Short-Term Psychodynamic Psychotherapy Versus Treatment as Usual for Depressive and Anxiety Disorders

A Randomized Clinical Trial of Efficacy

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Abstract: This randomized clinical trial aimed to evaluate the clinical efficacy of short-term psychodynamic psychotherapy (STPP) in the treatment of patients suffering from anxiety or depressive disorders, as compared with a control case sample composed of patients undergoing treatment as usual (TAU). Sixty patients with depressive or anxiety disorders according to DSM IV-TR were randomly assigned in a 1:1 ratio to an intervention group (STPP) or control group for 12 months (T1). Primary outcome measures were the Symptom Checklist 90-Revised (SCL-90-R), the Inventory of Interpersonal Problems (IIP), and the Clinical Global Impression Improvement Scale. Intention to treat analysis revealed that patients who received STPP showed significantly more improvements in comparison with those who were in the TAU group on Clinical Global Impression Improvement Scale and IIP measures. This study offers evidence that STPP is an effective treatment for patients with anxiety or depressive disorders, and it could be more effective than TAU in improving interpersonal problems as measured by IIP.

Key Words: Psychodynamic psychotherapy, anxiety disorders, depressive disorders, longitudinal study, outcome.

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Several studies have till now addressed the efficacy of short-term psychodynamic psychotherapy (STPP) across different types of disorders and for specific psychiatric disorders.

However, important meta-analyses, using different methods and samples, have produced conflicting results (Svartberg and Stiles, 1991; Crits-Christoph, 1992; Anderson and Lambert, 1995; Leichsenring et al., 2004; Abbass et al., 2006; Leichsenring and Leibing, 2007; Lewis et al., 2008).

The first one (Svartberg and Stiles, 1991) evidenced that STPP was superior to a no-treatment control condition, but inferior to alternative psychotherapies at post-treatment, and even more so at 1-year follow-up. In particular, STPP was inferior to cognitive-behavioral therapy for major depression, whereas it was equally successful with mixed neurotics.

In Crits-Christoph meta-analysis (1992) brief dynamic psychotherapy demonstrated larger effects relative to waiting list conditions, but only slight superiority to nonpsychiatric treatments, and its effects were about equal to those of other psychotherapies and medications.

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Following this, Anderson and Lambert (1995) corroborated the findings of Crits-Christoph although the effect sizes of STPP were a bit lower, and Leichsenring et al. (2004) using rigorous selection criteria, found that effect sizes of STPP assessed for target problems, general psychiatric symptoms, and social functioning, significantly exceeded those of waiting-list controls and treatment as usual (TAU), whereas no differences were found between STPP and other forms of psychotherapy. Three years later, Leichsenring and Leibing (2007) confirmed these conclusions in a review of 23 randomized controlled trials of manual-guided psychodynamic psychotherapy applied in specific psychiatric disorders.

A formal Cochrane review (Abbass et al., 2006) included all randomized controlled trials of STPP for common mental disorders, the range of nonpsychotic symptoms and behavior disorders frequently seen in primary care and psychiatric services that are of great expense to society and cause personal suffering for those afflicted. STPP showed modest benefits that were generally maintained in medium and long-term follow-up. However, findings were limited because of variability in study design, treatment delivery, and quality, and needed confirmation with further research.

Finally, a review from Lewis et al. (2008) identified 18 studies produced between 1996 and 2006, suggesting that STPP for depression can be equal in effects to other psychological treatment and it is significantly better than no treatment in the short-term. Moreover, increasing evidence emerged which supported STPP as a treatment for generalized anxiety disorder, panic disorder, and some personality disorders.

The main aim of this controlled study was to evaluate the efficacy of STPP in comparison with TAU in the treatment of outpatients with anxiety or depressive disorders.

Our hypotheses were as follows: first, after STPP, patients would show equal or greater decrease in psychiatric symptoms than patients of the control group and second, after STPP, patients would show fewer interpersonal problems than patients of the control group.

METHODS

Patients Eligibility Criteria

Subjects recruited were out-patients admitted to the Psychotherapy Service, Department of Psychiatry, at Milan's Ospedale Maggiore Policlinico, Fondazione IRCCS (Institute of Hospitalization and Care With Scientific Character).

Inclusion criteria were main diagnosis of anxiety (Panic Disorder, Generalized Anxiety disorder, Social phobia) or depressive disorder (Major Depressive disorder, dysthymic disorder) assessed using the Structured Clinical Interview for DSM IV-TR Axis I Disorders (First et al., 2001) and for Axis II disorders (Pfohl et al., 1995); age was between 18 and 60 years and subjects were not to have been on psychotropic medication for a period of at least 2 weeks (4 weeks for monoamine oxidase inhibitors).

Criteria for exclusion from the study were (*a*) evidence of mental retardation, lifetime history of organic mental disorders, schizophrenic disorders, bipolar disorders or substance abuse; (*b*) severe axis II psychopathology (cluster A personality disorders, antisocial personality disorder and borderline personality disorder according to DSM-IV-TR); (*c*) currently being treated at a psychosocial service or privately.

Structured Clinical Interview for DSM IV-TR and assessment for eligibility were performed by a psychiatrist who did not participate in the study as a therapist.

Setting and Location

Data were collected in the Psychotherapy Service, Department of Psychiatry, at Milan's Ospedale Maggiore Policlinico, Fondazione IRCCS.

Interventions

We used STPP derived from Malan's focused short-term technique (Malan, 1976; Malan and Osimo, 1992), designed to cover 40 sessions. Sessions were weekly, lasting 45 minutes, individually administered and conducted face-to-face. The technique employed aims to achieve an in-depth understanding of the psychological elements at play and furthermore, it requires and allows the psychological work to be organized around a focus (i.e., a specific, strategic conflictual area to reach an understanding of the psychopathological picture manifesting as a crisis). The therapist takes an active role and selectively disregards any information that the patient may provide him, which falls outside the main area agreed on and by working through the central conflictual area in the psychic life of the patient, promotes the change of his personality as a whole.

The therapists were 4 psychiatrists who were trained in psychodynamic psychotherapy and who had long experience in practicing STPP (range, 10–15 years; mean, 12.3, standard deviation [*SD*] = 3.6). A weekly review of the case notes and supervision of treatment adherence according to manuals were performed by a fifth therapist also experienced in STPP. The therapists were supervised both individually (sessions once a week, lasting 50 minutes), by a psychiatrist who worked within the research team, and in group (sessions once a week, lasting 90 minutes) by a therapist who worked within the framework and another one who was out of it. The supervisors were helped in their work by "verbatim" typewritten scripts of the sessions' and of the tape recording's "verbatim" transcription of sessions 1, 2, 3, 20, 21, 22, 38, 39, and 40. A low rate of diversion from Malan's technique was observed, however when this happened, additional individual supervision was performed and when the patient moved away from the focus previously arranged without carrying out useful elements for STPP, the therapist was invited to bring him actively closer to it. The raters were 2 therapists from the group that performed STPP and they evaluated adherence to the model on the basis of the accordance of the therapist's interventions with the focus arranged at the beginning of STPP.

As concomitant psychotropic medication, only benzodiazepines at a maximum of 3 mg lorazepam equivalent per day for severe anxiety and zolpidem tartrate (5–10 mg/d) at bedtime for insomnia, was allowed during the first 3 weeks of the study.

TAU consisted of drug treatment combined with a series of clinical interviews carried out by the patient's treating psychiatrist according to guidelines of the American Psychiatric Association (2006). The frequency of the interviews varied from case to case, with a minimum of 1 session per month to a maximum of 4 sessions per month, during which the treating psychiatrists evaluated clinical state, compliance, and adverse side effects, and adjusted the medication dose. Patients were followed up for 40 weeks.

We did not standardize the drug treatment administered, although the patient had to be taking an Selective Serotonin Reuptake Inhibitors (SSRI)/Serotonin–Norepinephrine Reuptake Inhibitors (SNRI) to be included in the study. We used sertraline (ranged between 50 and 100 mg/d; mean dose ± *SD*: 62.50 ± 20.92 mg/d), paroxetine (20–40 mg/d; mean dose ± *SD*: 24.00 ± 8.94 mg/d), citalopram (20–60 mg/d; mean dose ± *SD*: 33.33 ± 16.33 mg/d), escitalopram (10–20 mg/d; mean dose ± *SD*: 15.00 ± 5.77 mg/d), venlafaxine (75–225 mg/d; mean dose ± *SD*: 112.5 ± 62.75 mg/d); duloxetine (60–120 mg/d; mean dose ± *SD*: 80.00 ± 34.64 mg/d). The patients were not given any individual or group psychotherapeutic treatment other than that provided in the routine psychiatric treatment.

Outcome Measure

Three primary outcome measures were used, to give a comprehensive picture of patient- and clinician-rated symptoms.

The Clinical Global Impression scale (CGI; Guy, 1976) is a standard clinician-rated, 7-point scale; the severity scale (CGI-S) was applied at the initial visit, and the improvement scale (CGI-I) was applied at the follow-up, specifically to rate change in symptoms, by an independent evaluator blind to the treatment condition.

The Symptom checklist-90-revised (SCL-90-R; Derogatis, 1994) is a symptom inventory framed in a self-report format of 90 statements, and it requires a sixth-grade reading level. This inventory measures psychological symptom patterns of medical and psychiatric respondents as well as symptom patterns of individuals without psychiatric disturbance. In the current study, we considered the Global Severity Index (GSI)—that is the total mean score of SCL-90-R—as a primary outcome measures and Symptom Checklist Anxiety, Depression, and Social Phobia Scales as secondary outcomes.

The Inventory of Interpersonal Problems (IIP; Horowitz et al., 1988) is a 127-item self-report measure of difficulties in interpersonal functioning and associated distress. The total mean score was used to assess patients' problems with assertiveness, intimacy, sociability, submissiveness, control, and responsibility for others. In this study, we used an Italian version validated by Clementel Jones et al. (1996).

The data were assessed 2 times: T0 at the recruitment, T1 at 12 months after admission.

Randomization

A blocking, stratified randomization was used to ensure close balance of the numbers in each group at any time during the trial. After every block of 10 participants, they were matched by diagnoses, level of education, and age and assigned to 2 different blocks of 5 subjects, then randomly allocated, using computer-generated random numbers drawn up by a statistician, to one of the following conditions: STPP (experimental group) and TAU (control group).

STATISTICAL METHODS

An intention-to-treat analysis was performed, with the last observation carried forward for participants who did not complete the trial, and *chi square* tests were used to compare demographic and clinical characteristics of the 2 groups where appropriate, whereas independent sample Student *t* test were used to compare continuous variables in the 2 groups (age, education level).

At T1, treatment efficacy within groups was analyzed by using the Student *t* test for paired samples on SCL-90-R and IIP and within-group effect sizes for all measures were also assessed using the Cohen *d* statistic (Cohen, 1988).

The hypothesis tested in this study was that the outcome measures at T1 differ between the 2 subject groups. This hypothesis was examined by analysis of covariance in which baseline scores

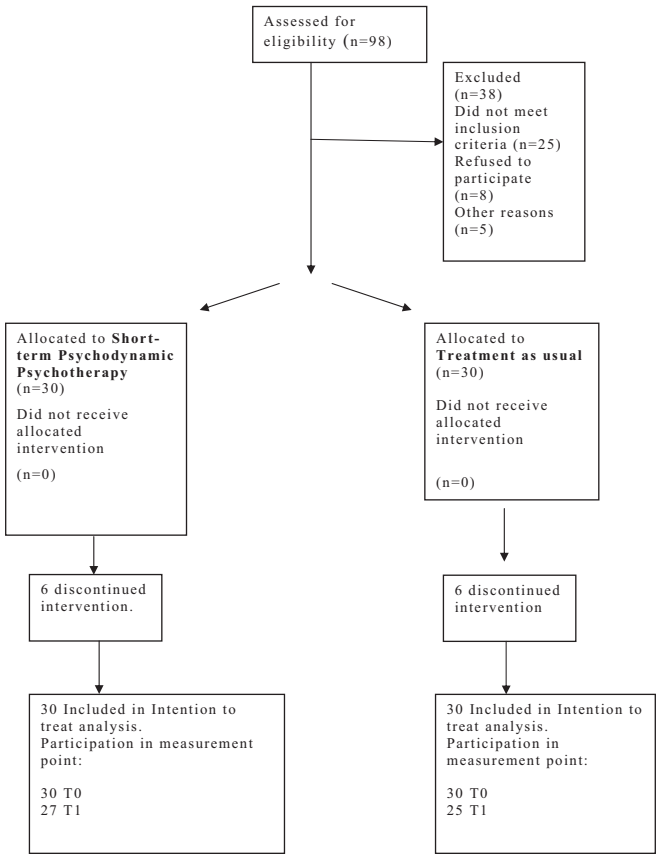

FIGURE 1. Flowchart of patients.

were used as the only covariates and, more specifically, for the CGI-I analyses, baseline CGI-S score was used as covariate. Cohen *d* for all between group analyses was also provided.

A categorical analysis of responders versus nonrepsonders was conducted using a *chi square* test, defined a CGI-I score of 2 or 1.

Finally, clinically significant change was assessed according to Jacobson and Truax (1991) and Jacobson et al. (1999) calculating Reliable Change Index and cutoff point *c* for the SCL-90-R GSI and IIP total scores in both groups. Patients who met both of these criteria (reliable change and scores under cutoff points) were considered to have achieved clinically significant change. Normative parameters were from Derogatis (1977) for SCL-90-R and from Woodward et al. (2005) for IIP. These 2 rates of change were also compared across STPP and TAU using *chi square*.

All statistics are 2-tailed with a 0.05 level of significance.

Data were analyzed using Statistical Package for Social Science (SPSS) version 14.0.

RESULTS

Flow of Participants

Ninety-eight subjects were screened consecutively for inclusion in this study and 73 were considered because they fulfilled the requirements. After a complete description of the study, 60 subjects gave their written informed consent to participate and 13 refused consent (8 refused a study treatment and 5 refused for other reasons). Figure 1 shows the recruitment history.

Of the 60 participants randomized, 30 to intervention group (STPP) and 30 to control group (TAU), 48 (80%) completed the trial, 24 on STPP and 24 on TAU. People withdrawing from the experimental group were individually accounted for as follows: 2 people did not return without explanation after 15 and 22 sessions (CGI-I 3 and 2), one to seek private treatment (CGI-I 3) after 10 sessions, 3 patients were deemed by their study therapist and the objective ombudsman to require medication for worsening anxiety (CGI-I 3 and 4) and depressive symptoms (CGI-I 4). They were discharged from the study–respectively–after 8, 15, 20 sessions and referred to pharmacotherapy. Withdrawals from the control group were individually accounted for as follows: 2 persons before week 3, 1 without explanation (CGI-I 3), and 1 because of work schedule (CGI-I 3); and 4 persons by week 8, 2 noncompliant with treatment visit (CGI I 4 and 5), and 2 to seek private treatment (CGI-I 2 and 5).

Although every effort was made to continue assessing dropouts, only 4 of 12 subjects agreed to participate in follow-up ratings after withdrawing from the randomized treatment. The analyses described adhered to the intention-to-treat principle using last observation carried forward to impute missing data for the primary and secondary outcomes. In addition, based on the study protocol criteria, dropouts were classified as nonresponders on the secondary categorical outcome, responder status.

Recruitment

Patients were recruited between October 2005 and October 2006. The last follow-up assessments were done in October 2007.

Baseline Data

Demographic and clinical characteristics of each group are described in Table 1 and as shown, there was no significant difference at T0 between the 2 groups regarding these variables; moreover, there was no significant difference at T0 between the 2 groups regarding psychometric variables (CGI-S, SCL-90-R and IIP scores).

Outcomes

Table 2 shows mean SCL-90-R and IIP scores at recruitment (T0) and 12 months later (T1) in the treatment and control groups.

Regarding STPP, results revealed statistically significant changes in all measures and these changes were considered to be large or moderate in effect (from 0.64 to 1.22). Symptom distress (GSI score) decreased significantly during the course of the treatment ($t = 5.976$; $p < 0.001$) and this change was also considered to be very large in effect ($d > 1.0$). At the same time, IIP total score significantly decreased ($t = 3.131$; $p = 0.005$) with a moderate effect size of 0.64.

In the control group all SCL-90-R scores were shown to significantly decrease during the course of treatment whereas IIP total score did not significantly decrease ($t = 1.306$; $p = 0.204$). Changes were considered to be moderate on SCL-90-R measures and small on IIP ($d = 0.27$). As observed in the STPP group, symptom distress decreased significantly ($t = 3.160$; $p = 0.004$) and this change was considered to be moderate in effect ($d > 0.5$).

Comparison between STPP and TAU at T1 is presented in Table 3. The 6 analysis of covariance analyses of the 3 primary outcome variables suggested that STPP was significantly superior to TAU according to CGI-I ($p = 0.002$) and IIP ($p = 0.025$) with a large and moderate effect size, respectively.

Categorical analysis of responder status—as defined by CGI-I scores of 2 or 1—revealed a 60% response rate on STPP group ($n = 18$) and a 40% response rate on TAU group ($n = 12$) (χ^2 test = 4.090, $df = 1$, $p = 0.043$). Considering only treatment completers, response rate was 75% on STPP and 50% on TAU group.

Finally, clinically significant change—as defined by Jacobson and Truax (1991)—in the SCL-90-R GSI index (cut score = 0.64) occurred in 9 of 24 patients in the STPP group and in 5 of 24 patients in the TAU group ($\chi^2 = 1.613$; $df = 1$; $p = 0.204$). The change in

TABLE 1. Demographic and Clinical Characteristics

	Intervention Group ($n = 30$)	Control Group ($n = 30$)	p
Mean age ± *SD*, yr	35.75 ± 9.25	38.67 ± 9.28	0.281[a]
Gender			0.999[b]
Male	7 (23.3%)	7 (23.3%)	
Female	23 (76.7%)	23 (76.7%)	
Marital status			0.129[b]
Single	18 (60%)	12 (40%)	
Married	9 (30%)	15 (50%)	
Divorced/widowed	3 (10%)	3 (10%)	
Educational level (yr ± *SD*)	13.25 ± 3.96	12.71 ± 29	0.609[a]
Occupation			0.360[b]
Student	8 (26.6%)	4 (13.3%)	
Household	2 (6.8%)	5 (16.7%)	
Employee	17 (56.6%)	16 (53.3%)	
Self-employed	3 (10%)	4 (13.3%)	
Executive		1 (3.4%)	
Average length of illness (yr ± *SD*)	2.33 ± 5.39	1.71 ± 4.45	0.663[a]
Diagnosis (Axis I)			0.997[b]
Major depressive disorder	7 (23.4%)	8 (26.6%)	
Dysthymic disorder	3 (10%)	3 (10%)	
Panic disorder	8 (26.6%)	7 (23.4%)	
Social phobia	4 (13.4%)	4 (13.4%)	
Generalized anxiety disorder	8 (26.6%)	8 (26.6%)	
Diagnosis (Axis II)			0.970[b]
No one	16 (53.3%)	17 (56.6%)	
Histrionic	3 (10%)	4 (13.3%)	
Narcissistic	3 (10%)	2 (6.7%)	
Avoidant	2 (6.7%)	2 (6.7%)	
Dependent	3 (10%)	3 (10%)	
Obsessive-compulsive disorder	3 (10%)	2 (6.7%)	

[a]ANOVA.
[b]Fisher exact test (2-sided).
SD indicates standard deviations.

the IIP total score (cut score = 1.01) achieved clinical significance in 13 of 24 patients in the STPP group and in 5 of 24 patients in the TAU group ($\chi^2 = 5.69$; $df = 1$; $p = 0.036$).

DISCUSSION

Although several studies have addressed the efficacy of STPP for a broad range of disorders and it has been widely used in clinical practice, it remains the subject of controversial discussion, especially with regard to empirical evidence.

This Randomized Clinical Trial sought to extend the previous research into its efficacy by responding to established criteria and utilizing clinical significance methodology.

More precisely, the present study fulfilled the methodological requirements indicated by Leichsenring et al. (2004) for research in psychotherapy, which are as follows: a randomized controlled design, the use of specific short-term dynamic psychotherapy as represented in a manual-like treatment guide, therapists who were trained and experienced in brief dynamic therapy (BDT), reliable and valid diagnostic measures.

The primary aim was to assess the efficacy of STPP in comparison with TAU in the treatment of patients affected by anxiety or depressive disorders. In particular, we hypothesized that at the end of treatment patients treated with STPP would show more or equal improvement in comparison to patients treated with TAU in general psychiatric problems, and more improvement in interpersonal problems.

With regard to the first hypothesis, both treatment regimens showed a significant improvement in symptomatology at T1 compared with baseline whereas the comparative evaluation revealed that the mean improvement in CGI score with STPP was clinically modest (2.17), although statistically greater than TAU mean improvement of 3.12 with a large effect size ($d > 0.8$). Response rate was also significantly higher on STPP group (60%), according to results reported by Leichsenring et al. (2004), where TAU generally can be expected to be superior to placebo and inferior to psychotherapy.

Finally, STPP yielded significant and large effect sizes in SCL-90-R scores, whereas TAU yielded effect sizes ranging from 0.51 to 0.75.

The large within-group effect sizes after treatment for STPP patients are in line with the findings of a study conducted by Svartberg et al. (2004) with a sample of 50 outpatients with cluster C personality disorders. In fact, in the SCL-90-R, (the measure that the 2 studies had in common) the effect size for STPP patients in the current study was higher than the effect size reported by Svartberg et al. (2004) ($d = 1.22$, compared with $d = 1.01$).

However, larger effect sizes were observed in symptom distress ($d = 1.22$) and in depressive symptoms ($d = 1.15$) corroborating the results reported by Maina et al. (2005) regarding efficacy of BDT in the treatment of minor depressive disorders, but we need to note that Maina et al. (2005) compared 3 treatment groups with a total sample of 30 patients (BDT, brief supportive psychotherapy, and waiting list condition) in a 6-month follow-up.

Regarding the 60% response rate, we found it was in line with results observed by Hilsenroth et al. (2003) on a sample of 21 patients with a depressive spectrum disorder using intention-to-treat sample.

Turning now to the second hypothesis, it can be seen that patients who received STPP showed a significantly superior improvement in interpersonal problems as assessed by IIP total score. In particular, 54.2% of the patients who completed STPP showed a clinically significant change as defined by Jacobson and Truax (1991) versus 27.8% of the patients who completed TAU.

This is probably the main result of the present study and in particular—citing Jacobson and Truax (1991) again—we consider the efficacy of psychotherapy with respect to the benefit derived from it, its potency, its impact on clients, or its ability to make a difference in peoples' lives and the improvement in interpersonal functioning through better self-understanding and to affect tolerance as the main goal of psychodynamic psychotherapy.

On the other hand, it is important to mention that effect size observed was lower than the effect size reported in the mentioned study by Svartberg et al. (2004) ($d = 0.64$, compared with $d = 1.07$) and by Leichsenring et al. (2004) who found STPP to be superior to TAU condition with between-group effect sizes medium to large for general psychiatric symptoms and social functioning.

It was noted, however, (Perry et al., 1999) that self-reported measures produce smaller effects than observer-rated ones and tend to yield more conservative estimates of treatment effects in these patients population (Svartberg et al., 2004).

In interpreting the findings of our study, several limitations should be considered.

TABLE 2. Mean SCL-90 R and IIP Scores in Intervention (STPP) and Control Group (TAU) at Recruitment (T0) and 12 Months Later (T1): Paired Sample *t* Test and Cohen Effect Sizes

	T0 Mean (*SD*)	T1 Mean (*SD*)	*t* (*df*)[a]	*p*	*d*[b]
STPP					
SCL-90-R depression	1.54 (0.77)	0.87 (0.64)	5.639 (23)	<0.001	1.15
SCL-90-R phobic anxiety	0.69 (0.56)	0.28 (0.42)	3.682 (23)	0.001	0.75
SCL-90-R anxiety	1.43 (0.83)	0.8 (0.75)	3.442 (23)	0.002	0.70
SCL-90-R global severity index (GSI)	1.17 (0.53)	0.62 (0.5)	5.976 (23)	<0.001	1.22
IIP total score	1.08 (0.43)	0.8 (0.41)	3.131 (23)	0.005	0.64
TAU					
SCL-90-R depression	1.83 (0.9)	1.39 (0.94)	2.387 (23)	0.026	0.51
SCL-90-R phobic anxiety	1.2 (0.89)	0.7 (0.92)	3.684 (23)	0.001	0.75
SCL-90-R anxiety	1.74 (0.93)	1.1 (0.86)	3.382 (23)	0.003	0.69
SCL-90-R global severity index (GSI)	1.47 (0.72)	1.05 (0.76)	3.160 (23)	0.004	0.64
IIP total score	1.34 (0.62)	1.22 (0.55)	1.306 (23)	0.204	0.27

[a]Paired sample *t* test.
[b]Cohen effect size estimate ($d > 0.80$ = large, $d > 0.50$ = moderate, $d > 0.20$ = small). The values of *d* associated with the change rates are within-group effect sizes.
SCL-90-R indicates symptom check list 90 revised; STPP, short-term psychodynamic psychotherapy; TAU, treatment as usual; *SD*, standard deviations; IIP, inventory of interpersonal problems.

TABLE 3. Baseline (T0) and End Point (T1) Primary and Secondary Outcome Measures in Intervention (STPP) and Control (TAU) Groups: Analysis of Covariance (ANCOVA)

	STPP			TAU					
	T0 Mean (*SD*)	T1 Mean (*SD*)	Change (95% CI)	T0 Mean (*SD*)	T1 Mean (*SD*)	Change (95% CI)	Test-Statistic[a]	*p*	*d*[b]
Primary outcome measures									
CGI-I		2.17 (0.76)			3.12 (1.26)		$F = 10.728$	0.002	0.98
SCL 90-R GSI	1.17 (0.53)	0.62 (0.5)	0.36–0.74	1.47 (0.72)	1.05 (0.76)	0.13–0.69	$F = 2.461$	0.124	0.47
IIP total score	1.08 (0.43)	0.8 (0.41)	0.09–0.46	1.34 (0.62)	1.22 (0.55)	−0.07–0.31	$F = 5.404$	0.025	0.69
Secondary outcome measures									
SCL 90-R depression	1.54 (0.77)	0.87 (0.64)	0.42–0.91	1.83 (0.9)	1.39 (0.94)	0.05–0.81	$F = 3.383$	0.072	0.55
SCL 90-R phobic anxiety	0.69 (0.56)	0.28 (0.42)	0.18–0.64	1.2 (0.89)	0.7 (0.92)	0.22–0.79	$F = 0.336$	0.565	0.17
SCL 90-R anxiety	1.43 (0.83)	0.8 (0.75)	0.25–1.01	1.74 (0.93)	1.1 (0.86)	0.24–1.02	$F = 0.714$	0.403	0.25

[a]For each primary and secondary variables, the analysis of covariance has one covariate (baseline score).
[b]Cohen effect size estimate ($d > 0.80$ = large, $d > 0.50$ = moderate, $d > 0.20$ = small). The values of *d* associated with the change rates are between-group effect sizes.
STPP indicates short-term psychodynamic psychotherapy; TAU, treatment as usual; *SD*, standard deviation; CI, confidence interval; CGI-I, clinical global impression–improvement; SCL-90-R GSI, symptom check list 90-revised global severity index; IIP, inventory of interpersonal problems.

First of all, because of the absence of a follow-up evaluation and small sample size these results may be unstable and should be considered preliminary.

No formal rating of adherence or competence was conducted for the study and in our opinion further research is necessary, using specific scale to assess treatment fidelity such as the Comparative Psychotherapy Process Scale described by Blagys and Hilsenroth (2000, 2002).

Finally, it's worth noting that patients were recruited in a out-patients Psychotherapy Service, where subjects were usually referred by primary care physicians or other specialist practices, and they were highly motivated. In other words, it's possible that the improvement of symptoms were mostly related to motivation for change which is considered a key predictor of success in brief dynamic psychotherapy (Hoeglend, 1996) and not to the intervention per se. At the same time, ethical reasons and evidence in the literature (Valbak, 2004) highlight that assessment of patient's suitability for psychoanalytic psychotherapy seems to be necessary before beginning this kind of treatment. Further research is necessary using inpatients samples to extend the implications of the present findings.

CONCLUSIONS

This study corroborated evidence that STPP is an effective treatment for patients with depressive and anxiety disorders, and it could be more effective than TAU in improving interpersonal functioning as measured by IIP. However, further research with larger sample and prospective design is needed to evaluate stability of outcome in the longer term.

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