapy facilitates deeper and lasting changes that continue to develop even after treatment concludes.

Personality disorder status emerged as a critical moderator of treatment efficacy. Patients diagnosed with personality disorders benefited significantly more from long-term therapy, showing greater improvements across multiple domains. In contrast, patients without personality disorders experienced similar outcomes regardless of whether they received short-term or long-term therapy. This finding highlights the importance of tailoring treatment duration to the complexity of a patient's diagnosis. For those without personality pathology, short-term therapy may be sufficient and offers additional practical advantages, such as a faster initial response and a lower likelihood of dropping out – 8.6% for short-term therapy compared with 33.3% for long-term therapy.

Social support also played a role in moderating treatment outcomes. Patients with higher levels of social support tended to fare better with long-term therapy, whereas those with lower levels of social support showed faster early improvement with short-term treatment. This somewhat unexpected result challenges traditional assumptions and suggests that individuals who are more socially isolated may respond better to the structure and time limitations of brief therapy.

Finally, dropout rates differed between the two approaches. Long-term therapy was associated with significantly higher dropout – 33% compared with just 9% for short-term therapy. This finding highlights a considerable real-world limitation of long-term therapy, indicating that the extended commitment it requires may not be practical or desirable for many patients, despite its potential for greater long-term efficacy.

Comparison with existing literature

Our findings partially align with and extend previous systematic reviews in this area. Consistent with earlier reviews, such as Leichsenring and Rabung's (2008) meta-analysis, long-term psychodynamic therapy was found to be superior to shorter treatments for complex mental disorders, particularly personality disorders. The present review supports this conclusion for symptomatic outcomes but introduces important nuance by highlighting that differences in interpersonal and functional domains were not sustained over time. The results of the present review also align with the recent comprehensive review conducted by Lilliengren (2023) which provides a comprehensive descriptive overview of 298 randomised controlled trials (1967–2022) examining psychodynamic psychotherapies (PDTs). Lilliengren's (2023) review reveals a significant disproportion in the literature in favour of short-term therapies, with only 12.6% of studies devoted to long-term interventions. Although Lilliengren, in his limited parametric studies, noted the superiority of long-term psychodynamic psychotherapy (LTPP) over short-term psychodynamic psychotherapy (STPP) in half of the direct comparisons, the present detailed analysis refines this general picture by indicating that this superiority is not immediate but becomes clear over a longer time frame (3 to 10 years). The results thus confirm the broader thesis that both forms of psychodynamic therapy are effective – consistent with the general picture of PDT effectiveness – contrary to the tendency to average results, treatment length plays a key role for patients with complex

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diagnoses, such as personality disorders, thus filling a research gap highlighted in the general review.

In contrast to some findings, such as those of Abbass et al. (2014), who reported large effect sizes for short-term psychodynamic psychotherapy comparable to or exceeding longer treatments, the present review provides a different perspective. Notably, Abbass et al.'s analysis primarily compared short-term psychodynamic psychotherapy with control conditions or other therapeutic modalities, rather than conducting direct comparisons with long-term psychodynamic therapy, which limits the applicability of their conclusions to questions concerning treatment duration. The results of the present review also diverge from those of Juul et al. (2023), who systematically reviewed randomised trials comparing shorter vs. longer durations of the same psychotherapy modalities for adult mental health disorders. Their review included 19 trials (3,447 participants), all at high risk of bias, across anxiety, depression, posttraumatic stress disorder, and personality disorders. Overall, the evidence was of very low certainty evidence, and the limited meta-analyses showed no clear differences in outcomes. Key findings highlighted sparse, heterogenous data, inconsistent definitions of treatment length, poor reporting of harms, and an urgent need for rigorously designed randomised trials to determine optimal psychotherapy duration across illness severities. By focusing specifically on direct, head-to-head randomised controlled trial comparisons, the present review offers clearer evidence regarding the relative efficacy of short-term vs. long-term psychodynamic psychotherapy. Furthermore, the inclusion of interpersonal process data, as presented by Fjeldstad et al. (2017), enhances the understanding of temporal trajectories in treatment outcomes, providing insights not captured in most previous syntheses.

STRENGTHS AND LIMITATIONS

Strengths

This review possesses several strengths. The methodology was rigorous, adhering to PRISMA-compliant systematic search and screening procedures conducted across multiple databases. The research question was clearly focused, specifically comparing treatment durations within the psychodynamic modality and thereby avoiding confounding by differences between therapeutic approaches. By limiting inclusion to randomised controlled trials with direct, head-to-head comparisons, the review provides more definitive evidence than analyses relying on indirect comparisons. Furthermore, the synthesis encompassed multiple outcome domains – including symptomatic, interpersonal, and functional outcomes – which allows for a comprehensive perspective on treatment efficacy. Importantly, the included studies featured long-term follow-up, tracking participants for up to three years and enabling an assessment of the sustained effects of the interventions.

Limitations

Limitations of the present review

The review faces several limitations that should be considered when interpreting its findings. First, the number of available studies is limited, with only two randomised controlled trials meeting the inclusion criteria. This restricts the robustness of the conclusions and precludes the possibility of conducting a meta-analysis. It is notable that the evidence base for such a clinically important question remains surprisingly sparse. Furthermore, all included studies were conducted in Nordic countries – specifically Finland and Norway – raising concerns about the generalisability of the results to other healthcare systems, cultural settings, and populations. Replication in more diverse environments is necessary to strengthen the evidence. Furthermore, the two studies included delineate the outcomes of distinct interventions: individual and group psychodynamic psychotherapy, which, despite their similarities, involve different mechanisms of change. The incorporation of studies detailing varied interventions diminishes the robustness of the findings and is warranted solely due to the paucity of research explicitly comparing short-term and long-term psychodynamic therapy.

Limitations of the included studies

Methodological shortcomings were also evident across the studies. Critical details such as allocation concealment, use of intention-to-treat analyses, and therapist adherence were often inadequately reported. In addition, important statistical parameters – including standardised effect sizes and confidence intervals – were frequently missing, making it difficult to fully assess the quality of the studies and the magnitude of observed effects. Attrition bias poses another significant concern, particularly given the high and differential dropout rates reported in the primary group therapy trial (33.3% vs. 8.6%). Such disparities may mean that those who completed treatment differ systematically from those who dropped out, potentially biasing results in favour of long-term therapy if more symptomatic patients discontinued participation.

The interventions themselves were heterogeneous, with variations in format (group vs. individual), number of sessions, and theoretical orientation, even though all were categorised as psychodynamic therapy. This diversity limits the ability to draw definitive conclusions about optimal treatment protocols. Outcome measurement was another limitation, as most studies relied primarily on self-report measures. The inclusion of clinician-rated outcomes, objective functional assessments, and neurobiological indicators would provide a more comprehensive evaluation of treatment efficacy.

Additionally, none of the studies presented reproducible moderator analyses to identify which patient characteristics predict differential benefit from short- vs. long-term treatment – a gap that hinders progress towards personalised care.

The possibility of publication bias cannot be overlooked, as studies reporting no significant differences between treatment durations may be less likely to appear in the literature, potentially exaggerating observed effects. Finally, none of the included studies conducted economic evaluations, leaving an important gap in understanding the cost-efficacy of different treatment durations – a crucial consideration for healthcare policy and planning.

Theoretical implications

The findings support psychodynamic theories positing that changes in personality structure require extended therapeutic work, whereas symptomatic improvement can be achieved more rapidly. The delayed emergence of long-term therapy benefits, with continued improvement after treatment ends, suggests that extended therapy initiates ongoing developmental processes that persist beyond active treatment. This aligns with previous research indicating that clients often experience significant changes in self-perception and interpersonal relationships long after therapy termination (Arias et al., 2025).

The counterintuitive social-support finding – namely, that patients with low support show a faster response to short-term therapy – challenges assumptions that socially isolated individuals require longer treatment to compensate for limited external resources (Høglend, 2003). This may indicate that different therapeutic mechanisms are needed for socially isolated vs. well-supported patients, with brief, structured interventions being more effective for the former.

Implications for practice

Clinical recommendations emphasise the importance of a comprehensive pre-treatment assessment, which should include a structured evaluation for personality disorders and an appraisal of the patient's social support networks. Treatment duration should be matched to individual patient characteristics: for those with a personality disorder, long-term psychodynamic psychotherapy is recommended, whereas patients without a personality disorder should be offered short-term psychodynamic psychotherapy as the initial treatment. It is also crucial to educate patients about expected timelines of improvement. Patients undergoing short-term therapy should anticipate faster initial progress, while those in long-term therapy should understand that change tends to occur more gradually, with continued improvement even after treatment concludes.

Given that approximately one-third of patients terminate long-term therapy prematurely, strategies to enhance treatment retention are essential. These include explicit discussions about expected duration and commitment at the outset of therapy, regular reviews of progress and treatment goals, proactive identification of barriers to attendance, and flexibility in session frequency when appropriate. Additionally, clinicians should monitor whether patients seek auxiliary treatments during therapy, as this may signal an inadequate response to the initial intervention.

A stepped-care approach can be particularly beneficial for patients without personality disorders. In such cases, beginning with short-term therapy and extending treatment only for those who do not respond sufficiently can help optimise both outcomes and resource use.

From a training perspective, therapists should be proficient in both brief and extended psychodynamic approaches. Training programmes should place particular emphasis on assessment skills, especially in evaluating personality disorders, and on case formulation that explicitly considers optimal treatment duration. Supervisors play a key role in guiding trainees to align treatment planning with patient characteristics.

At the healthcare system level, it is important to ensure that both short-term and long-term psychodynamic therapy options are available. Systems should implement assessment protocols designed to identify patients who require extended treatment and develop reimbursement models that support appropriate treatment durations based on clinical need. Ongoing monitoring of treatment duration patterns is necessary to ensure that patients are being matched with the most suitable treatment options.

IMPLICATIONS FOR RESEARCH

Priority research questions in the field of psychodynamic psychotherapy revolve around several important areas. A key line of inquiry concerns dismantling studies, which aim to determine which specific components of long-term therapy – such as the total number of sessions, the extended therapeutic relationship, repeated working-through, and therapist expertise – are responsible for the advantages observed in patients with personality disorders. Another area of interest is the evaluation of stepped-care models: researchers are examining whether beginning with short-term therapy and offering extended treatment only to those who do not initially respond can yield outcomes comparable to assigning all patients to long-term therapy from the outset, while also making more efficient use of resources.

Additional research aims to identify patient characteristics that predict differential responses to varying treatment durations. Potential moderators include attachment style (e.g. insecure attachment may necessitate longer treatment), severity of childhood trauma, quality of object relations, mentalisation capacity, baseline symptom severity, and diagnostic categories beyond the binary of personality disorder vs. no personality disorder.

Mechanism studies seek to clarify how long-term therapy produces delayed yet superior therapeutic effects. Proposed mechanisms include opportunities for deeper exploration of unconscious conflicts, more extensive working-through of transference patterns, greater scope for corrective emotional experiences, and the consolidation of structural personality changes over time.

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Social support mechanisms are also a focus, particularly given findings that patients with low social support respond more quickly to short-term therapy. Researchers are exploring whether this reflects a better fit with structured, goal-focused approaches, challenges in sustaining lengthy therapeutic engagement without external support, or fundamentally different therapeutic needs that may require alternative interventions.

Generalisability remains another critical area for future studies. It is uncertain whether current findings hold true in populations outside Scandinavia, across different healthcare systems, within diverse cultural contexts, among patients with more severe personality disorders, and with various psychodynamic treatment approaches such as mentalisation-based therapy.

Economic analyses are needed to compare the cost-effectiveness of short-term vs. long-term therapy. Such analyses should incorporate direct treatment costs, use of auxiliary treatments, levels of functional impairment and work disability, healthcare utilisation, and outcomes measured in quality-adjusted life years (QALYs).

Another important question concerns whether there is an optimal number of sessions for long-term therapy, or whether benefits continue to accrue with additional treatment. For example, the Norwegian Group Psychodynamic Therapy Trial utilised 80 sessions, whereas the Helsinki Psychotherapy Study included up to three years of therapy, potentially exceeding 150 sessions. It remains unclear whether this difference in treatment duration has a meaningful impact on outcomes.

Research must also determine whether the moderator effects of personality disorders generalise across different treatment formats, such as individual vs. group therapy. While the Norwegian Group Psychodynamic Therapy Trial focused on group therapy, replication in individual therapy for patients with personality disorders is required to draw broader conclusions.

Finally, there is growing interest in whether machine-learning techniques can be used to identify multivariate predictor profiles. Such profiles may provide a more accurate method for matching patients to optimal treatment duration than reliance on single moderators alone.

Methodological recommendations for future studies

Future studies should be designed with sufficiently large sample sizes powered to detect moderator effects, enabling robust examination of how patient characteristics influence outcomes. Researchers should pre-specify potential moderators to prevent data dredging and maintain the integrity of findings. Analyses should primarily utilise an intention-to-treat approach, including all participants as originally allocated, regardless of whether they completed the treatment, to yield unbiased results (Skovlund, 2013).

To address the issue of differential attrition, active strategies must be implemented to minimise dropout across treatment groups. Wherever feasible, outcome assessments should be conducted in a blinded manner to reduce bias. It is also important to match therapist experience between study conditions to avoid confounding effects resulting from differences in expertise (Chiesa, 2011).

Studies should carefully monitor and control the use of auxiliary treatments to ensure that outcomes can be attributed to the intervention under investigation. Extended follow-up periods – ideally a minimum of three years, and preferably five to ten years – are recommended to capture long-term effects and sustainability of treatment benefits. Alongside efficacy assessments, economic evaluations should compare the cost-effectiveness of different treatment durations (Steinert et al., 2016).

Finally, researchers are encouraged to employ implementation-science methodologies to evaluate the real-world efficacy of psychodynamic psychotherapy within routine clinical practice. This approach will provide insights into how evidence-based treatments perform outside research settings and help bridge the gap between clinical trials and everyday healthcare delivery (Abbass et al., 2014).

CONCLUSIONS

This systematic review provides moderate-certainty evidence that the comparative efficacy of short-term vs. long-term psychodynamic psychotherapy depends critically on patient characteristics and the timing of outcome assessment. Short-term therapy produces faster initial benefits, while long-term therapy demonstrates superiority at extended follow-up periods of three to ten years.

Most importantly, personality disorder status emerged as a critical moderator: patients with personality disorders benefit significantly more from long-term therapy (effect sizes $d = 0.5–0.6$), whereas patients without personality disorders achieve comparable outcomes with short-term therapy. Social support further moderates outcomes, with high-support patients benefiting more from long-term therapy and low-support patients showing a faster response to short-term treatment.

These findings support a paradigm shift from uniform treatment-duration recommendations towards personalised, stratified treatment selection based on comprehensive assessment of personality pathology and psychosocial resources. Long-term psychodynamic psychotherapy should be considered the treatment of choice for patients with personality disorders, while short-term therapy appears sufficient for those without personality pathology.

The higher dropout rate in long-term therapy (33% vs. 9%) represents a significant real-world limitation, underscoring the need for targeted retention strategies. Future research should examine mechanisms underlying differential efficacy, evaluate stepped-care approaches, and expand moderator analyses to additional patient characteristics.

By matching treatment duration to patient needs, clinicians can optimise both individual outcomes and healthcare resource utilisation, moving towards truly personalised psychotherapy.

Conflict of interest

The authors are members of the Board of the Polish Scientific Association for Psychodynamic Psychotherapy. This role reflects a professional commitment to the advancement of psychodynamic psychotherapy and may be perceived as a potential conflict of interest. The authors affirm that the review was conducted with the intention of providing an objective, evidence-based assessment of the efficacy of psychodynamic psychotherapy, independent of institutional or organisational affiliations. The author AKK declares an additional potential conflict of interest related to the subject of this review. AKK is the owner and director of a psychodynamic psychotherapy training institute as well as a clinical practice offering psychodynamic psychotherapy. While every effort has been made to present an objective and balanced review of the available evidence, readers should be aware of the author's professional and financial interests in the field.

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Author contribution

Original concept of study; collection, recording and/or compilation of data; analysis and interpretation of data; final approval of manuscript: TP, AKK. Writing of manuscript: TP. Critical review of manuscript: AKK.

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