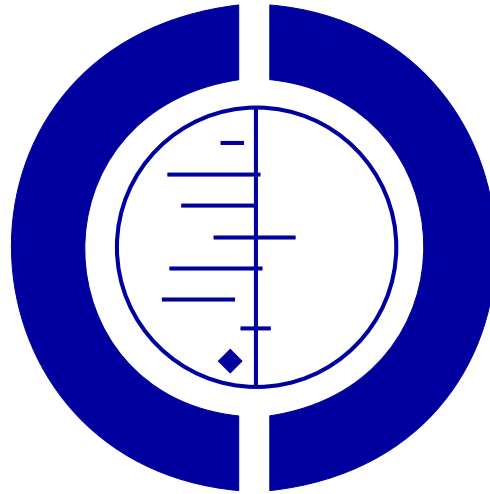


# Short-term psychodynamic psychotherapies for common mental disorders (Review)

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## ABSTRACT

### Background

Over the past 40 years, short-term psychodynamic psychotherapies (STPP) for a broad range of psychological and somatic disorders have been developed and studied. Four published meta-analyses of STPP, using different methods and samples, have found conflicting results.

### Objectives

This review evaluated the efficacy of STPP relative to minimal treatment and non-treatment controls for adults with common mental disorders.

### Search strategy

We searched CCDANCTR-Studies and CCDANCTR-References on 25/4/2005, CENTRAL, MEDLINE, CINAHL, EMBASE, PsycINFO, DARE and Biological Abstracts were also searched. We contacted trialists and checked references from papers retrieved.

### Selection criteria

All randomised controlled trials (RCT) of adults with common mental disorders, in which a brief psychodynamic therapy lasting less than 40 hours in total, and provided in individual format, were included.

### Data collection and analysis

Three reviewers working in pairs evaluated studies. Studies were selected only if pairs of reviewers agreed they met inclusion criteria. A third reviewer was consulted if two reviewers could not reach consensus. Data were collected and entered into Review Manager. Study quality was assessed and scored by pairs of raters. Publication bias was assessed using a funnel plot. Sensitivity analyses were also conducted.

### Main results

23 studies of 1431 randomised patients with common mental disorders were included. These studies evaluated STPP for general, somatic, anxiety, and depressive symptom reduction, as well as social adjustment. Outcomes for most categories of disorder suggested significantly greater improvement in the treatment versus the control groups, which were generally maintained in medium and long term follow-up. However, only a small number of studies contributed data for each category of disorder, there was significant heterogeneity between studies, and results were not always maintained in sensitivity analyses.

### Authors' conclusions

STPP shows promise, with modest to moderate, often sustained gains for a variety of patients. However, given the limited data and heterogeneity between studies, these findings should be interpreted with caution. Furthermore, variability in treatment delivery and treatment quality may limit the reliability of estimates of effect for STPP. Larger studies of higher quality and with specific diagnoses are warranted.

## PLAIN LANGUAGE SUMMARY

Short-term psychodynamic psychotherapies for common mental disorders

Short-term psychodynamic psychotherapies have been subjected to randomised controlled trials for a range of common mental disorders, including anxiety disorders, depression, stress-related physical conditions, certain behaviour disorders and interpersonal or personality problems mixed with symptom disorders. Previous meta-analyses have yielded conflicting results. This review included all RCTs of STPP for common mental disorders, and found modest treatment benefits that were generally maintained in medium and long term follow-up. However, variability in study design means that our conclusions are tentative, and need confirmation with further research.

## BACKGROUND

Common mental disorders are the range of non-psychotic symptom and behaviour disorders frequently seen in primary care and psychiatry services. They include non bipolar depressive disorders, anxiety disorders, somatoform disorders, and other conditions often mixed with interpersonal or personality disorders. These are extremely common conditions, with 12 month prevalences of 11.9% for depression, 14.5% for anxiety disorders and 11.0% for somatoform disorders in a recent German survey (Jacobi 2005). Collectively they produce great expense to society and personal suffering for those afflicted. Treatment of these conditions may include a range of psychotherapy and medication options. Psychotherapies, including cognitive behavior therapy and interpersonal therapy, have established effectiveness in some of these conditions. Medications such as antidepressants are frequently employed and, although there is some controversy about the magnitude of their effectiveness in real world samples, these appear to be marginally superior to placebo control in short-term randomised controlled trials for many of these conditions.

Short-term psychodynamic psychotherapy (STPP) has been developed over the past 40 years by a number of proponents including Mann, Malan, Davanloo and Sifneos (Davanloo 1980). Common features of these therapies include the use of selection criteria, therapeutic focus, active therapist involvement, use of the transference (therapeutic) relationship and time restriction. Furthermore, most STPP methods use the triangle of conflict (feelings, anxiety and defence) and the triangle of person (past, therapist and current) in the therapeutic focus (Davanloo 1980). In the early phase of STPP development, case-based research showed that a range of patients could be successfully treated by these brief therapies, and that the gains were maintained at follow-up (Davanloo 1980).

Over the past 20 years, clinicians have studied STPP with a broad range of patients in randomised and controlled trials. Our preliminary estimate was that there were over 50 such studies published in the English language literature. With this major upsurge in research, meta-analyses have been performed as a means of further evaluating and summarising the literature. These meta-analyses have yielded differing results over time, due to differences in study selection and methods of analysis, and varied interpretation

of results. Two meta-analyses found STPP to be superior to no treatment (Crits-Christoph 1992, Anderson 1995). Using narrow inclusion criteria, Crits-Christoph 1992 found STPP to be significantly superior to minimal treatment controls and equal to other treatment controls. Svartberg 1991, using a largely different group of studies, found the treatment to be inferior to other treatments, and equal to minimal treatments with loss of this effect in follow-up. Anderson (Anderson 1995) again found STPP to be superior to wait-list controls and minimal treatment controls, but found it equal to other formal therapies. Areas of conflict and controversy across these reviews include the inclusion or exclusion criteria for studies of Interpersonal Therapy, and how to evaluate the studies with major differences in methodologies (Svartberg 1993).

During the time this review was being conducted, a new meta-analysis was published. Leichsenring and colleagues (Leichsenring 2004) using rigorous selection criteria, found STPP methods to be equal to other therapies and superior to minimal treatment and wait-list controls, with robust effect sizes. A Cochrane review conducted by Binks 2006 reviewed available studies of patients with borderline personality disorder, but found no studies of short-term psychodynamic psychotherapies.

Thus, the stage was set for a formal Cochrane review of these treatment approaches compared to non-treatment and minimal treatment controls for patients with common mental disorders.

## OBJECTIVES

This review evaluated the efficacy of STPP treatments for the treatment of adults with common mental disorders in randomised controlled trials. The review also sought to specify the differential effects of STPP for patients with different disorders (eg depression, anxiety, somatoform disorders, mixed disorders and personality disorder) and treatment characteristics (e.g. manualised vs non-manualised therapies).

## CRITERIA FOR CONSIDERING STUDIES FOR THIS REVIEW

### Types of studies

All randomised controlled trials (RCTs) in which STPP was compared with wait-list controls, minimal treatment controls which had been designed as psychological “placebo treatments” and treatments as usual.

### Types of participants

The population was limited to adult outpatients with common mental disorders (i.e. patients over 17 years old). The common mental disorders reviewed included among others, anxiety disorders, depression, stress-related physical conditions, certain behaviour disorders and interpersonal or personality problems mixed with symptom disorders. We accepted studies with medical or psychiatric co-morbidity, including personality disorder, although studies of patients with psychotic disorders were excluded.

### Types of intervention

All psychotherapies in which:

- (1) the authors designated at least one treatment group as psychodynamic in nature and treatment lasted 40 weeks or less on average
- (2) the treatment technique was derived from the work of one or more developers of short-term psychodynamic psychotherapies such as Mann, Sifneos, Malan, Davanloo, Luborsky (Davanloo 1980) or was specifically developed and described for a brief psychodynamic approach
- (3) the treatment under investigation was given in an individual format
- (4) with standard length sessions of 45-60 minutes

We have defined brief psychotherapy as being less than 40 sessions, as this is the definition used in previous meta-analyses.

### Types of outcome measures

#### Primary outcome measures

The primary outcomes measured were as follows:

- (a) general symptoms as defined by standardised psychiatric instruments or criteria such as the Beck Depression Inventory (Beck 1961).
- (b) somatic symptoms
- (c) anxiety
- (d) depression

#### Secondary outcome measures

Secondary outcome measures of interest were:

- (a) Social adjustment e.g. the Social Adjustment Scale (Weissman 1978).
- (b) Quality of life e.g. Short Form 36 scores (Ware 1993).
- (c) Behavioural measures e.g. attempts at self-harm
- (d) Interpersonal problem measures
- (e) Patient satisfaction as measured by standardised instruments

- (f) Health service use e.g. hospital admission, outpatient contacts, visits to primary care
- (g) Cost measures e.g. medication cost changes
- (h) Death (suicide and all-cause mortality)
- (i) Drop-outs

## SEARCH METHODS FOR IDENTIFICATION OF STUDIES

See: Cochrane Depression, Anxiety and Neurosis Group methods used in reviews.

### 1. The CCDAN specialised registers searches;

CCDANCTR-Studies - searched on 25/4/2005

Intervention = Psychodynamic or Dynamic or Psychoanalytic or Analytic  
and  
Age Group = Adult or Aged

CCDANCTR-References - searched on 25/4/2005

Free-Text = Psychodynamic or Dynamic or Psychoanalytic or Analytic

### 2. Further Electronic searches

Electronic databases such as the Cochrane Controlled Trial Register (CCTR)/ Cochrane Library CENTRAL Register, MEDLINE (1966 to present), CINAHL (1982 to present) EMBASE (1980 to present), PSYCH Info (1887 to present), the Database of Abstracts of Reviews of Effectiveness (DARE) and Biological Abstracts (January 1980 to present) were also searched to identify potentially eligible studies and review articles. For CCTR we used the following search terms:

- #1 ANXIETY
- #2 DEPRESSION
- #3 (PANIC next DISORDER)
- #4 (DEPRESSIVE next DISORDER)
- #5 (DEPRESSIVE next SYMPTOMS)
- #6 (ANXIOUS next SYMPTOMS)
- #7 (SOMATIZATION next SYMPTOMS)
- #8 (SOMATIZATION next SYMPTOMS)
- #9 (SOMATIZATION next DISORDER)
- #10 (SOMATIZATION next DISORDER)
- #11 (SOMATOFORM next SYMPTOMS)
- #12 (SOMATOFORM next SYMPTOMS)
- #13 (((((#1 or #2) or #3) or #4) or #5) or #6) or #7) or #8) or #9) or #10) or #11) or #12)
- #14 (BRIEF next PSYCHODYNAMIC)
- #15 (BRIEF next DYNAMIC)
- #16 (TIME-LIMITED next PSYCHODYNAMIC)
- #17 (TIME-LIMITED next DYNAMIC)
- #18 (BRIEF next PSYCHOANALYTIC)
- #19 (BRIEF next ANALYTIC)
- #20 (TIME-LIMITED next PSYCHOANALYTIC)

#21 (TIME-LIMITED next ANALYTIC)  
#22 ((((((#14 or #15) or #16) or #17) or #18) or #19) or #20)  
or #21)#19 (#13 and #22)

All relevant foreign language papers were translated. For MEDLINE, we expanded the search to ANALYTIC, PSYCHOANALYTIC, DYNAMIC or PSYCHODYNAMIC as the National Library of Medicine has defined brief psychotherapy as being not more than 20 sessions for indexing purposes since 1973. This ensured we did not miss therapies of up to 40 sessions.

### 3. Reference lists

The reference lists of all retrieved and potentially relevant papers, as well as relevant systematic reviews and literature reviews, were checked to identify other potentially relevant articles. These articles were retrieved and assessed for possible inclusion in the review.

### 4. Personal communications

The lead author of relevant studies was written to in order to ascertain if they knew of any additional related published or unpublished data that may have been relevant to the review.

### 5. Handsearching

Abstracts from national and international psychiatry and psychology conferences were scrutinised to identify unpublished studies. These included meetings organised by national and international medical colleges, specialty societies and professional organisations. The authors of these studies were contacted to obtain further details about the study and to enquire if they knew of any other unpublished or published relevant work.

## METHODS OF THE REVIEW

### Selection of studies

Two reviewers independently selected suitable studies for inclusion in this review as detailed below. Where the two reviewers disagreed about the inclusion of a study, disagreements were resolved by consensus of opinion, and a third reviewer was consulted if they could not be resolved. Where resolution was not possible the author was contacted to obtain more information and clarification.

The titles and abstracts of studies identified by searching electronic databases were assessed to determine whether each article met the eligibility criteria. In order to prevent any bias, a list of all titles and abstracts was printed out excluding the author's names, institutions, and journal title. If the title and abstract contained sufficient information to determine that an article did not meet the inclusion criteria, then that article was rejected. A record of all rejected papers and the reasons for rejection was documented.

The full papers of all remaining titles and abstracts deemed relevant were then retrieved. In addition, all other potentially relevant articles identified by the various search strategies (reference checking, personal communications etc) were also reviewed. All

papers in languages other than English were translated or reviewed by someone who speaks the language.

### Data extraction and management

All articles were reviewed independently by two of the reviewers, each of whom completed a form for each study and scored the quality of the research as defined below. The reasons for exclusion were documented. Where the same study had more than one article written about the outcomes, all articles were treated as one study and the results were presented only once.

### Assessment of methodological quality of included studies

Assessment of the quality of a particular trial was made in accordance with guidelines in the Cochrane Handbook.

#### 1. Assessment of the method and adequacy of randomisation

To prevent selection bias, someone who was not responsible for recruiting the participants, such as a central trial office or someone not involved in the trial should conduct the randomisation. The method of randomisation was noted on the data extraction form.

#### 2. Assessment of the degree of blinding (treatment and outcome assessment)

Allocation concealment was assessed as follows as described in the Cochrane Reviewers Handbook (Clarke 2000):

- A - adequate description of the allocation procedure;
- B - unclear description of the allocation procedure;
- C - inadequate description of the allocation procedure;
- D - allocation concealment was not used.

If the reviewers disagreed over which category a trial was allocated to, resolution was attempted by discussion or by obtaining further information. In addition, reviewers were blinded to the author's names, institutions and journal title to prevent any bias.

#### 3. Losses to follow-up

The paper should give an adequate description of the loss of its participants in terms of the number of withdrawals, dropouts, and protocol deviations. Where more than 20% of those originally randomised had been lost to follow-up, the data were not presented in this review.

#### 4. Assessment of publication bias

Data from all identified and selected trials were used to draw a funnel plot (size of study versus effect size) (Egger 1997), to attempt to detect the possibility of publication bias.

CCDAN Quality Rating Scale (Moncrieff 2001) criteria were used to determine external validity and study quality. This scale had 23 items with a maximum possible score of 46. Parameters included clarity of objectives, sample size, duration, power calculation, method of allocation, concealment of allocation, treatment description, blinding, source of subjects, use of diagnostic criteria, record of exclusions, sample description, blinding of assessors, assessment of compliance, side effects, withdrawals, description of outcome measures, adjustments for differences, inclusion of withdrawals in analysis, presentation of results, statistical analysis,

justification of conclusions and declaration of interests. Each study was rated on 23 items to give a score ranging from 0 to 46.

### Data extraction

The two reviewers completed the extraction of data from the papers onto a form to elicit the following information:

- (1) General: (Published/unpublished, title, authors, source, contact address, country, language of publication, year of publication, duplicate publications).
- (2) Interventions (frequency, timing, individual vs group, up to 20 sessions vs 20-40 sessions, manual driven vs non-manualised therapies), comparison interventions, concurrent medications.
- (3) Patient characteristics - sampling, exclusion criteria, number of participants, age, sex, ethnicity, marital status, educational status, duration of symptoms, number of complications, similarity of groups at baseline (including any co-morbidity), withdrawals/losses to follow-up (reasons/descriptions).
- (4) Primary diagnosis (e.g. depression, anxiety or somatoform disorders).
- (5) Type of medical co-morbidity if present.
- (6) Type of psychiatric co-morbidity - clinical diagnosis or symptomatology assessed by questionnaire.
- (7) Type of outcome - self-report or observer-rated.
- (8) Type of assessment tool used to assess psychiatric co-morbidity - e.g. Beck Depression Inventory, Zung Depression Scale, Hospital Anxiety and Depression Scale, Structured interview, DSM-IV criteria.
- (9) Cut-off used on psychiatric scale, percentage of people defined as psychiatric cases on this basis; mean (SD) symptom score.
- (10) Timing of follow-up: short term (<3 months), medium term (3-9 months) and long term (>9 months).
- (11) Assessment of methodological quality - This was stratified into four categories using CCDAN criteria (scores of 0 to 9, 10 to 19, 20 to 29, and 30 or more) including but not limited to the following:
  - (i) method of randomisation used, if stated;
  - (ii) method of allocation concealment (adequate, unclear, inadequate, or allocation concealment not used);
  - (iii) blinding of outcome assessors (yes, no, unclear);
  - (iv) patients lost to follow-up (cut-off of 20% attrition or more), intention-to-treat analysis.

### Data Analysis

#### 1. Data entry

A summary of data extracted from included studies was reported. If studies were available that were sufficiently similar and of sufficient quality, we pooled those that could be grouped together and used the statistical techniques of meta-analysis through the use of RevMan.

#### 2. Method of analysis

The comparisons necessary to achieve the review objectives and to test hypotheses were as follows:

- (i) STPP versus no treatment control

- (ii) STPP versus minimal treatment or treatment as usual.

The effect of these different comparators was examined in sensitivity analyses, as described later.

#### 3. Obtaining unpublished data for the included trials

Where it was not possible to quantitatively analyse data as reported in published studies, we contacted the first author to obtain the additional data required. Where no further usable data was provided, studies were not included in the meta-analysis, and were listed as excluded due to missing data.

#### 4. Data types

Outcomes were assessed using continuous (for example, changes on depression scales), categorical (for example, one of three categories on a quality of life scale, such as 'better', 'worse' or 'no change'), or dichotomous (for example, either depressed or not-depressed) measures.

#### Continuous data

Many rating scales are available to measure outcomes in psychological trials. These scales vary in the quality of their validation and reliability. Therefore, if a rating scale's validation had not been published in a peer-reviewed journal, then the data were not included in this review. In addition, the rating scale should have been either self-report or completed by an independent observer or relative. Trials that used the same instrument to measure specific outcomes were used in direct comparisons where possible. Where continuous data were presented from different scales rating the same effect, both sets of data were presented and the general direction of the effect inspected. The mean and standard deviation was reported. Where standard deviations were not reported in the paper, attempts were made to obtain them from the authors or to calculate them using others measures of variation that were reported, such as the confidence intervals. Where possible, we meta-analysed data from different scales, rating the same effect using the Standardised Mean Difference (SMD).

#### Dichotomous data

Continuous outcome measures were converted to dichotomous data where necessary. If the authors of the study had used a designated cut-off point for determining clinical effectiveness, the reviewers used this where appropriate. Otherwise, cut-offs on rating scales were identified and participants were divided on the basis of whether they were 'clinically improved' or 'not clinically improved'. For dichotomous outcomes, a Mantel-Haenszel odds ratio with its associated 95% confidence intervals (CI) was estimated. As a summary measure of effectiveness, where possible, the number needed to treat statistic (NNT) was also calculated.

#### 5. Heterogeneity

Graphical representations of the data were inspected. If the confidence intervals for the results of the studies did not overlap, differences were likely to be statistically significant (Walker 1988).

In addition, differences between the results of each included trial



were checked formally using a Chi<sup>2</sup> test for heterogeneity. As these tests usually have low statistical power, a type I error level of 0.10 rather than the customary 0.05 was used for rejecting the null hypothesis of homogeneity. Results were analysed using both the fixed effect and random effects methods. However, where there was significant heterogeneity, a random effects model was used and the reviewers attempted to explore the reasons for this heterogeneity in post hoc analyses.

## 6. Subgroup analyses

Factors that may have lead to differences between the results of individual studies were investigated using subgroup analyses. Studies were dichotomized along 3 parameters and outcomes of these 2 subgroups were compared. This review investigated differences in outcome between:

- (a) differences between different diagnostic groups including depression, anxiety, somatoform disorders, mixed disorders and personality disorder.
- (b) manualised vs non-manualised therapies
- (c) therapy of up to 20 sessions vs 20-40 sessions
- (d) differences between studies that give self-reported or observer-rated outcomes

## 7. Sensitivity Analyses

The differences between analyses involving all studies and excluding trials of low methodological quality as defined by CCDAN criteria were compared in order to determine the impact of study quality on outcomes. Because of the range of interventions offered to the control groups, we also undertook a sensitivity analysis of the effect of using treatment as usual as opposed to minimal treatment or wait list controls as a comparator.

## DESCRIPTION OF STUDIES

### Excluded Studies

57 studies were considered for inclusion. Of these, 34 were excluded. Most were studies which had other treatment controls. One study had too high a drop out rate (Burnand 2002). We could not retrieve any additional information from primary authors in 1 case (Rosser 1983). Others were not randomised trials.

### Included Studies

Twenty-three randomised controlled trials comprising of 1431 participants were identified.

### Settings and participants

All studies were of outpatient adult samples. Four studies (Baldoni 1995, Cooper 2003, Marmar 1988, Alstrom 1984b) only included female participants while almost all of the studies had a majority of females. Primary problems were diverse and included somatoform disorders (N=8), mixed conditions (N=6), anxiety (N=4), depression, (N=2), personality disorders (N=2) and self-induced poisoning (N=1). The somatoform disorders included irritable bowel syndrome (N=3), chronic pain, urethral syndrome,

pelvic pain, chronic dyspepsia, peptic ulcer disease and atopic dermatitis. Anxiety disorders included agoraphobia, social phobia, panic disorder and post-traumatic stress disorder. Several studies included patients with a symptom disorder mixed with personality disorders. (Winston 1994, Abbass 2006)

Over one half of these studies included challenging to treat populations. Several studies included patients with comorbid personality disorders among their samples or as the main study sample. One study included patients with deliberate self poisoning, (Guthrie 2001). Several studies were of "treatment resistant", "high utilizers", "chronic" or "severe" populations (N=5) while two included patients who were not candidates for a traditional psychoanalytic treatment. (Alstrom 1984a; Alstrom 1984b)

### Interventions

A range of brief psychodynamic-based psychotherapy methods were represented in these studies. These courses of therapy averaged 14.8 sessions (SD 8.9, Range 4-40). They were described as employing common factors of brief dynamic therapies such as focus on unconscious operations and emotions, and their link to symptoms or behavioral problems. All but one study described the use of some brief therapy framework, while two (Sloane 1975 and Cooper 2003) had a general psychoanalytic model of short duration. Eleven of these studies described using experienced therapists, but it was often unclear whether the therapists were experienced in the specific brief therapy approach versus other psychotherapy models. Nine referred to specific manuals while others referenced models including those of Malan, Mann, Davanloo, Strupp and Binder and Horowitz.

### Controls

A range of control groups were employed in these studies. Nine had treatment as usual, which included medical management and, in some cases, psychotherapeutic support. Eight had minimal psychological interventions used as controls. Six had wait list controls. Overall, treatment as usual control situations provided less face-to-face therapist contact time than the STPP groups, although these were considered standard treatment approaches with presumed effectiveness. Less treatment benefits, due in part to less intense therapeutic exposures, would be expected in the wait list and minimal treatment controls.

### Outcomes

Fifteen studies reported on general psychiatric symptoms, 14 used measures of depression, 12 used measures of anxiety, 8 used somatic symptom measures and 4 used measures of social adjustment. Other measures were used only a few times or were not comparable enough to combine in this review.

### Duration of follow-up

Follow-up periods varied from immediately post treatment up to 4 years (Baldoni 1995).

## METHODOLOGICAL QUALITY

Using the CCDAN Quality Rating Scale, (see Methods) the total scores ranged from a low of 17.5 to a high of 36 with a mean of 28.4 (see Table 03). One study rated between 10 and 19, 12 rated between 20 and 29, and 10 were between 30 and 39. Thus, the majority of these studies were of at least moderate quality and validity using this measure. The sample size averaged 58.

Regarding the concealment of randomisation:

A - indicated adequate concealment

B - indicated uncertainty about the adequacy of concealment

C - indicated the allocation was definitely not concealed

D - indicated the score was not assigned.

Of included trials, 18 scored B, 3 scored A, 2 scored C and zero scored D.

Some of the elements of the CCDAN scale were not relevant to this type of treatment research. There was no blinding of psychotherapy subjects and specific "side effects" were reported.

To limit the influences of attrition bias, we only included studies with less than 20% drop outs. This was a high standard for psychotherapy research of complex populations where drop outs rates not infrequently top 40%. One such excluded study, (Burnand 2002) reported beneficial outcomes, including cost benefits, with a challenging group of depressed patients who frequently drop out of treatment.

## RESULTS

### Primary outcome measures

We were able to combine results from studies for general psychiatric symptoms as well as anxiety, depression and somatic symptoms. In each case, we have grouped findings under the following diagnostic groups: depression, anxiety, somatoform and mixed disorders. We highlighted any differences between groups in the section on sub-group analyses. For many of the outcomes, the study by Sjodin 1986 diverged markedly from the results of the other studies. This was a study of peptic ulcer from 20 years ago before the introduction of triple therapy for the eradication of *helicobacter pylori*. Aside from the sensitivity analyses outlined in our proposal, we repeated analyses for all relevant measures without this study. The relevant issues have been discussed more fully under heterogeneity.

#### (a) General measures

We were able to incorporate fourteen studies which reported measures of general psychiatric symptoms. The fixed effects model showed modest but significant improvements relative to controls in the short-term (SMD -0.42, 95% confidence interval (CI) -0.58 to -0.27), medium-term, (SMD -0.62, 95% CI -1.02 to -0.22 ) and long-term (SMD -0.51, 95% CI -0.72 to -0.31). Using the random effects (RE) model, the difference between the treatment

and control reached significance in the short term (SMD -0.71, 95% CI -1.43 to -0.00,  $P=0.05$ ) and medium-term (SMD -0.62, 95% CI -1.02 to -0.22,  $P=0.002$ ). In the case of long-term follow-up, the results marginally failed to reach significance (SMD -1.17 (95% CI -2.39 to 0.05,  $P=0.06$ ). When we excluded the study by Sjodin 1986 the results of the random effects model more closely resembled those of the fixed effects model, with significant differences for the treatment group compared to the controls in the short-term. The short-term SMD (RE) was -0.97 (95% CI -1.51 to -0.42), and the long-term SMD (RE) was -1.51 (95% CI -3.14 to 0.12).

#### (b) Somatic measures

Somatic measures also showed significant treatment effects relative to controls in the short-term (SMD -0.67, 95% CI -0.85 to -0.48), medium-term, (SMD -0.87, 95% CI -1.37 to -0.38 ) and long-term (SMD -0.95, 95% CI -1.19 to -0.70) on the fixed effects model. With the random effects model, the difference between treatment and control groups remained significant in the short-term (SMD -0.86, 95% CI -1.69 to -0.02) and medium-term (SMD -0.87, 95% CI -1.37 to -0.38). In the long-term the SMD marginally failed to reach significance (SMD -2.27, 95% confidence interval -4.57 to 0.03,  $P=0.05$ ). When we excluded the study by Sjodin 1986, the short-term SMD (RE) was -0.81 (95% CI -1.82 to 0.20), and the long term SMD (RE) was -2.21, (95% CI -5.49 to 1.07).

#### (c) Anxiety

Anxiety ratings showed moderate treatment effects relative to controls in the short-term (SMD -0.46, 95% CI -0.64 to -0.27), medium-term, (SMD -0.96, 95% CI -1.26 to -0.66) and long-term (SMD -0.46, 95% CI -0.71 to -0.21) with the fixed effects model. With the random effects model, the results remained significant in the medium-term (SMD -0.96, 95% CI -1.60 to -0.31) but not in the short-term (SMD -0.72, 95% CI -1.70 to 0.26) and long-term (SMD -0.85, 95% CI -2.36 to 0.67). When we excluded the study by Sjodin 1986 the difference reached statistical significance in the short-term (SMD -1.08, 95% CI -1.79 to -0.37) and marginally failed to reach significance in the long-term (SMD -1.35, 95% CI -2.73 to 0.03,  $P=0.05$ ).

#### (d) Depression

Measures of depression showed moderate treatment effects relative to controls in the short-term (SMD -0.47, 95% CI -0.61 to -0.33), medium-term, (SMD -0.32, 95% CI -0.55 to -0.10) and long-term (SMD -0.78, 95% CI -0.99 to -0.57) on the fixed effects model. Each of these results were maintained using the random effects model in the short-term (SMD -0.59, 95% CI -1.13 to -0.05) the medium-term (SMD -0.41, 95% CI -0.79 to -0.03) and long-term (SMD -0.98, 95% CI -1.91 to -0.04).

### Secondary outcome measures

In our protocol, we stated that we would consider secondary outcome measures including quality of life, behavioural measures, interpersonal problem measures and patient satisfaction as measured

by standardised instruments. However, studies reported very different measures in insufficient detail for quantitative integration of data in most cases.

#### **(a) Social adjustment**

Four studies reported on social adjustment and showed significant and modest effects in both the short term (SMD -0.51, 95% CI -0.76 to -0.26) and long-term (SMD -0.45, 95% CI -0.70 to -0.21) using both the fixed and random effects models. Guthrie 1999 also found significant and superior improvements on the social functioning subscale of the SF-36 compared to controls.

#### **(b) Quality of life**

Guthrie 1999 using the EuroQol 5D, did not find significant differences at termination but did find significantly higher quality of life ratings in the STPP group in follow-up. Creed 2003 found significant and persistent improvements on the SF-36 physical scores relative to controls, but found significant superiority of STPP only in the short term on mental symptom sub scales relative to controls.

#### **(c) Behavioural measures**

In a unique and high quality study, Guthrie 2001 found treated patients had a reduction in suicidal ideation and self harm episodes relative to treatment as usual in patients who had self-induced poisoning. In a study excluded only because it had no standardised measures of interest to this review, Dare 2001 found STPP to produce superior weight gains and recovery rates compared to controls in a group of adults with anorexia nervosa.

#### **(d) Interpersonal problem measures**

Monsen 2000 found significant improvements in interpersonal problem ratings relative to treatment as usual in patients with chronic pain. Abbass 2006 (unpublished data) found significant improvement in interpersonal problems relative to controls in a sample of symptomatic patients with personality disorders. Alstrom 1984a found a significantly superior improvement in interpersonal relations in socially phobic patients but he did not find this in patients with agoraphobia (Alstrom 1984b).

#### **(e) Patient satisfaction**

No data were available for this outcome.

#### **(f) Health service use**

No data were available for this outcome.

#### **(g) Cost measures**

Creed 2003 found STPP was more cost effective than treatment as usual over the first year of treatment in patients with irritable bowel syndrome, while paroxetine was not significantly more cost effective than the control. Guthrie 1999 found STPP to significantly reduce several costs measures compared to treatment as usual in a mixed sample of high service utilizing patients. Hamilton 2000 did not find significant cost savings relative to the control treatment but did note significant cost savings compared to the period before treatment. Abbass 2006 (unpublished data) found

treatment costs were more than offset by reductions in disability and medication costs by one year after treatment.

#### **(h) Death**

No data were available for this outcome.

#### **(i) Drop out rates**

de Jonghe 2004 specifically compared drop out rates with STPP added to treatment with medications versus medications alone. They found a significant reduction in drop out rates using STPP as well as significantly superior outcomes compared to medication alone in depressed patients.

#### **(j) Occupational functioning**

Monsen 2000 found those treated with STPP had significantly more job advancements and Creed 2003 found STPP treated patients had significantly less work disability compared to the paroxetine treated group. Abbass 2006 (unpublished data) found significantly more works hours and employment in treated patients versus controls. Alstrom found significantly superior improvement in work capacity relative to controls in the agoraphobic group (Alstrom 1984b) but not in the socially phobic group (Alstrom 1984a).

#### **Heterogeneity**

Tests for heterogeneity were statistically significant at the  $P < \text{or} = 0.10$  level except in the cases of general measures in the medium term, somatic symptoms in the medium term and social adjustment in both short and long term. This heterogeneity was largely due to two studies: Svedlund 1983 and Sjodin 1986. When we repeated our analyses without these two studies, heterogeneity was not significant in most cases. However, our findings of reductions in symptomatology must be treated with caution in categories where this test is positive, and greater reliance placed on those derived from the random effects model.

#### **Subgroup and sensitivity analyses**

Because of the small number of trials in each analysis, these results are limited and should be interpreted with caution. Given the degree of heterogeneity, we only present the results using the random effects model, and we did not include Sjodin 1986.

#### **Subgroup analyses (see Table 01; Table 02; Table 03)**

##### **(a) differences in outcomes between different diagnostic groups**

Because of the relatively few studies in subcategories, it was difficult to draw any conclusions about differences between these groups. There were only two pure depression studies (Cooper 2003, de Jonghe 2004) and they did not have measures used in the other symptom categories. Likewise, there were only four pure anxiety studies and they did not have many other measures to allow comparative outcomes between these groups. In general, the greatest difference between intervention and control groups occurred for the symptom most specific to the condition under consideration, (e.g. depressive symptoms in depressive disorders, or anxious symptoms in anxiety disorders).

### **(b) differences between manualised and non-manualised therapies**

There was no change to the results in the short-term when analyses were restricted to manualised therapies only. However, significant differences between the intervention and control groups were only maintained in the long-term for anxiety symptoms.

### **(c) therapy of up to 20 sessions versus 20-40 sessions**

When we considered therapy of up to 20 sessions only, differences between the intervention and control groups disappeared in the short-term but became apparent in the medium-term in most cases. However, in the case of depression, the effect of treatment only became significant at long-term follow-up.

### **(d) differences between studies that gave self-reported or observer-rated outcomes**

The effect size remained significant in all categories and time frames except anxiety and depression in the long-term and social adjustment in the short term.

### **Sensitivity analysis**

#### **(a) differences between analyses involving all studies and excluding trials of low methodological quality as defined by CCDAN criteria**

There was no change to the results when analyses were restricted to those of high methodological quality only.

#### **(b) differences between analyses involving studies that used treatment as usual (TAU) as opposed to minimal treatment or wait list controls**

Differences between intervention and controls lost significance when analyses were restricted to studies that used TAU as opposed to minimal treatment or wait list controls, except in the case of short term depression.

### **Assessing publication bias: funnel plot analysis**

Funnel plots were explored as an indication of publication bias. The largest number of studies available was in each of the short-term outcome measures. Each of these had funnel plots that had some features of an inverted funnel (somatic) or had studies with similar Standard Errors (anxiety, depression), leaving a flat but dispersed distribution. Other categories had too few studies to allow an interpretation. Thus, we could not draw definitive conclusions about publication bias using this method.

### **Improving and updating the review**

It is anticipated that this review will be updated in no longer than two years after publication. In the interval, colleagues who have been working in this same area internationally will be contacted to solidify the team performing this review. Methods of this review maybe revised to incorporate what we have learned about this body of research. For example, sub group analyses of studies with higher treatment quality versus lower treatment quality may be performed to determine if this parameter impacted on outcomes.

## **DISCUSSION**

This meta-analysis of 23 RCTs of short-term psychodynamic psychotherapies (STPP) found it to have modest to moderate effects relative to controls across a broad range of common mental disorders. In somatic, depressive and general symptoms, treatment effects were increased over long-term follow-up suggesting maintained or increased gains in the long term. Benefits were observed across depression, anxiety, somatic and general measures, as well as social adjustment. Individual studies also found improvements in interpersonal relationships, reduced self-injury and weight gain in anorexia nervosa, suggesting behavioural as well as symptomatic gains. Moreover, the observed reduction in somatic symptoms may contribute to observed reductions in healthcare use and improved occupational functioning. Indeed, there may be financial benefit to these systems through providing this brief treatment. However, there are a number of issues which limit the interpretation and utilization of these results. These include:

### **1. Diagnostic criteria**

The lack of specific diagnostic criteria in some studies and the use of mixed samples limit the clinician's ability to determine suitability of STPP for individual patients in his or her practice.

### **2. Study quality**

The studies were of variable quality as described above. Manuals and adherence measures were not employed in each study calling into question the quality of psychotherapy provided. Therapist experience was in question in many studies, raising the chance that the therapy was not provided in an optimal fashion. It was unclear in a few studies whether the model of STPP was a bona fide STPP method versus a series of psychoanalytic therapy sessions without a specific brief therapy methodological basis. The CCDAN Quality Rating System we used did not include ratings on these parameters, which were relevant to the interpretation of psychotherapy study quality. We discuss this issue in the next paragraph.

### **3. Treatment methods**

The diversity of the treatment methods was another potential problem with this body of data. Within the STPPs, a range of techniques are used to make unconscious processes conscious. These include interpretation, pressure to feelings, emotional experiences and linking of various phenomena. In these studies treatment methods were described, but the degree to which emotional processes versus intellectual processes dominated the treatment sessions was not reported in most studies. Thus, there is a possibility that treatments provided were more different than similar. Even if the treatments were more different, there is a lack of clear research to tell us whether this diversity matters in overall psychotherapy outcome. Although STPP common factors are the core of the treatment, many therapy directions are possible. A further issue is that the quality of the STPP varied between studies raising the probability that STPP may have been provided sub-optimally in some of the included studies. The efficacy of STPP may therefore

have been underestimated in this meta-analysis. Indeed, Leichsenring 2004 found greater effect sizes with his sample of STPP studies that were selected for quality of, and validation of, treatment provided. However, given the option of excluding studies of questionable therapy technique, we decided to include all studies meeting our basic criteria. Our decision was to err on the side of caution in avoiding a possible selection bias where information was lacking or vague regarding these parameters in most studies.

#### 4. Study heterogeneity

The significant heterogeneity in most study categories was a major concern. This heterogeneity was largely due to two studies: Svedlund 1983 and Sjodin 1986. This may be due to the fact that these were both studies of physical disorders, without major mental symptoms and that both were conducted relatively early in the history of STPPs technical development. When we repeated our analyses without these two studies, heterogeneity was not significant in most cases. However, our findings must be treated with caution in data where the test of heterogeneity was significant. The above noted methodological and treatment variability may account for the observed heterogeneity of study outcomes. Differences in the control conditions (i.e. treatment as usual versus wait list versus minimal treatment) may have brought more or less treatment effects in these studies leading to inter-study variability as illustrated by our sensitivity analyses (Vinnars 2005). Another factor that probably contributed was the collection of diverse patient populations with a broad range of physical and psychological symptoms including depression, anxiety, personality problems and diverse somatic conditions such as ulcer disease. Arguably, studies included in this review should include patients with clear and specific diagnoses while excluding other confounding diagnoses. However, these studies reflect the heterogeneity and complexity of patients who present with multiple problems including symptom, somatic and personality disorders. Thus, this body of studies may tell us more about the real-world utility of STPP, than would a highly-selected sample of patients who often do not exist in public and private psychotherapy offices.

#### 5. Comparison to other meta-analyses

This study had the same main finding as three previous meta-analyses while using a largely different sample of studies. The most recent meta-analysis for example (Leichsenring 2004), used only eight of our included studies. They noted very strict inclusion criteria including use of a manual, trained or experienced therapists, specific samples and diagnoses (no mixed samples) and specific diagnostic procedures. Thus, they ended up having relatively few studies included in our review and the other reviews before his. Both this group and the present review excluded studies of interpersonal therapy, but these were included in Crits-Christoph 1992 and Anderson 1995. Nonetheless, with different samples and different methods, all four systematic reviews of STPP concluded that it was more efficacious than minimal treatment and wait-list controls in the short term. The Svartberg and Stiles review (Svartberg 1991) was the review to find weaker outcomes in the

long term while the others, including ours, found maintained or improved gains in long-term follow-up.

## AUTHORS' CONCLUSIONS

### Implications for practice

We have attempted to draw modest conclusions, based on the available evidence, and to highlight areas requiring further study rather than draw conclusions that may not be based on evidence of high quality. STPP treatments appear effective for a broad range of common mental disorders, with evidence of modest to moderate benefits which generally persist in the medium and longer term. Although cost comparisons were not made in this review, it should be noted that these therapies are relatively short and much less expensive than long-term psychotherapy models. Therefore they represent an economical approach to problems as complex as chronic pain, personality disorder, panic disorder, self-induced poisoning and other challenging to treat conditions. They are also less expensive than even one year of some psychotropic medications, depending on who is delivering the therapy and the setting (public versus private pay), and they may directly provide cost benefits through reduced service use and disability.

### Implications for research

Future research in these approaches should aim to improve study quality through the use of specific treatment manuals, videotaped adherence rating, cost-benefit measures and treatment-specific, experienced therapists. This would yield higher quality studies and thereby further test the efficacy of these methods. Indeed, even one more high quality study showing benefits would cause the borderline non-significant measures to convert to statistical significance. More studies would also tend to reduce the heterogeneity observed here. Some future studies should also focus on specific diagnostic categories to allow clinicians evidence with which to consider these treatments for specific populations. Research into the specific therapy processes that lead to specific outcomes is warranted as a means of clarifying crucial treatment factors in these methods. For example, the degree emotional experience versus intellectual insight occurred in therapy sessions could be compared between patient groups to see which ingredients had the most bearing on outcomes (Blatt 2005). Such information would further inform practice with the broad range of patients who appear to be candidates for STPP.

## POTENTIAL CONFLICT OF INTEREST

The principal reviewer, Allan Abbass has an academic focus on a variant of STPP, and was the lead author on one of the included studies. He acknowledges a psychotherapeutic bias in his clinical work and teaching in favour of some of these methods. However,

he is aware of the need to review the literature, and improve upon the research done in this field. To balance this view, three colleagues without such a bias participated in this review.

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\*Indicates the major publication for the study

## TABLES

### Characteristics of included studies

Study	<b>Abbass 2006</b>
Methods	Multicentre randomised controlled trial of 2 parallel conditions
Participants	27 patients referred from physicians or mental health professionals. Inclusion: between 18-70, 1 or more DSM IV Personality Disorder. Those with comorbid non psychotic symptom disorders were acceptable. Exclusion: psychosis, organic brain syndrome, mental retardation, current substance dependence, acute suicidal behaviour, violent behaviour, no new psychotropic medication in the previous 3 months
Interventions	Intensive Short-term Dynamic Psychotherapy, manualised, based on Davanloo, 2000 or minimal contact wait-list (mean duration 14.8 weeks). 5 therapists with over 5 years training and experience in ISTDP. Mean number of sessions 27.7. All sessions videotaped, adherence rated through sampling of videotapes using adherence rating scale.
Outcomes	Brief Symptom Inventory (BSI), Inventory of Interpersonal Problems, GAF Symptoms and Social Occupational, medication use and cost, work hours and function, all measured at pre therapy, post therapy and in 1 and 2 year follow-up.
Notes	CCDAN QRS score: 28
Allocation concealment	B – Unclear

Study	<b>Alstrom 1984a</b>
Methods	Single-centre randomised controlled trial, between 1973 and 1979, parallel design with four arms.
Participants	Inclusion criteria: 18-60 years old, sought help for social phobia at outpatient services. Exclusion criteria: any form of continuous treatment for the previous 6 months, drug abuse, dementia, neurological signs of brain damage, symptoms of endogenous depression, schizophrenia, obsessive-compulsive neurosis or mental retardation, or poor knowledge of Swedish language. Study included 42 social phobic men and women. They were all assessed as not suitable for insight-oriented psychotherapy.
Interventions	Common to each group - psychoeducation, information on prolonged exposure in vivo, encouragement to participate in anxiety-provoking situations. Patients could continue to take medications. (1) Basal therapy - included the above, and meetings once a month for 20-30 minutes; vs. behavioural therapy (prolonged exposure in vivo); vs. (2) relaxation therapy; vs. (2) psychodynamically oriented supportive therapy, based on Dewald, 30 min appointments once/week for 3 mos (~12 app'ts). No mention of manual for therapy, measures of therapist adherence.
Outcomes	Measured pre-treatment, end (post-) treatment, and 9 mos follow-up. Measures were scales constructed by the authors to measure indirect manifestations of anxiety (target phobia, other phobias, OCD symptom), direct manifestations of anxiety, ego-restriction and social functions, and a global rating. Also, intellectual ability was measured with the SRB test, personality with the Eysenck Personality Inventory, and the Cesarec-Marke Personality Schedule. Therapist rated measures.
Notes	CCDAN QRS score: 27.5. Free anxiety measures and global symptom data used.
Allocation concealment	B – Unclear

Study	<b>Alstrom 1984b</b>
Methods	Single-centre randomised controlled trial, between 1973 and 1979, parallel design with four arms.
Participants	Inclusion criteria: 18-60 years old, sought help for agoraphobic syndromes at outpatient services. Exclusion criteria: any form of continuous treatment for the previous 6 months, drug abuse, dementia, neurological

## Characteristics of included studies (Continued)

signs of brain damage, symptoms of endogenous depression, schizophrenia, obsessive-compulsive neurosis or mental retardation, or poor knowledge of Swedish language. Study included 73 agoraphobic women. They were all assessed as not suitable for insight-oriented psychotherapy.

Interventions	Common to each group - psychoeducation, information on prolonged exposure in vivo, encouragement to participate in anxiety-provoking situations. Patients could continue to take medications. (1) Basal therapy - included the above, and meetings once a month for 20-30 minutes; vs. behavioural therapy (prolonged exposure in vivo); vs. (2) relaxation therapy; vs. (2) psychodynamically oriented supportive therapy, based on Dewald, 30 min appointments once/week for 3 mos (~12 app'ts). No mention of manual for therapy, measures of therapist adherence.
Outcomes	Measured pre-treatment, end (post-) treatment, and 9 mos follow-up. Measures were scales constructed by the authors to measure indirect manifestations of anxiety (target phobia, other phobias, OCD symptom), direct manifestations of anxiety, ego-restriction and social functions, and a global rating. Also, intellectual ability was measured with the SRB test, personality with the Eysenck Personality Inventory, and the Cesarec-Marke Personality Schedule. Therapist rated measures. Global scale and free anxiety measures were used in this review.
Notes	CCDAN QRS score: 27.5. Both Alstrom studies in this review used the same methods. Free anxiety measures and global symptom data used. Could not use 9 month follow-up data as more than 20% of sample lost to follow-up.
Allocation concealment	B – Unclear

### Study

#### Baldoni 1995

Methods	Single centre randomised controlled trial, two year study, parallel design.
Participants	Urethral syndrome (urinary symptoms and pain without organic lesions) patients, female, aged 18 to 63 (mean 40); 36 participants. All complained of urgency, dysuria and tenesmus at the first evaluation.
Interventions	Short-term dynamic psychotherapy (Malan's technique) vs. "traditional urological treatment". The psychotherapy consisted of 12-16 weekly sessions lasting 1 hour conducted by a single psychotherapist. Traditional urological treatment included medical therapy (anti-cholinergic and alpha-antagonist drugs) and urethral dilatation. Both groups had 3-4 months of therapy for an average of 14 weeks.
Outcomes	Pre, 6 mos post, 4 yrs posttreatment. Presence and nature of urinary disorders such as urgency, dysuria, tenesmus; Number of day and night micturitions; Pain in the pelvic area and its features; The Symptom Questionnaire (SQ) which can discriminate between psychiatric patients and others and between various psychological discomfort levels by assessing anxiety, depression, somatic symptoms, and hostility. Continuous data from SQ used as obtained from authors.
Notes	CCDAN QRS score: 17.5. 4 participants allocated to STDP group were given anti-depressant pharmacotherapy (a combination of amitriptyline and mianserin) but two broke off therapy before completion and are not considered in the results. Data obtained from authors in form of means, standard deviations for outcomes of interest: anxiety, depression and somatic symptoms of SQ.
Allocation concealment	C – Inadequate

### Study

#### Brom 1989

Methods	Randomised controlled trial with 4 parallel conditions.
Participants	112 patients diagnosed with post-traumatic stress disorder with DSM-III criteria, with the condition that not more than 5 years had elapsed since the incurring event. They were recruited through a general assessment with one of the authors, and a further interview to make sure the patient could stand a confronting therapy. Ages 18 to 73 (mean 42.0), 79% were women, 21% were men.

### Characteristics of included studies (Continued)

Interventions	Trauma desensitization (mean length of treatment 15.0 sessions) vs. hypnotherapy (mean 14.4 sessions) vs. brief psychodynamic therapy (mean length 18.8 sessions) based on Horowitz (1976) vs. waiting-list group (4 months long).
Outcomes	Pre-, post-, and 3 mos post-treatment. SCL-90, with five subscales; State-Trait Anxiety Inventory (STAI); State-Trait Anger Inventory; Dutch Personality Questionnaire; Introversion-Extroversion scale of the Amsterdam Biographical Questionnaire; scale for internal vs. external control.
Notes	CCDAN QRS score: 23.5. SCL-90 total score and STAI data used in the review. Unable to use personality data as it was broken down only into subscales.
Allocation concealment	B – Unclear

#### Study **Cooper 2003**

Methods	Single-centre randomised controlled trial.
Participants	Large consecutive series of primiparous women (3222) identified through birth records of Addenbrooke's Hospital, Cambridge, UK, screened between January 1990 and August 1992 for mood disturbance in the early post-partum period, using postal administration of Edinburgh Postnatal Depression Scale (EPDS). EPDS score of 12 or greater assessed; those with PPD invited to take part. Inclusion: 15-mile radius to hospital, English as first language. Exclusion: delivered prematurely, if infant had any gross congenital abnormality, if they did not have a singleton birth, or were intending to move out of the area during the study period. 206 women identified; 193 agreed to take part.
Interventions	Women assigned to one of four conditions: "routine primary care" (as control), or cognitive-behavioural therapy (CBT), or psychodynamic therapy, as described by Cramer & Stern (Cramer, 1990; Stern, 1995) or non-directive counselling. Therapy was conducted in women's homes on a weekly basis from 8 weeks to 18 weeks post-partum. There were six study therapists: specialist in each of the three research treatments and 3 non-specialists. A Therapist Rating Scale was administered to participant to measure adherence to treatment.
Outcomes	Follow-up at 4.5, 9 and 18 months. 5 year F/U for those who had completed therapy. Symptoms of depression, as measured by the Edinburgh Post-natal Depression Scale (EPDS). Also, measures of infant-mother attachment and behaviour.
Notes	CCDAN QRS score: 28.5. Primary care condition used as minimal treatment control. EPDS data used in depression outcome of review.
Allocation concealment	B – Unclear

#### Study **Creed 2003**

Methods	Multicentre randomised controlled trial with three parallel conditions. Patients were stratified by hospital and severity.
Participants	257 patients with severe IBS recruited from gastroenterology clinics. Inclusion criteria: Rome I criteria for IBS satisfied, IBS symptoms >6 months, failure to respond to usual medical treatment for 3 months or more, severe abdominal pain, no contraindications to psychotherapy or paroxetine, ability to complete questionnaires, aged 18-65.
Interventions	Psychodynamic interpersonal therapy based on Hobson, manualized, for one long, 2 hour session, and 7, 45 min sessions over 3 months or paroxetine 20 mg orally each day for 3 months or "treatment as usual", continuing to see gastroenterologist or GP for duration of study. For the psychotherapy or paroxetine groups, after three months they returned to GP to decide on further management.

### Characteristics of included studies (Continued)

Outcomes	Trial entry, 3 months, 1 year post-treatment. IBS symptoms - VAS of severity of abdominal pain, record of days of pain, change in symptoms. SF-36 (health related quality of life), GSI of SCL-90, health care costs, utilization.
Notes	CCDAN QRS score: 36. VAS scale data for abdominal pain used for somatic symptoms. SCL-90 score data used for general psychiatric symptom measures in long-term follow-up comparison; 20% of sample lost in the 3 month follow-up assessment.
Allocation concealment	A – Adequate

#### Study Guthrie 1993

Methods	12 week, single centre randomised controlled trial with two parallel conditions.
Participants	102 patients who had been diagnosed with irritable bowel syndrome (IBS) and had been experiencing symptoms for over 1 year, and who had been treated for a minimum of 6 months with no improvement on bulking agents and/or antispasmodic therapy.
Interventions	Dynamic psychotherapy based on the conversational model of Hobson, consisting of one long 2 hour session, and six follow-up sessions or a control group at attended on three occasions (2, 4, and 8 weeks) to discuss their daily bowel habits. All patients continued standard medical treatment in the gastroenterology clinic.
Outcomes	Pre, post 12 week trial. BDI, Symptoms Rating Test, PAS (a modified PSE).
Notes	CCDAN QRS score: 32. Same trial as Gurthrie, 1991, but further data analysis and later follow-up. BDI score used at end-treatment.
Allocation concealment	B – Unclear

#### Study Guthrie 1999

Methods	Two year, multicentre randomised controlled trial with two parallel conditions.
Participants	110 patients referred from consultant psychiatrists who had received treatment for longer than 6 months. Inclusion criteria: between age 18 and 65 with no improvement in psychological symptoms while in psychiatric treatment. Exclusion criteria: schizophrenia, dementia, brain damage, learning difficulties, and limited command of English. 69 were female, and the mean age was 41.4.
Interventions	Psychodynamic-Interpersonal therapy, manualized, based on Hobson (1985), for 8 sessions or “treatment as usual” under the care of their consultant psychiatrist. Adherence was checked through supervision, audiotapes, and used of the SPRS.
Outcomes	Pre, post, and 6 mos follow-up. GSI of SCL-90-R, SF-36 (health status), Euro-QoL5D (quality of life), all self-rated. Direct treatment costs, nontreatment costs, indirect costs.
Notes	CCDAN QRS score: 34.5 SCL-90 GSI and depression subscale data used; could not use 6 month follow-up data as drop-out rate was >20%. SF-36 only presented as subscales, no overall measures to use; Euro-QoL5D data not presented in a form to be useable in review.
Allocation concealment	A – Adequate

#### Study Guthrie 2001

Methods	Randomised controlled trial with two parallel treatment conditions.
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### Characteristics of included studies (Continued)

Participants	119 patients presenting to the emergency department with an episode of deliberate self-poisoning, aged 18-65, able to read and write English, live within the catchment area of the hospital, registered with a GP, not need inpatient psychiatric treatment.
Interventions	Psychodynamic interpersonal therapy, manualized, based on Hobson, 4 sessions within one week of presentation, 50 minutes long, in the patient's home, or "treatment as usual" - often consists of assessment by ER doctor or junior psychiatrist, one third referred for outpatient psychiatric treatment, some to addiction services, the rest to GPs. Adherence to treatment through weekly supervision, audiotaping, rating by SPRS.
Outcomes	Entry, one month, 6 mos. Beck scale for suicidal ideation, detailed description of episodes of self-harm, health care utilization.
Notes	CCDAN QRS score: 35. BDI data at 6 month follow-up used; >20% loss to follow-up in data at end-treatment.
Allocation concealment	A - Adequate

#### Study **Hamilton 2000**

Methods	Randomised controlled trial with two parallel treatment conditions.
Participants	71 patients fulfilling criteria for functional dyspepsia, having continuous symptoms for 6 mos, had been unresponsive to at least 2 medical treatments.
Interventions	PI therapy, based on Hobson, manualized, one 3 hr session and 6 50 minute sessions or supportive therapy, with session length and number identical to PI. Adherence to therapy by therapists was measured through SPRS rating of audiotapes.
Outcomes	Entry, end of 12 week intervention, 12 mo follow-up. Self-rating of dyspeptic symptoms, gastro. rating of dyspeptic symptoms, SCL-90-R and GSI, health care use (gastro clinic visits, meds, inpatient stays, procedures).
Notes	CCDAN QRS: 35. Patients with reflux were included in the study, but a subanalysis was performed excluding them. Data used for somatic symptoms and SCL-90 scores at end of treatment. More than 20% of participants were lost to follow-up, so one-year follow-up data was not used.
Allocation concealment	B - Unclear

#### Study **Linnert 2001**

Methods	Single centre randomised controlled trial with two parallel conditions.
Participants	32 adults (32 women, 9 men) with atopic dermatitis. Between 18 and 60 yrs old (mean 28.3), diagnosed with mild to moderate AD by a dermatologist, suffering from no other somatic or psychiatric disease.
Interventions	Psychodynamic psychotherapy, based on Malan, for 11-18 sessions (mean 15.5) over 6 months or no treatment. Both groups were instructed to continue their dermatologic treatment and keep it as stable as possible.
Outcomes	STAI, Scoring of Atopic Dermatitis Index (SCORAD) at entry, 6 mos (end-treatment), 12 mos (6 months post-treatment).
Notes	CCDAN QRS score: 22. SCORAD and Trait anxiety data scores used in review. Loss of >20% at 12 month follow-up, so this data was not used in the review.
Allocation concealment	B - Unclear

#### Study **Maina 2005**

Methods	Single centre randomised controlled trial with three parallel arms.
Participants	30 subjects recruited from the waiting list for Brief Dynamic Therapy (BDT) at the Mood and Anxiety Disorders unit, Dept. of Neuroscience of the University of Turin, Italy. Inclusion criteria of BDT waiting

## Characteristics of included studies (Continued)

list: patient request for psychotherapeutic approach, presence of a focal problem and/or a recent precipitant life event, and age 18-60 yrs. Exclusion: evidence of mental retardation, organic mental disorders, psychotic disorders, bipolar disorders, substance abuse, severe axis II pathology. Inclusion for study: dysthymic disorder, minor depressive disorder, or adjustment disorder with depressed mood; and CGI-S score >2. Exclusion: current suicidal ideation, current pharmacological treatment, evidence of severe or unstable or active neurological or physical diseases, and on the waiting list for > 1 mo.

Interventions	BDT, manualized, based on Malan, 15 to 30 sessions (mean 19.6) for 45 minutes, provided by psychiatrists with personal training in psychodynamic psychotherapy. Case notes reviewed by experienced BDT therapist for supervise treatment adherence. The other arms received Brief Supportive Therapy or were on the waiting list where they were contacted weekly by telephone.
Outcomes	HAM-D, HAM-A, CGI-I, CGI-S. Intake, post-treatment, 6 mo F/U, 12 mo F/U for both treatment conditions. Waiting list controls were only measured at intake and posttreatment.
Notes	CCDAN QRS score: 28. Data from HAM-D, HAM-A and CGI-S at post-treatment used in the review.
Allocation concealment	B – Unclear

### Study **Marmar 1988**

Methods	Randomised controlled trial with two parallel conditions.
Participants	61 women who sought treatment following the death of their husbands. DSM-III axis I diagnoses were 29 cases of adjustment disorder, 17 cases of PTSD, 10 cases of major depressive episode, and 5 cases of major depressive episode and PTSD. Exclusion: past or present psychotic illness, previous psychiatric hospitalisation, history of drug or alcohol abuse, concurrent psychological treatment, pending litigation, or widowhood less than 4 months or greater than 3 years duration.
Interventions	Brief dynamic therapy, based on Malan, Sifneo, Mann, and Horowitz, for 12 weekly sessions or mutual-help group treatment lead by women who had experienced the deaths of their own husbands. The BDP session were conducted by 11 faculty therapists with a mean 9.3 years of experience.
Outcomes	Pre, 4 mos post-treatment, 1 yr follow-up. Stress measures: Impact Event Scale (self-report) Stress Response Rating Scale (clinician report). SCL-90, short BDI, clinician report Brief Psychiatric Rating Scale. Social Adjustment Scale (SAS), GAS.
Notes	CCDAN QRS score: 29 SCL-90, BDI, SAS and SCL-90 subscale data used in review.
Allocation concealment	B – Unclear

### Study **Monsen 2000**

Methods	Randomised controlled trial of matched pairs of participants in two parallel conditions.
Participants	40 patients (35 women), all employees of a large Norwegian office company, self-referred to company's health service because of pain problems. Inclusion criteria: diagnosis of pain disorder associated with psychological factors according to the DSM-IV. Exclusion criteria: pain associated with other medical conditions, such as spine prolapse, neuralgia, or chronic disorders manifested in organ systems other than the musculoskeletal system (such as irritable colon).
Interventions	Psychodynamic Body Therapy, a variant of the affect-consciousness treatment model (ACT), based on Monsen & Monsen (1999). The PBT group received an average of 33 individual, one-hour sessions during a period of 9 months (ranging from 15-41 sessions). Psychotherapy was done by the project leader who is a well qualified clinical psychologist and physical therapist. The control group received treatment as usual (TAU): 3 patients received traditional physical therapy, 5 patients received both traditional physical therapy and pain-reducing medication, 3 patients received pain-reducing medication, and 1 patient received psychological counseling. 8 patients in the control group received no treatment during the intervention period. The treatment was done by the project leader who is a well qualified clinical psychologist and physical therapist.

## Characteristics of included studies (Continued)

The control group received treatment as usual (TAU), that is, three patients received traditional physical therapy, five patients received both traditional physical therapy and pain-reducing medication, three patients received pain-reducing medication, and one patient received psychological counseling. Eight patients in the control group received no treatment during the intervention period.

Outcomes	Measured at pre-treatment, post, and 1 yr F/U. Measures were Visual-analogue pain scale, SCL-90, Revised, IIP-C, MMPI, Affect-Consciousness Scales, and job advancement.
Notes	CCDAN QRS score: 24 Data used from SCL-90 scores and VAS for pain.
Allocation concealment	B – Unclear

### Study Piper 1990

Methods	Randomised controlled trial (patients matched in pairs by QOR, sex, and age, then assigned to one condition or another) with crossover design. Wait-list controls are used here for comparison.
Participants	105 psychiatric outpatients referred from a walk-in clinic. Axis I DSM-III diagnoses were affective (31%), adjustment (23%), anxiety (7%), and impulse control (8%). 32% of patients had Axis II diagnoses. Mean age 31, 65% female.
Interventions	Short-term individual psychotherapy, manualized, based on Malan (1976) and Strupp and Binder (1984), for a maximum of 20 weekly 50 min sessions (actual mean 18.6) or wait-list control. Wait-list control subsequently received STI therapy. Sessions were audiotaped, rated by Therapist Intervention Rating System. 8 therapists, mean experience 11.5 yrs (range 4-35).
Outcomes	Quality of Object Relations (QOR), SAS, Interpersonal Dependency Scale (two subscales used), Interpersonal Behaviour Scale, GSI of SCL-90, BDI, Trait Anxiety Scale, Rosenberg's Pre-(therapy, wait-list), post (therapy, wait), follow-up/ post-therapy, then overall follow-up - 5 month intervals. Self-Esteem Scale, Insight Scale, life satisfaction by 7-point Likert scale.
Notes	CCDAN QRS score: 25. Only immediately post-treatment data used for SCL-90, BDI and trait anxiety. Unable to use SAS data as not presented with means and standard deviations.
Allocation concealment	B – Unclear

### Study Shefler 1995

Methods	Single centre randomised controlled trial with crossover design.
Participants	33 patients referred from a walk-in psychiatric clinic, 9 male, 24 female, age range 23-42. Exclusion: schizophrenia and any subtypes, bipolar disorder, schizoid characters, obsessional characters with major defences of isolation and intellectualization, borderline conditions and psychosomatic disorders; also, further suitability for therapy. Only 45 of 404 patients from the clinic were deemed suitable for TLP. This was attributed to only 15% of patients being suitable for psychodynamic therapy due to higher percentages of patients with psychoses, and severe social and personality disorders in the centre's catchment area. DSM-III-R diagnoses were performed. On Axis I: 9 received no diagnosis, 7 had anxiety disorders, 6 had depressive disorders, 10 had adjustment disorders, and 1 had a life phase problem. Axis II: 5 had diagnoses (not given).
Interventions	Time-limited psychotherapy, based on Mann (1973), 12 weekly 50 min sessions, or wait-list control, then crossover into other condition. All 9 therapists were graduates in TLP courses
Outcomes	Assessments done at pre-treatment, mid (end TLP or wait), end TLP and wait, follow-up 6 mos, follow-up 12 mos. TCS, SCT, BSI-53 (brief revision of SCL-90), HSRS, GAS.
Notes	CCDAN QRS score: 24.5.



## Characteristics of included studies (Continued)

BSI-53 data used for general psychiatric symptoms measure comparison.

Allocation concealment B – Unclear

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### Study Sjodin 1986

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Methods Randomised controlled trial with 2 treatment conditions.

Participants 103 patients with peptic ulcer disease, aged 16-60 (mean 45). Exclusion: other somatic or mental disorder that required treatment or if they had been treated surgically for PUD, inability to speak Swedish fluently, receipt of a disability pension.

Interventions Dynamically oriented psychotherapy, based on Malan (1976), weekly hour-long sessions over 3 months, limited to ten sessions, with treatment as usual, or “treatment as usual”, only. Treatment as usual consisted of antacids, anticholinergic agents and, in a minority, a combination of antacids and a histamine<sub>2</sub>-receptor antagonist.

Outcomes Measured at pre-treatment, end treatment, 15 mos after start of treatment. Mental symptoms measured by Comprehensive Psychopathological Rating Scale (CPRS), measuring 27 items relevant to PUD and 18 somatic symptoms. Also, Structured and Scaled Interview to Assess Maladjustment (SSIAM).

Notes CCDAN QRS score: 30.5.

Data used for somatic symptoms, and anxiety, depression and general symptoms. SSIAM for social adjustment.

Allocation concealment B – Unclear

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### Study Sloane 1975

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Methods Randomised controlled trial with 3 conditions. Patients matched within conditions by sex and severity of neurosis as measured by Eysenck Personality Inventory.

Participants 94 patients who had applied for treatment at a university psychiatric outpatient clinic, between 18-45, not too mildly ill, or too disturbed to risk waiting for four months. Exclusion: psychotic, mentally retarded, organic brain damage, or primarily in need of drug therapy. Participants were mostly in early 20s, 60% female.

Interventions Psychoanalytically oriented therapy (model vague), or Behaviour therapy, or wait-list control. Therapies were four months of weekly sessions, mean 13.2 sessions for behaviour therapy, 14.2 for psychoanalytic therapy. 3 therapists per therapy condition, range of experience 6-20 yrs. External rating used for adherence.

Outcomes Measured at pre-treatment, post-treatment, 1yr follow-up. Three target symptoms rated, SSIAM.

Notes CCDAN QRS score: 25.

Most frequent symptoms of patients were, in decreasing order, generalized anxiety, interpersonal difficulties, low self-esteem, generalized worry, and bodily complaints. 1/3 of patients had personality disorders.

Data for Target symptoms used at post-treatment. Unable to use data at other follow-up times as some of the sample went on to continue or have treatment.

SSIAM data not presented in parameters that could be combined with other continuous data.

Allocation concealment C – Inadequate

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### Study Svedlund 1983

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Methods Randomised controlled trial with 2 parallel conditions.

Participants 102 patients with irritable bowel syndrome, aged 16-60 (mean 24), 70 females. Exclusion: other somatic or mental disorders requiring treatment, had had previous abdominal surgery affecting the GI tract, were on a disability pension, or were not fluent in Swedish.

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### Characteristics of included studies (Continued)

Interventions	Brief dynamic psychotherapy, based on Malan (1976), for 10 hour-long sessions over 3 months (mean 7.4 sessions), with medical treatment as usual, or "treatment as usual" only. Treatment as usual consisted of bulk-forming agents and, when appropriate, anticholinergic drugs, antacids, and minor tranquilizers.
Outcomes	Pre, post, 15 months (after start of psychotherapy). Mental symptoms by CPRS and somatic symptoms, all rated by psychiatrist. On follow-up, patient rating. Also, Structured and Scaled Interview to Assess Maladjustment (SSIAM).
Notes	CCDAN QRS score: 30. Additional data provided by author used for psychiatric symptoms, anxiety symptoms, depression symptoms, and somatic symptoms. SSIAM data used for social adjustment measure. Data used for somatic symptoms, and anxiety, depression and general symptoms. SSIAM for social adjustment.
Allocation concealment	B – Unclear

#### Study **Wiborg 1996**

Methods	Randomised controlled trial with 2 parallel conditions.
Participants	40 patients (23 women, 17 men) with panic disorder, with or without agoraphobia. Inclusion: at least 1 panic attack per week in the 3 week period prior to inclusion into the study. There was comorbidity: generalized anxiety disorder (3), social phobia (3), hypochondriasis (3), simple phobia (14), secondary major depressive episode (2), secondary obsessive-compulsive disorder (2).
Interventions	Clomipramine with brief dynamic psychotherapy (manualized, based on Davanloo, Malan, and Strupp and Binder) or clomipramine alone. Clomipramine was administered with a flexible step-up procedure (during which time benzodiazepines were allowed), until a dosage of 150 mg/day, for 36 weeks. BDP was administered by one therapist with experience (yrs not given), 1 weekly visit for 15 weeks, with 3 sessions given before the start of pharmacotherapy.
Outcomes	Pre, during (weekly), post, 18 mos follow-up. Overall: SCL-90, STAI, GAS, CGI. Panic attack diary, Panic Attack and Anxiety Scale (PAAS), HAM-A, SDS, Phobia Scale, HRSD, Medical Events Checklist (register adverse effects of clomipramine).
Notes	CCDAN QRS score: 32 SCL-90, HAM-D, and HAM-A data used.
Allocation concealment	B – Unclear

#### Study **Winston 1994**

Methods	Randomised controlled trial with 3 parallel conditions.
Participants	93 psychiatric outpatients. Inclusion: age 18-60, evidence of at least one close personal relationship, no evidence of psychosis, organic brain syndrome, or mental retardation, no active DSM-III-R Axis III medical diagnosis, no evidence of current substance abuse, no acute suicidal behaviour, no history of violent behaviour or destructive impulse control problems, and no use of psychotropic medications, such as lithium, neuroleptics or antidepressants in the past year. Exclusion: axis II diagnoses of schizoid, paranoid, schizotypal, narcissistic, and borderline personality disorders.
Interventions	STDP, manualized, based on Malan, Mann, Sifneos, and Davanloo, or Brief adaptive psychotherapy or wait-list (mean wait-list time 14.9 weeks). 24 therapists (13 for STDP, 11 for BAP), mean experience 11.6 yrs, mean number of sessions, both techniques combined, 40.3. All sessions videotaped, adherence rated through systematic scales.
Outcomes	Assessed at pre-treatment and 1 month post-treatment: GSI of SCL-90-R, SAS, target complaints rating.

	6 mos post: target complaints.
Notes	CCDAN QRS score: 28.5. SCL-90 and SAS data used in review.
Allocation concealment	B – Unclear
<b>Study</b>	<b>de Jonghe 2004</b>
Methods	Single-centre randomised controlled trial with two parallel arms.
Participants	Consecutive newly registered psychiatric clinic outpatients. Inclusion criteria: 18-60 yrs of age, DSM-III-R major depression, Hamilton Depression Rating Scale baseline score of at least 14 points and informed consent. Exclusion: presentation of psycho-organic disorder, drug abuse, psychotic disorder, and/or dissociative disorder; communication barrier; patient is not considered “reliable” enough to participate; participation was physically impossible; contraindication for one of the anti-depressants in the trial; adequate pharmacotherapy treatment for the current MDE; pregnancy. 167 people were randomised to each arm, but 38 refused after randomisation so 129 participants started the trial.
Interventions	A combined treatment arm with with psychotherapy and pharmacotherapy, and an arm with pharmacotherapy alone for 24 weeks each. Psychotherapy was Short Psychodynamic Supportive Psychotherapy (SPSP), based on Werman, 1984, or de Jonghe, 1994, 18 sessions of 45 min, the first 8 weekly and the last 8 biweekly, performed by 6 psychotherapists who are not the psychiatrists providing medication; all have at least 5 years of experience in psychoanalytic supportive therapy. The therapy is manualised (by the authors) and there were weekly sessions to assess adherence to therapy. The pharmacotherapy was a stepwise approach in which participants where in the case of intolerance or inefficacy the treatment was changed from fluoxetine, to amitriptyline, then moclobemide.
Outcomes	Measures were the Hamilton Depression Rating Scale, the SCL-90 depression scale, the Clinical Global Impressions (CGI) Improvement and Severity scales, and the Quality of Life Depression Scale. These were measured at pre- and post-treatment. Remission rates were also measured at 8, 16 and 24 weeks. The study looked at intention to treat data (including those who refused treatment after randomisation), completers only data, and a per protocol set (all patients who started with the treatment to which they were allocated).
Notes	CCDAN QRS: 31. SCL Depression score used in short-term depression measures of ITT sample.
Allocation concealment	B – Unclear

### Characteristics of excluded studies

Study	Reason for exclusion
Abbass 2002	Not a randomised controlled trial
Abbass 2002a	Not a randomised controlled trial
Barkham 1999	Control group was active treatment (CBT).
Bassett 1985	Compared to active treatment, cognitively oriented psychotherapy, in patients with chronic pain.
Brodsky 1983	Length of sessions only 30 minutes.
Budman 1988	Compares individual STPP to an active treatment, group STPP
Burnand 2002	Drop-out rate was greater than 20% and the drop-outs were not included in the follow-up data.
Dare 2001	Does not include any of the outcomes of interest: somatic symptoms, depression, or anxiety.
Dubois 1997	Not a randomised controlled trial.
Fairburn 1986	Short-form focal therapy compared to an active treatment, a cognitive behavioural approach
Gallagher 1982	Compared STPP to two active treatments: behavioural therapy and cognitive therapy

Gallagher-T* 1994	Brief psychodynamic therapy compared with an active treatment, cognitive-behavioral therapy, for clinically depressed family caregivers
Hall 1987	Randomised controlled trial of 30 females with anorexia nervosa. Excluded because the treatment group was a combined individual psychodynamic psychotherapy and family therapy approach.
Hardy 1995	Psychodynamic-interpersonal therapy was compared to cognitive-behavioural therapy, an active control
Hellerstein 1998	Short-term Dynamic Psychotherapy, based on Davanloo (1980), was compared with an active treatment control, Brief Supportive Therapy, manualised by the authors, in patients with personality disorders.
Hersen 1984	Compares psychotherapy to active treatments in females with major depressive disorder. Each group had 12 weeks of initial treatment, then 6 months of treatment at a reduced rate of contact (maintenance treatment). Social skills training, with 12 weekly 1hr sessions of social skills training, plus amitriptyline, with initial dose 50mg/day, increased to up to 300mg (mean 178.2mg/day) or social skill training plus placebo or amitriptyline or psychotherapy, with 12 weekly 1hr sessions of time-limited dynamic therapy (orientation unknown). All groups went for weekly "drug monitoring".
Hilsenroth 2003	No control group.
Knekt 2004	Compared STPP to solution-focused therapy, long-term psychodynamic therapy, and 41 patients "self-selected" for psychoanalysis in the treatment of anxiety and depression.
Koblentz 1995	No control group.
Kool 2003	Short Term Psychodynamic Supportive therapy compared to active control (antidepressant therapy) in subjects with major depression.
Lerner 1992	Compared short-term versus long-term psychotherapy (an active treatment control).
McLean 1979	Short-term psychotherapy was compared to active controls in subjects with depression. Other treatments were relaxation therapy, behaviour therapy, or drug therapy with amitriptyline. Nondepressed subjects were also measured as controls.
Pierloot 1978	Short-term dynamic psychotherapy compared to an active control, systematic desensitization, in an RCT with adult out-patients with anxiety manifestations.
Pilkonis 1984	Compared individual, group and conjoint therapies with different therapist orientations, not all STPP. One third of participants not randomised to treatment.
Piper 1998	An RCT comparing two active forms of therapy, interpretive and supportive forms of short-term individual psychotherapy, in adult out-patients with a variety of axis I and II diagnoses.
Rosser 1983	STPP used to treat bronchitis. No response from authors for data to put into analysis.
Shapiro 1987	Exploratory (relationship-oriented) therapy, a "nonspecific dynamic therapy" is compared to an active control, Prescriptive (cognitive/behavioural) therapy.
Shapiro 1995	Psychodynamic-interpersonal therapy is compared to cognitive-behavioural therapy, an active control
Simpson 2003	Use of a brief therapy by GPs in patients with chronic depression. Method of psychotherapy used was "Freudian psychoanalysis", which is not a standard STPP.
Svartberg 2004	Compared short-term dynamic psychotherapy to cognitive therapy, an active treatment control
Thompson 1987	STDP is compared to two active treatments and a delayed treatment condition. Data for the wait-list could not be compared to the treatment as it was a partially case-controlled study, with the subjects in the wait-list groups ultimately being incorporated into the treatment conditions.
Vinnars 2005	Control group was an active psychotherapy.
Woody 1987	Primary diagnosis was substance dependence.
Woody 1995	Primary diagnosis was substance dependence.

Characteristics of excluded studies (Continued)

ADDITIONAL TABLES

Table 01. SMDs -fixed effects (no. of studies, no. of participants, effect size [95% CIs])

Outcome	Overall	Diagnosis: Mixed	Diagnosis: Anxiety	Diagnosis: Somatic	Diagnosis: Depression only	Self-report	High CCDAN ratings	Manualised therapies	Up to 20 sessions
General psychiatric symptoms - ST	13, 816, -0.42 [-0.58,-0.27]	6, 381, -0.46 [-0.67,-0.26]	1, 46, -0.37 [-0.96, 0.21]	4, 311, -0.07 [-0.35, 0.21]	-	8, 503, -0.46 [-0.64, -0.28]	4, 372, 0.00 [-0.24, 0.24]	5, 344, -0.49 [-0.71, -0.27]	10, 698, -0.30 [-0.47, -0.14]
Gen psych sx - MT	2, 101, -0.62 [-1.02,-0.22]	1, 61, -0.50 [-1.01, 0.01]	-	1, 40, -0.81 [-1.45, -0.16]	-	2, 101, -0.62 [-1.02, -0.22]	-	-	1, 61, -0.50 [-1.01, 0.01]
Gen psych sx - LT	5, 445, -0.51 [-0.72,-0.31]	1, 61, -0.60 [-1.11, -0.08]	1, 40, -0.91 [-1.56, -0.26]	3, 344, -0.44 [-0.68, -0.21]	-	No change	4, 384, -0.50 [-0.72, -0.27]	2, 184, -0.23 [-0.52, 0.06]	No change
Somatic sx - ST	7, 537, -0.67 [-0.85,-0.48]	-	1, 46, -0.34 [-0.92, 0.25]	6, 491, -0.70 [-0.90, -0.51]	-	4, 307, -0.25 [-0.48, -0.03]	4, 424, -0.77 [-0.98, -0.56]	2, 221, -0.14 [-0.41, 0.12]	6, 497, -0.65 [-0.85, -0.46]
Somatic sx - MT	2, 72, -0.87 [-1.37,-0.38]	-	-	No change	-	No change	-	-	1, 32, -0.94 [-1.71, -0.17]
Somatic sx - LT	4, 381, -0.95 [-1.19, -0.70]	-	-	No change	-	No change	3, 349, -1.05 [-1.31, -0.78]	1, 149, 0.05 [-0.27, 0.37]	No change
Anxiety - ST	11, 601, -0.46 [-0.64, -0.27]	3, 185, -0.52 [-0.82, -0.22]	4, 145, -0.90 [-1.25, -0.55]	4, 271, 0.01 [-0.31, 0.34]	-	5, 279, -0.39 [-0.62, -0.15]	3, 243, -0.25 [-0.62, 0.12]	3, 164, -0.83 [-1.16, -0.50]	10, 561, -0.44 [-0.64, -0.25]
Anxiety - MT	4, 256, -0.96 [-1.26, -0.66]	1, 61, -0.36 [-0.87, 0.15]	1, 21, -1.07 [-2.02, -0.12]	2, 174, -1.31 [-1.71, -0.91]	-	3, 235, -0.95 [-1.26, -0.63]	-	-	3, 216, -1.01 [-1.35, -0.68]
Anxiety - LT	5, 333, -0.46 [-0.71, -0.21]	1, 61, -0.51 [-1.02, 0.00]	1, 40, -0.82 [-1.47, -0.17]	3, 232, -0.36 [-0.67, -0.04]	-	4, 293, -0.4 [-0.67, -0.13]	3, 240, -0.41 [-0.72, -0.10]	1, 40, -0.82 [-1.47, -0.17]	No change
Depression - ST	11, 927, -0.47 [-0.61, -0.33]	4, 286, -0.39 [-0.62, -0.15]	1, 40, -0.79 [-1.44, -0.14]	4, 340, -0.39 [-0.63, -0.14]	2, 261, -0.61 [-0.86, -0.36]	7, 664, -0.50 [-0.66, -0.35]	6, 607, -0.44 [-0.62, -0.27]	6, 526, -0.53 [-0.71, -0.36]	10, 887, -0.46 [-0.60, -0.32]
Depres-	5, 319,	2, 61,	-	2, 72,	2,186,	No change	1, 95,	2, 186,	4, 279,

**Table 01. SMDs -fixed effects (no. of studies, no. of participants, effect size [95%CIs]) (Continued)**

Outcome	Overall	Diagnosis: Mixed	Diagnosis: Anxiety	Diagnosis: Somatic	Diagnosis: Depression only	Self-report	High CCDAN ratings	Manualised therapies	Up to 20 sessions
sion - MT	-0.32 [-0.55, -0.10]	-0.29 [-0.79, 0.22]		-0.84 [-1.34, -0.35]	-0.16 [-0.45, 0.13]		-0.37 [-0.78, 0.03]	-0.16 [-0.45, 0.13]	-0.30 [-0.54, -0.06]
Depression - LT	6, 422, -0.78 [-0.99, -0.57]	1, 61, -0.35 [-0.86, 0.16]	1, 40, -0.65 [-1.29, -0.01]	3, 232, -1.43 [-1.75, -1.12]	1, 89, 0.04 [-0.38, 0.46]	5, 382 -0.79 [-1.02, -0.57]	3, 240, -1.42 [-1.72, -1.11]	2, 129, -0.17 [-0.52, 0.18]	No change
Social adjustment - ST	3, 254, -0.51 [-0.76, -0.26]	-	-	2, 203, -0.51 [-0.79, -0.23]	-	1, 51, -0.48 [-1.03, 0.08]	2, 203, -0.51 [-0.79, -0.23]	1, 51, -0.48 [-1.03, 0.08]	2, 203, -0.51 [-0.79, -0.23]
Social adjustment - LT	3, 260, -0.45 [-0.70, -0.21]	1, 60, -0.53 [-1.04, -0.01]	-	2, 200, -0.43 [-0.71, -0.15]	-	1, 60, -0.53 [-1.04, -0.01]	2, 200, -0.43 [-0.71, -0.15]	-	No change

**Table 02. SMDs -random effects (no. of studies, no. of participants, effect size [95%CIs])**

Outcome	Overall	Diagnosis: Mixed	Diagnosis: Anxiety	Diagnosis: Somatic	Diagnosis: Depression only	Self-report	High CCDAN ratings	Manualised therapies	Up to 20 sessions
General psychiatric symptoms - ST	13, 816, -0.71 [-1.43, -0.00]	6, 381, -0.56 [-0.90, -0.21]	1, 46, -0.37 [-0.96, 0.21]	4, 311, -0.57 [-3.03, 1.89]	-	8, 503, -0.52 [-0.83, -0.21]	4, 372, -0.42 [-2.56, 1.71]	5, 344, -0.73 [-1.31, -0.14]	10, 698, -0.61 [-1.48, 0.26]
Gen psych sx - MT	2, 101, -0.62 [-1.02, -0.22]	1, 61, -0.50 [-1.01, 0.01]	-	1, 40, -0.81 [-1.45, -0.16]	-	2, 101, -0.62 [-1.02, -0.22]	-	-	1, 61, -0.50 [-1.01, -0.01]
Gen psych sx - LT	5, 445, -1.17 [-2.39, 0.05]	1, 61, -0.60 [-1.11, -0.08]	1, 40, -0.91 [-1.56, -0.26]	3, 344, -1.47 [-3.51, 0.58]	-	No change -1.32 [-2.89, 0.25]	4, 384, -1.32 [-2.89, 0.25]	2, 184, -0.44 [-1.26, 0.39]	No change
Somatic sx - ST	7, 537, -0.86 [-1.69, -0.02]	-	1, 46, -0.34 [-0.92, 0.25]	6, 491, -0.95 [-1.91, 0.02]	-	4, 307, -0.28 [-0.55, -0.01]	4, 424, -1.29 [-2.59, 0.02]	2, 221, -0.14 [-0.41, 0.12]	6, 497, -0.87 [-1.82, 0.09]
Somatic sx - MT	2, 72, -0.87 [-1.37, -0.38]	-	-	No change	-	No change	-	-	1, 32, -0.94 [-1.71, -0.17]
Somatic sx	4, 381, -	-	-	No change	-	No change	3, 349,	1, 149,	No change

**Table 02. SMDs -random effects (no. of studies, no. of participants, effect size [95% CIs])** (Continued)

Outcome	Overall	Diagnosis: Mixed	Diagnosis: Anxiety	Diagnosis: Somatic	Diagnosis: Depression only	Self-report	High CCDAN ratings	Manualised therapies	Up to 20 sessions
- LT	-2.27 [-4.57, 0.03]						-2.98 [-6.06, 0.09]	0.05 [-0.27, 0.37]	
Anxiety - ST	11, 601, -0.72 [-1.70, 0.26]	3, 185, -0.76 [-1.50, -0.02]	4, 145, -0.90 [-1.25, -0.55]	4, 271, -0.37 [-3.30, 2.55]	-	5, 279, -0.37 [-0.65, -0.10]	3, 243, -0.85 [-5.02, 3.32]	3, 164, -1.20 [-2.07, -0.33]	10, 561, -0.74 [-1.82, 0.34]
Anxiety - MT	4, 256, -0.96 [-1.60, -0.31]	1, 61, -0.36 [-0.87, 0.15]	1, 21, -1.07 [-2.02, -0.12]	2, 174, -1.23 [-2.10, -0.35]	-	3, 235, -0.93 [-1.73, -0.12]	-	-	3, 216, -1.02 [-1.92, -0.13]
Anxiety - LT	5, 333, -0.85 [-2.36, 0.67]	1, 61, -0.51 [-1.02, 0.00]	1, 40, -0.82 [-1.47, -0.17]	3, 232, -0.97 [-3.81, 1.86]	-	4, 293, -0.86 [-2.76, 1.05]	3, 240, -1.03 [-3.75, 1.68]	1, 40, -0.82 [-1.47, -0.17]	No change
Depression - ST	11, 927, -0.59 [-1.13, -0.05]	4, 186, -0.39 [-0.62, -0.15]	1, 40, -0.79 [-1.44, -0.14]	4, 340, -0.64 [-2.36, 1.07]	2, 261, -0.61 [-0.86, -0.36]	7, 664, -0.50 [-0.66, -0.35]	6, 607, -0.59 [-1.54, 0.37]	6, 526, -0.53 [-0.71, -0.35]	10, 887, -0.58 [-1.16, 0.00]
Depression - MT	5, 319, -0.41 [-0.79, -0.03]	1, 61, -0.29 [-0.79, 0.22]	-	2, 72, -0.92 [-1.79, -0.05]	2, 186, -0.16 [-0.58, 0.26]	No change	1, 95, -0.37 [-0.78, 0.03]	2, 186, -0.16 [-0.58, 0.26]	4, 279, -0.40 [-0.86, 0.06]
Depression - LT	6, 422, -0.98 [-1.91, -0.04]	1, 61, -0.35 [-0.86, 0.16]	1, 40, -0.65 [-1.29, -0.01]	3, 232, -1.65 [-3.47, 0.17]	1, 89, 0.04 [-0.38, 0.46]	5, 382, -1.04 [-2.15, 0.06]	3, 240, -1.70 [-3.42, 0.02]	2, 129, -0.26 [-0.93, 0.41]	No change
Social adjustment - ST	3, 254, -0.51 [-0.76, -0.26]	-	-	2, 203, -0.51 [-0.79, -0.23]	-	1, 51, -0.48 [-1.03, 0.08]	2, 203, -0.51 [-0.79, -0.23]	1, 51, -0.48 [-1.03, 0.08]	2, 203, -0.51 [-0.79, -0.23]
Social adjustment - LT	3, 260, -0.45 [-0.70, -0.21]	1, 60, -0.53 [-1.04, -0.01]	-	2, 200, -0.43 [-0.73, -0.13]	-	1, 60, -0.53 [-1.04, -0.01]	2, 200, -0.43 [-0.73, -0.13]	-	No change

**Table 03. Properties of studies**

Study	Diagnosis	CCDAN rating	Manualised tx?	20 or less sessions
Abbass	Mixed: personality disorders	28	Yes	No
Alstrom, 1984a	Anxiety: social phobia	27.5	No	Yes

**Table 03. Properties of studies** (Continued)

Study	Diagnosis	CCDAN rating	Manualised tx?	20 or less sessions
Alstrom, 1984b	Anxiety: agoraphobia	27.5	No	Yes
Baldoni, 1995	Somatic/medical: urethral syndrom	17.5	No	Yes
Brom, 1989	Anxiety: post-traumatic stress disorder	23.5	No	Yes
de Jonghe, 2004	Depression: major depression	31	Yes	Yes
Cooper, 2003	Depression: postpartum depression	28.5	Yes	Yes
Creed, 2003	Somatic/medical: irritable bowel syndrome	36	Yes	Yes
Guthrie, 1993	Somatic/medical: irritable bowel syndrome	32	No	Yes
Guthrie, 1999	Mixed diagnoses: general outpatient referrals	34.5	Yes	Yes
Guthrie, 2001	Mixed diagnoses: self-poisoning presenting to emergency	35	Yes	Yes
Hamilton, 2000	Somatic/medical: functional dyspepsia	35	Yes	Yes
Linnet, 2001	Somatic/medical: atopic dermatitis	22	No	Yes
Maina, 2005	Mixed: mood and anxiety disorders	28	Yes	Yes
Marmar, 1988	Mixed: major depression, PTSD, adjustment disorders	29	No	Yes
Monsen, 2000	Somatic/medical: pain syndromes	24	No	No
Piper, 1990	Mixed: mood, anxiety, adjustment, axis II	26	Yes	Yes
Shefler, 1995	Mixed: anxiety, depression, adjustment disorders	28	No	Yes
Sjodin, 1986	Somatic/medical: peptic ulcer disease	32	No	Yes
Sloane, 1975	Mixed: "psychoneuroses" and axis II	23	No	Yes
Svedlund, 1983	Somatic/medical: irritable bowel syndrome	31	No	Yes
Wiborg, 1996	Anxiety: panic disorder	32	Yes	Yes
Winston, 1994	Mixed: personality disorders	31	Yes	No

## ANALYSES

### Comparison 01. STPP vs wait-list/TAU/minimal treatment

Outcome title	No. of studies	No. of participants	Statistical method	Effect size
01 Reduction in general psychiatric symptoms: short-term	13	816	Standardised Mean Difference (Random) 95% CI	-0.71 [-1.43, 0.00]
02 Reduction in general psychiatric symptoms: medium-term	2	101	Standardised Mean Difference (Random) 95% CI	-0.62 [-1.02, -0.22]
03 Reduction in general psychiatric symptoms: long-term	5	445	Standardised Mean Difference (Random) 95% CI	-1.17 [-2.39, 0.05]



04 Reduction in somatic symptoms: short-term	7	537	Standardised Mean Difference (Random) 95% CI	-0.86 [-1.69, -0.02]
05 Reduction in somatic symptoms: medium-term	2	72	Standardised Mean Difference (Random) 95% CI	-0.87 [-1.37, -0.38]
06 Reduction in somatic symptoms: long-term	4	381	Standardised Mean Difference (Random) 95% CI	-2.27 [-4.57, 0.03]
07 Reduction in anxiety symptoms: short-term	11	601	Standardised Mean Difference (Random) 95% CI	-0.72 [-1.70, 0.26]
08 Reduction in anxiety symptoms: medium-term	4	256	Standardised Mean Difference (Random) 95% CI	-0.96 [-1.60, -0.31]
09 Reduction in anxiety symptoms: long-term	5	333	Standardised Mean Difference (Random) 95% CI	-0.85 [-2.36, 0.67]
10 Reduction in depressive symptoms: short-term	11	927	Standardised Mean Difference (Random) 95% CI	-0.59 [-1.13, -0.05]
11 Reduction in depressive symptoms: medium-term	5	319	Standardised Mean Difference (Random) 95% CI	-0.41 [-0.79, -0.03]
12 Reduction in depressive symptoms: long-term	6	422	Standardised Mean Difference (Random) 95% CI	-0.98 [-1.91, -0.04]
13 Social adjustment: short-term	3	254	Standardised Mean Difference (Random) 95% CI	-0.51 [-0.76, -0.26]
14 Social adjustment: long-term	3	260	Standardised Mean Difference (Random) 95% CI	-0.45 [-0.70, -0.21]

## INDEX TERMS

### Medical Subject Headings (MeSH)

Mental Disorders [\*therapy]; Psychotherapy, Brief [\*methods]; Randomized Controlled Trials; Somatoform Disorders [therapy]

### MeSH check words

Humans

## COVER SHEET

<b>Title</b>	Short-term psychodynamic psychotherapies for common mental disorders
<b>Authors</b>	Abbass AA, Hancock JT, Henderson J, Kisely S
<b>Contribution of author(s)</b>	Abbass is the guarantor of this review Abbass and Hancock originally conceived the review Abbass, Kisely and Hancock designed the review Hancock, Henderson and Abbass did data collection for the review Hancock developed the search strategy Hancock and Henderson undertook searches All review authors screened and retrieved papers against inclusion criteria Abbass, Henderson and Kisely appraised quality of papers Hancock, Henderson and Abbass abstracted data from papers Abbass, Hancock and Henderson wrote to authors of papers for additional information Henderson did data management for the review Henderson and Kisely entered data into RevMan All review authors analysed and interpreted data All review authors provided a methodological perspective Abbass provided a clinical perspective

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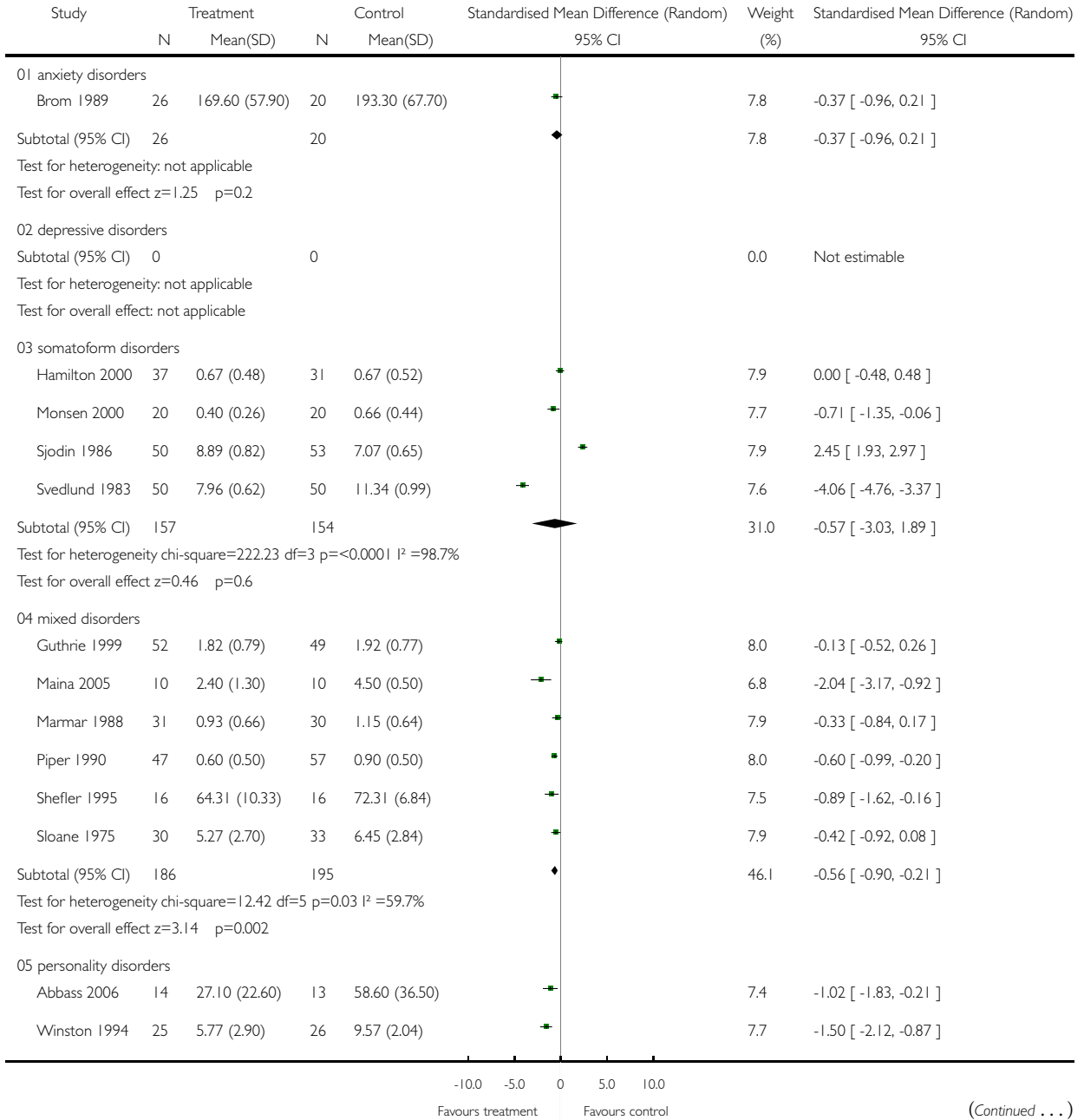
## GRAPHS AND OTHER TABLES

**Analysis 01.01. Comparison 01 STPP vs wait-list/TAU/minimal treatment, Outcome 01 Reduction in general psychiatric symptoms: short-term**

Review: Short-term psychodynamic psychotherapies for common mental disorders

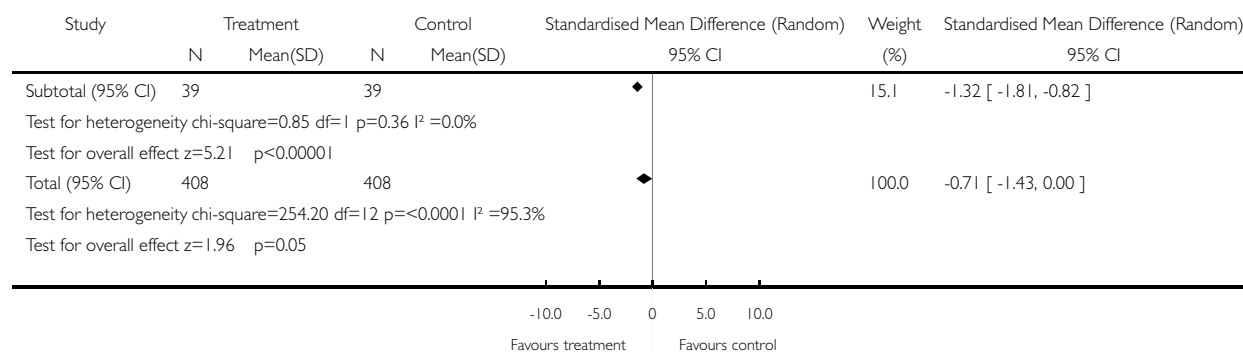
Comparison: 01 STPP vs wait-list/TAU/minimal treatment

Outcome: 01 Reduction in general psychiatric symptoms: short-term



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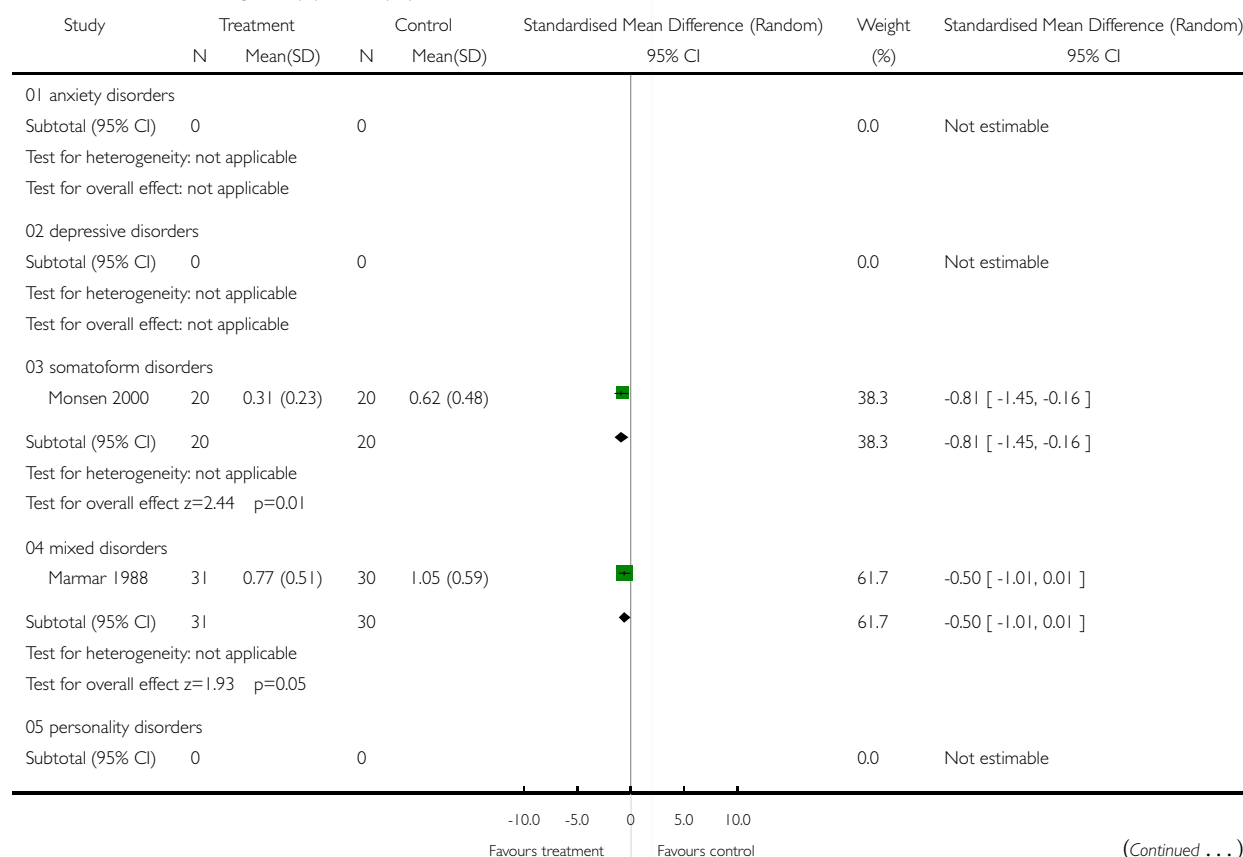


### Analysis 01.02. Comparison 01 STPP vs wait-list/TAU/minimal treatment, Outcome 02 Reduction in general psychiatric symptoms: medium-term

Review: Short-term psychodynamic psychotherapies for common mental disorders

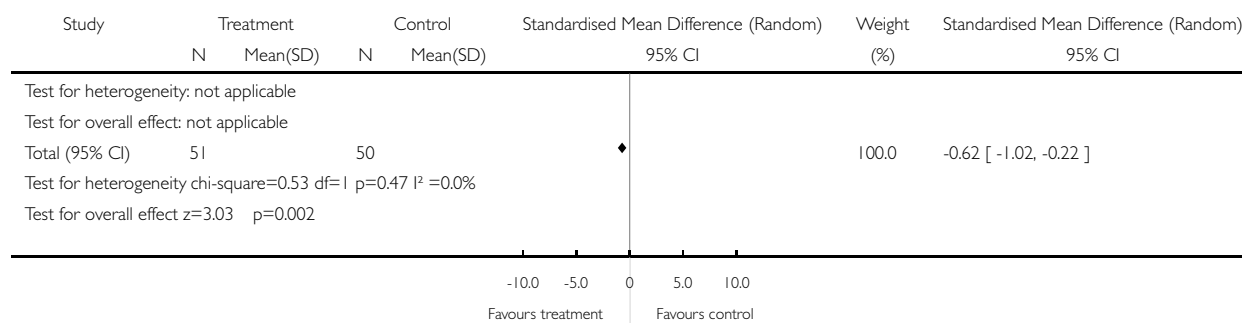
Comparison: 01 STPP vs wait-list/TAU/minimal treatment

Outcome: 02 Reduction in general psychiatric symptoms: medium-term



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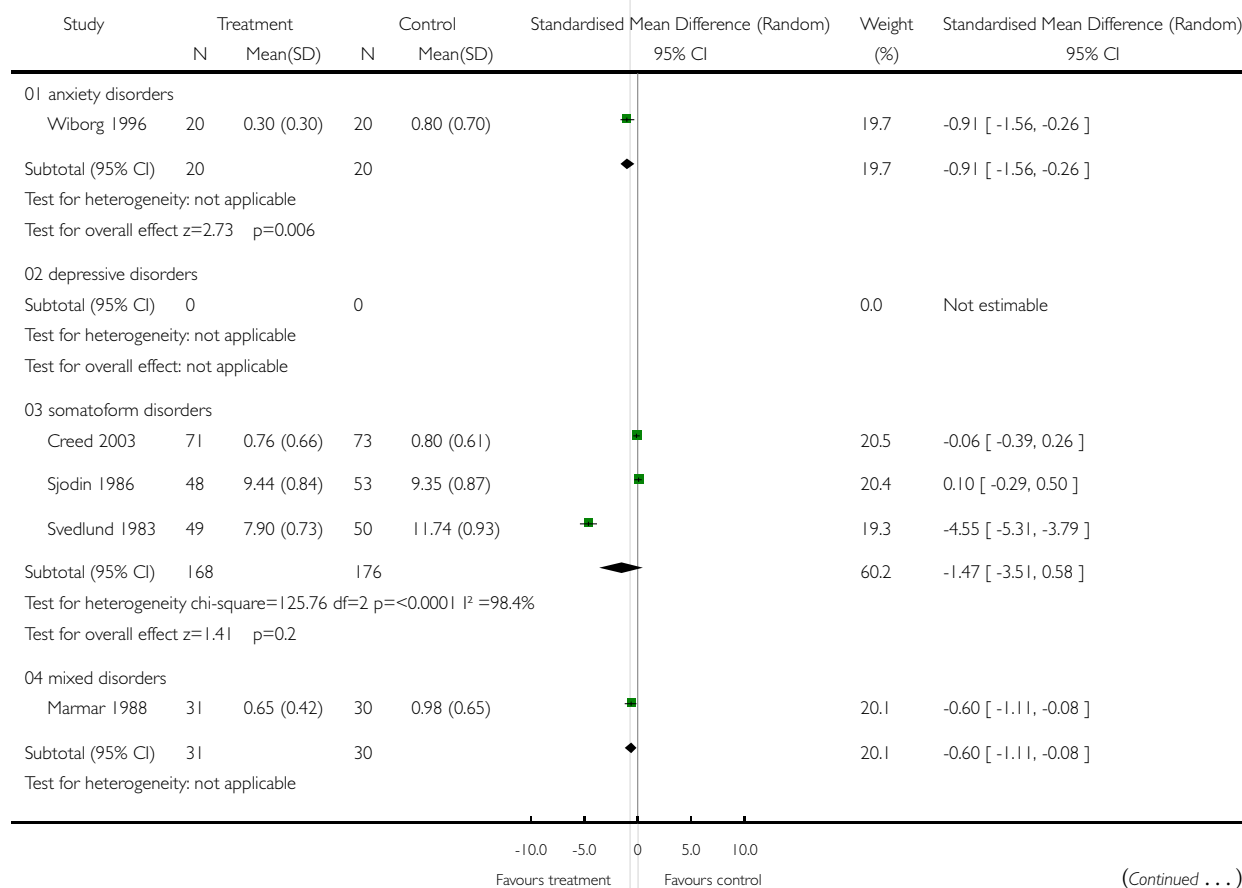


### Analysis 01.03. Comparison 01 STPP vs wait-list/TAU/minimal treatment, Outcome 03 Reduction in general psychiatric symptoms: long-term

Review: Short-term psychodynamic psychotherapies for common mental disorders

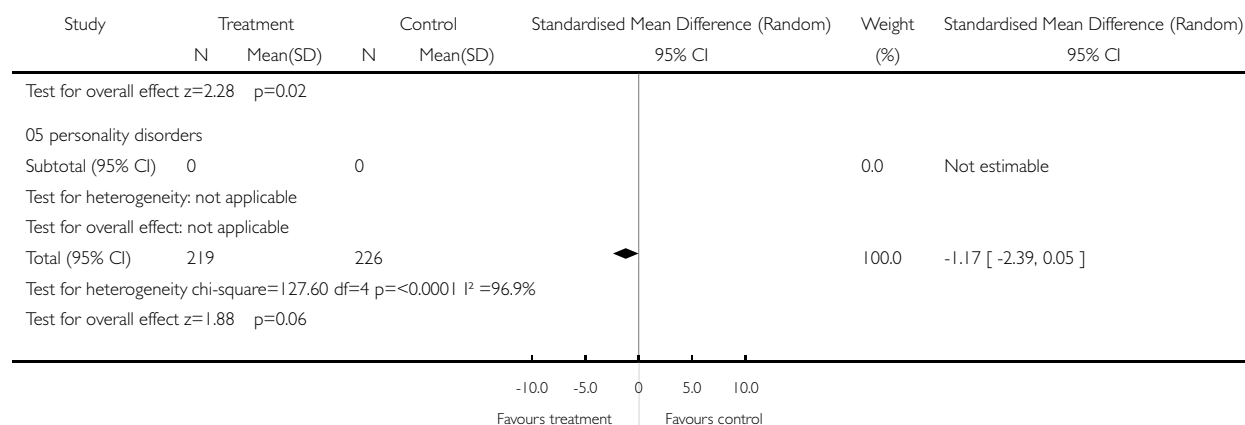
Comparison: 01 STPP vs wait-list/TAU/minimal treatment

Outcome: 03 Reduction in general psychiatric symptoms: long-term



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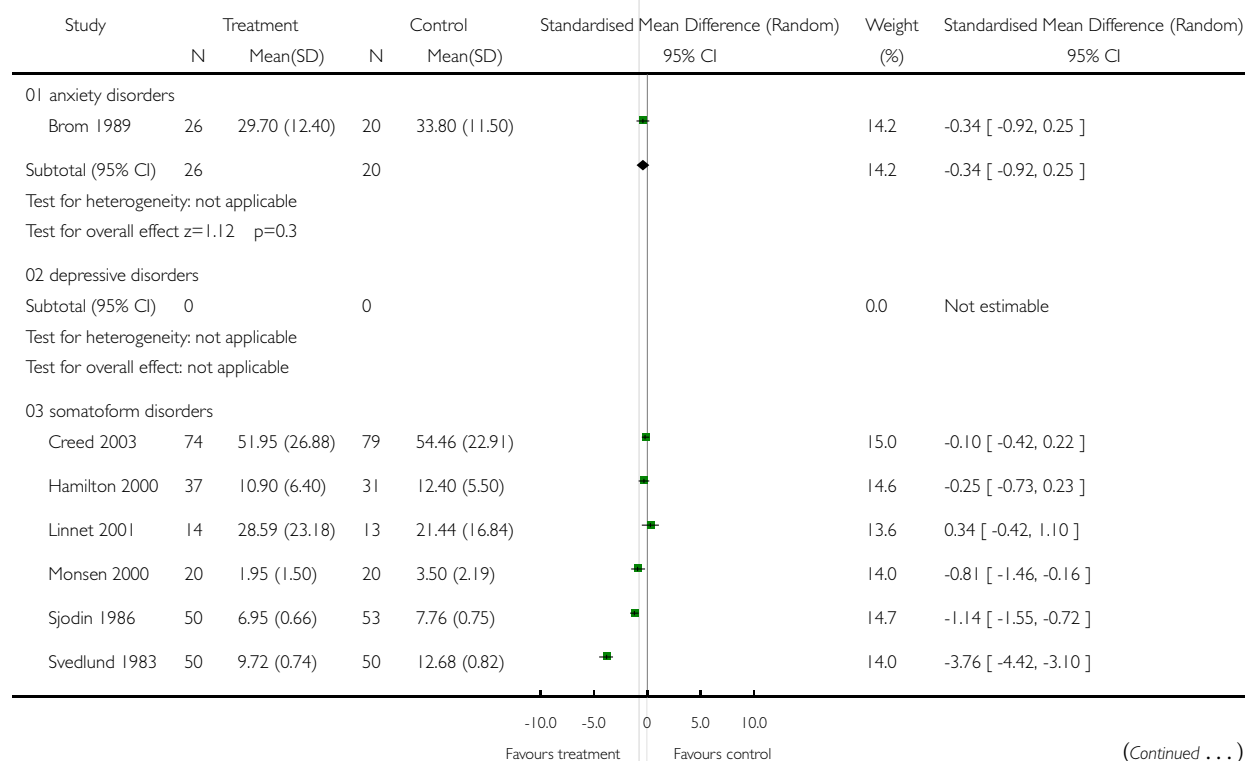


**Analysis 01.04. Comparison 01 STPP vs wait-list/TAU/minimal treatment, Outcome 04 Reduction in somatic symptoms: short-term**

Review: Short-term psychodynamic psychotherapies for common mental disorders

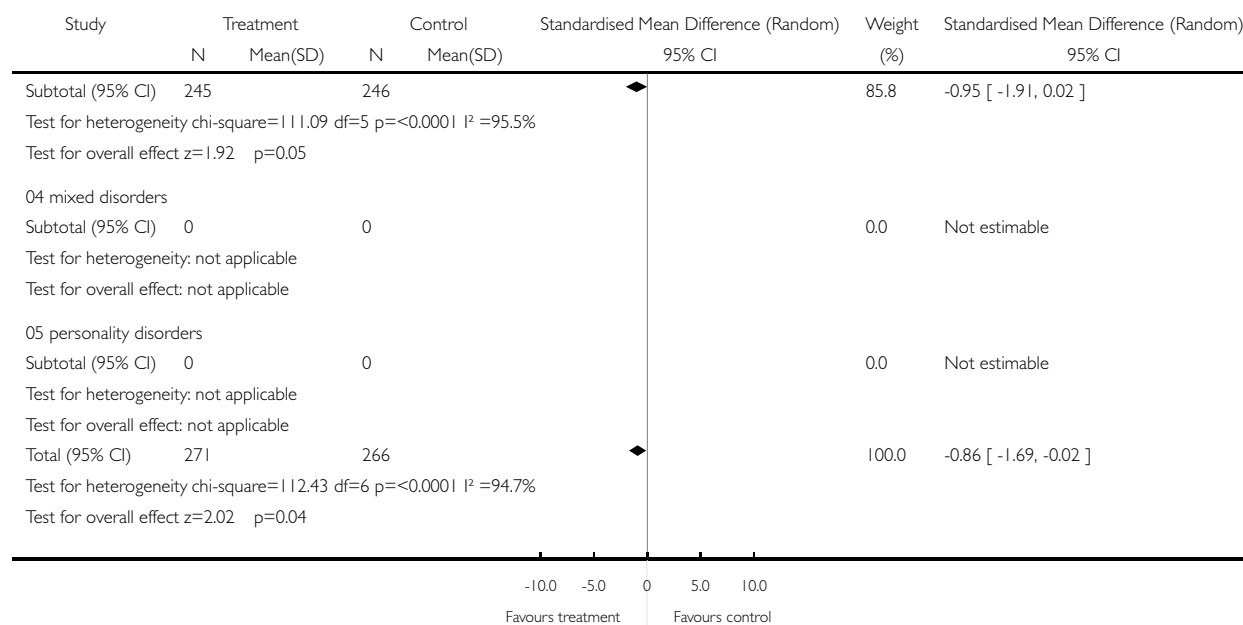
Comparison: 01 STPP vs wait-list/TAU/minimal treatment

Outcome: 04 Reduction in somatic symptoms: short-term



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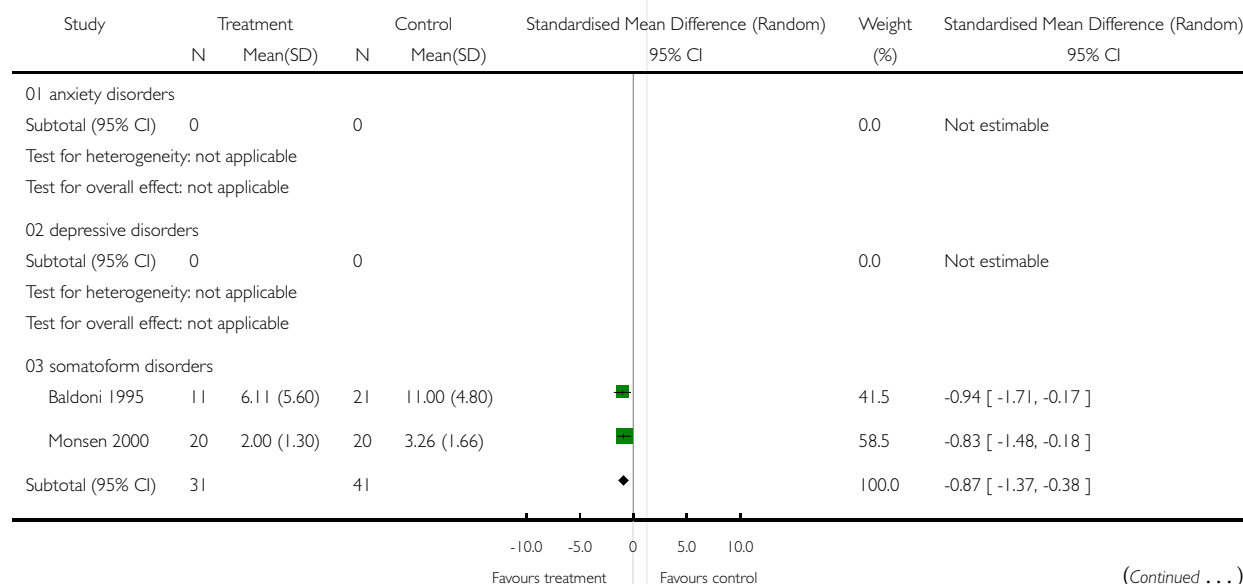


**Analysis 01.05. Comparison 01 STPP vs wait-list/TAU/minimal treatment, Outcome 05 Reduction in somatic symptoms: medium-term**

Review: Short-term psychodynamic psychotherapies for common mental disorders

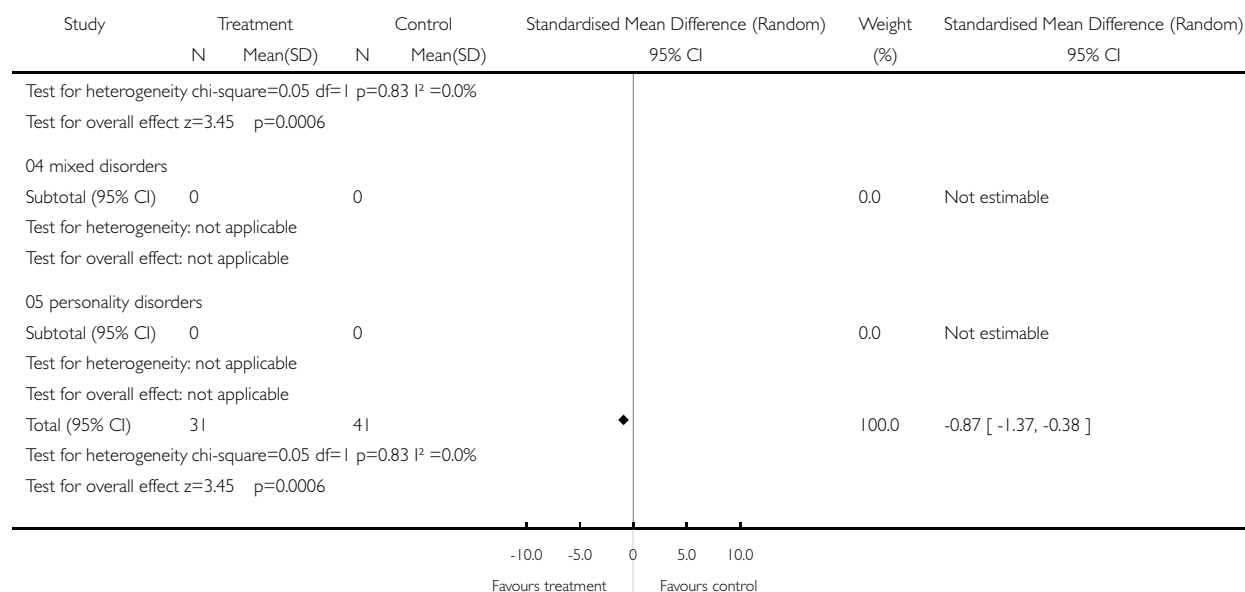
Comparison: 01 STPP vs wait-list/TAU/minimal treatment

Outcome: 05 Reduction in somatic symptoms: medium-term



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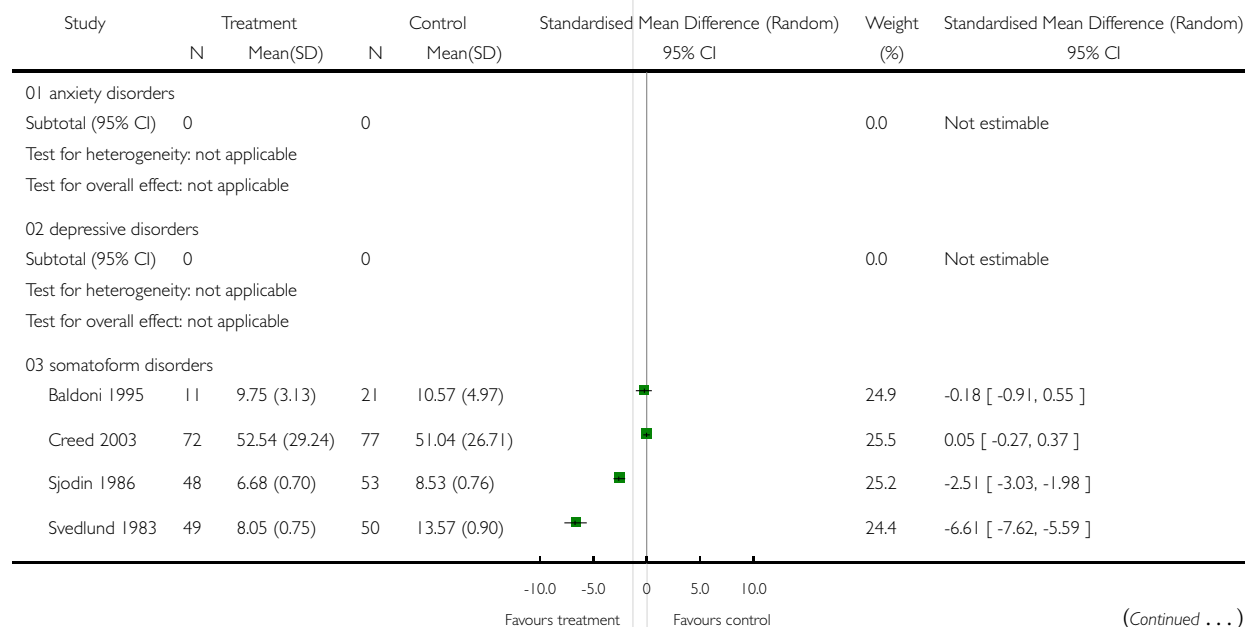


**Analysis 01.06. Comparison 01 STPP vs wait-list/TAU/minimal treatment, Outcome 06 Reduction in somatic symptoms: long-term**

Review: Short-term psychodynamic psychotherapies for common mental disorders

Comparison: 01 STPP vs wait-list/TAU/minimal treatment

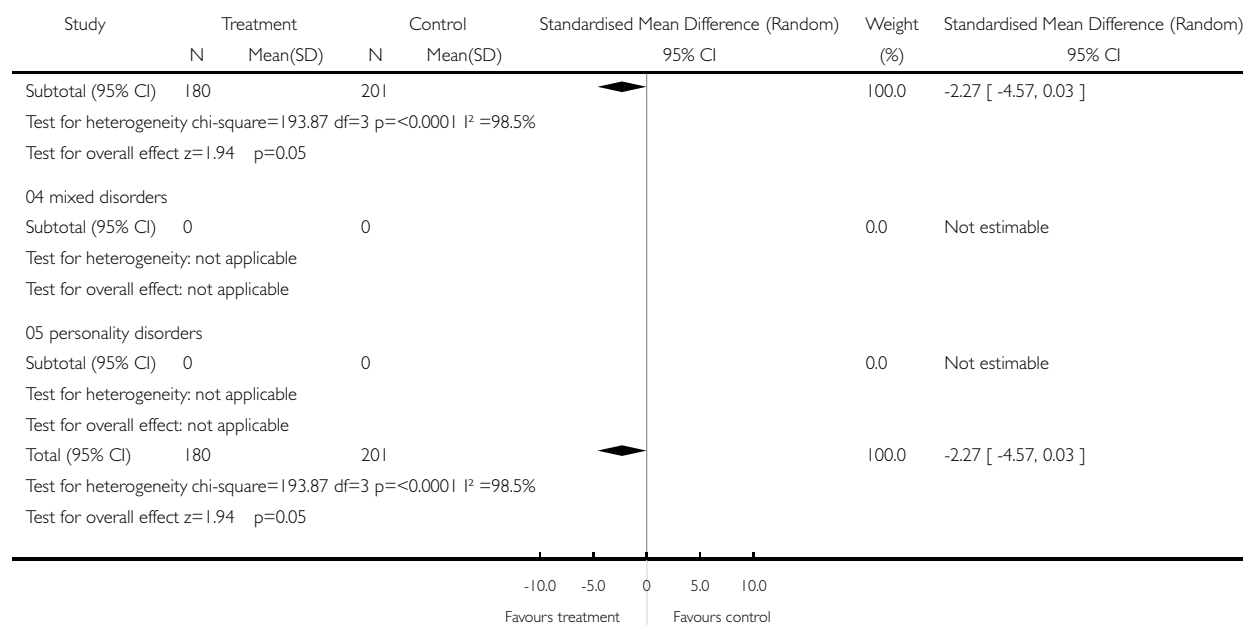
Outcome: 06 Reduction in somatic symptoms: long-term



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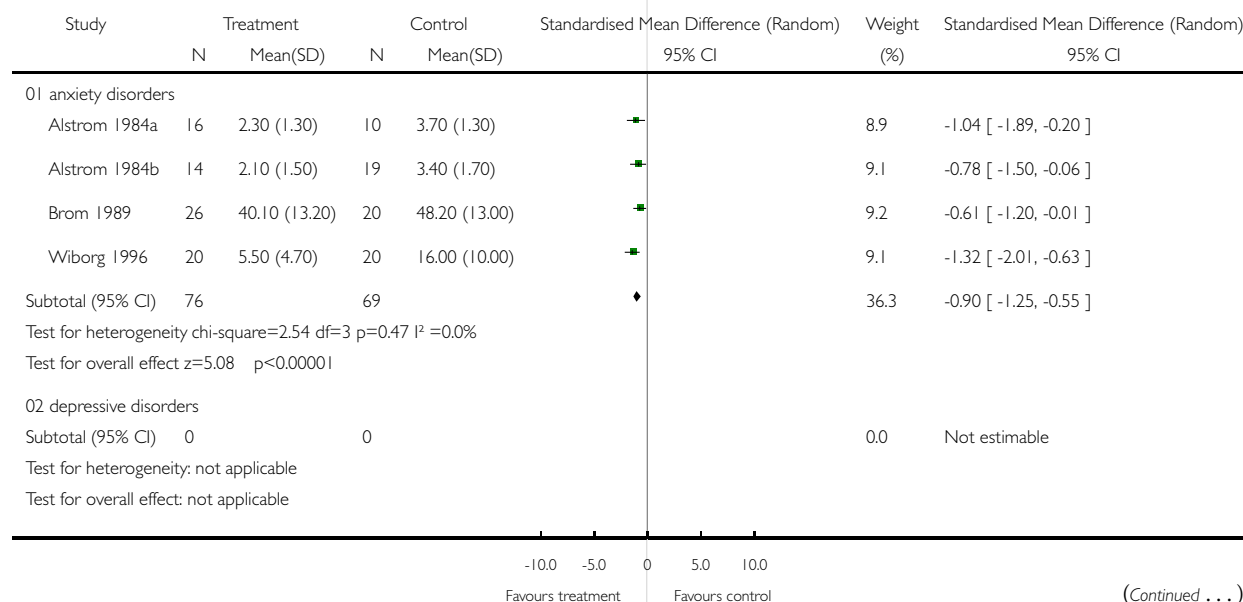


**Analysis 01.07. Comparison 01 STPP vs wait-list/TAU/minimal treatment, Outcome 07 Reduction in anxiety symptoms: short-term**

Review: Short-term psychodynamic psychotherapies for common mental disorders

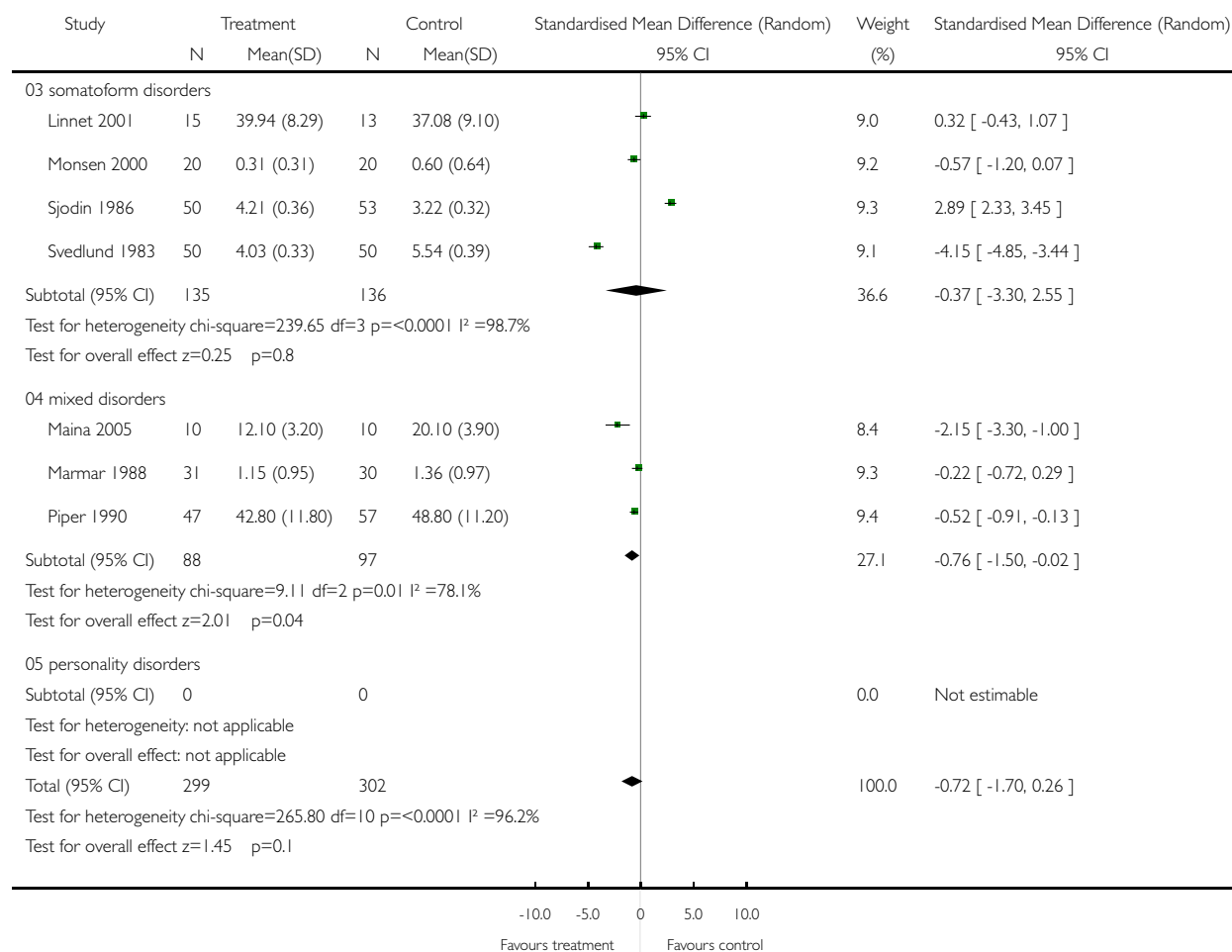
Comparison: 01 STPP vs wait-list/TAU/minimal treatment

Outcome: 07 Reduction in anxiety symptoms: short-term



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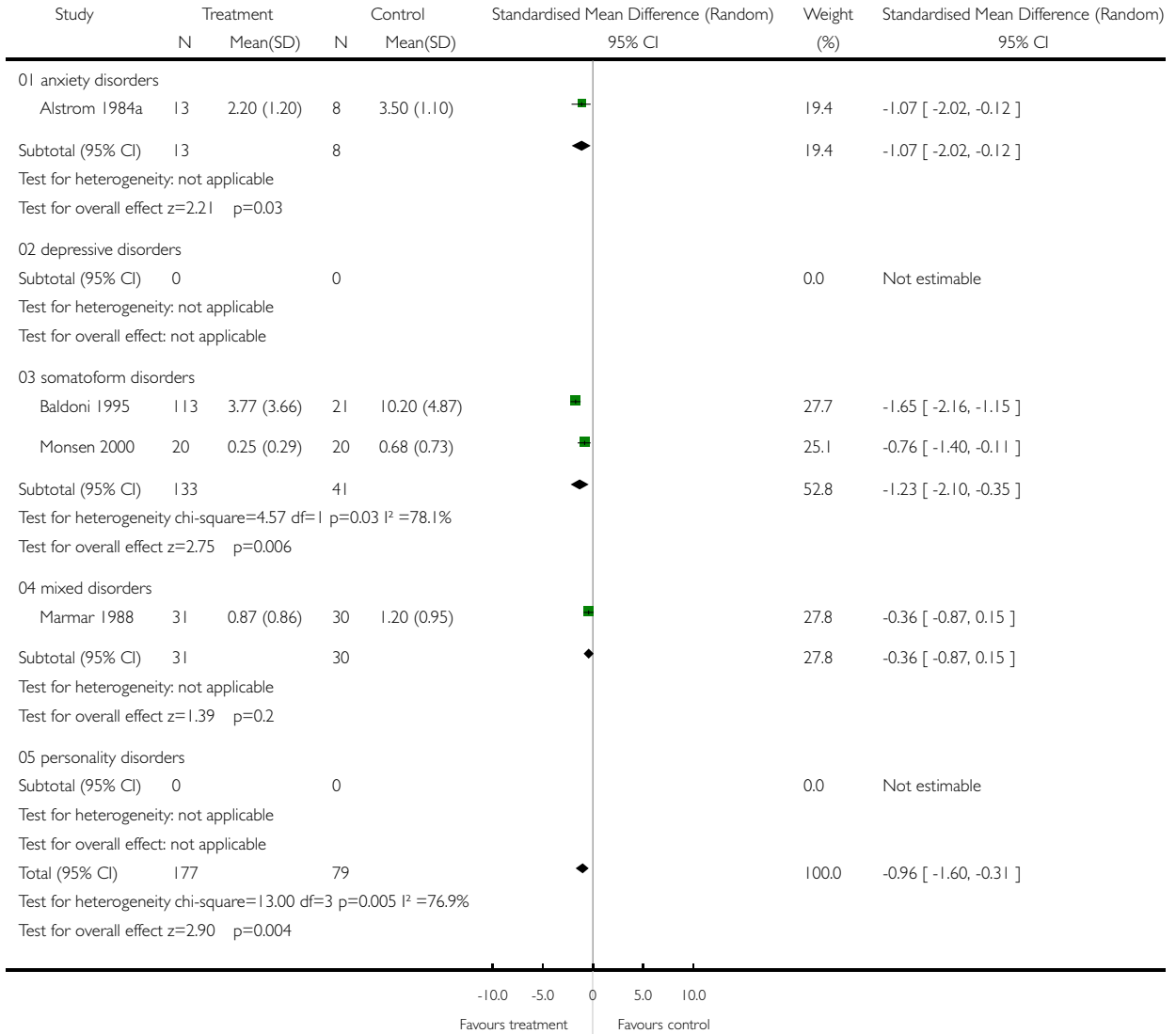


**Analysis 01.08. Comparison 01 STPP vs wait-list/TAU/minimal treatment, Outcome 08 Reduction in anxiety symptoms: medium-term**

Review: Short-term psychodynamic psychotherapies for common mental disorders

Comparison: 01 STPP vs wait-list/TAU/minimal treatment

Outcome: 08 Reduction in anxiety symptoms: medium-term

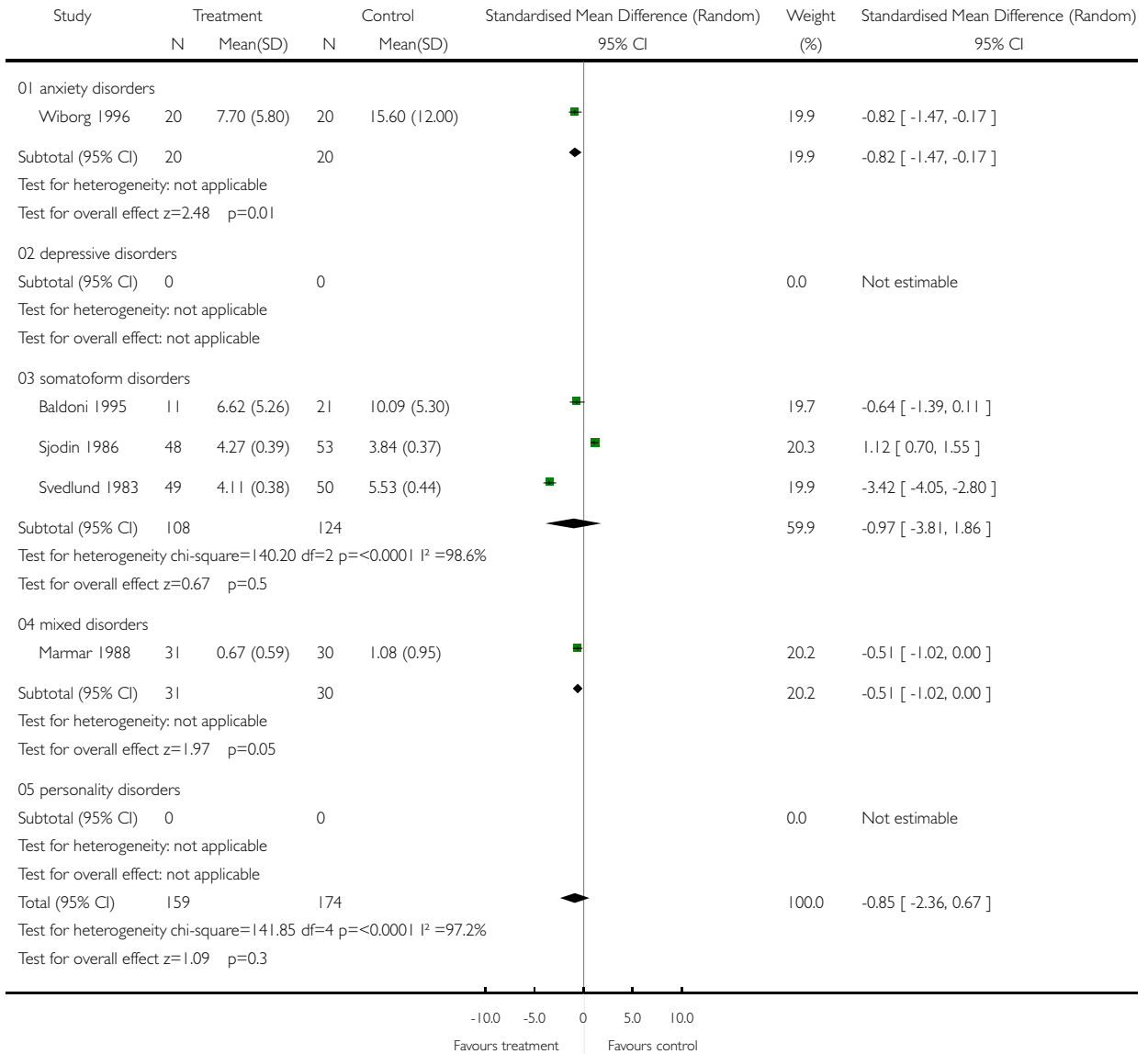


**Analysis 01.09. Comparison 01 STPP vs wait-list/TAU/minimal treatment, Outcome 09 Reduction in anxiety symptoms: long-term**

Review: Short-term psychodynamic psychotherapies for common mental disorders

Comparison: 01 STPP vs wait-list/TAU/minimal treatment

Outcome: 09 Reduction in anxiety symptoms: long-term

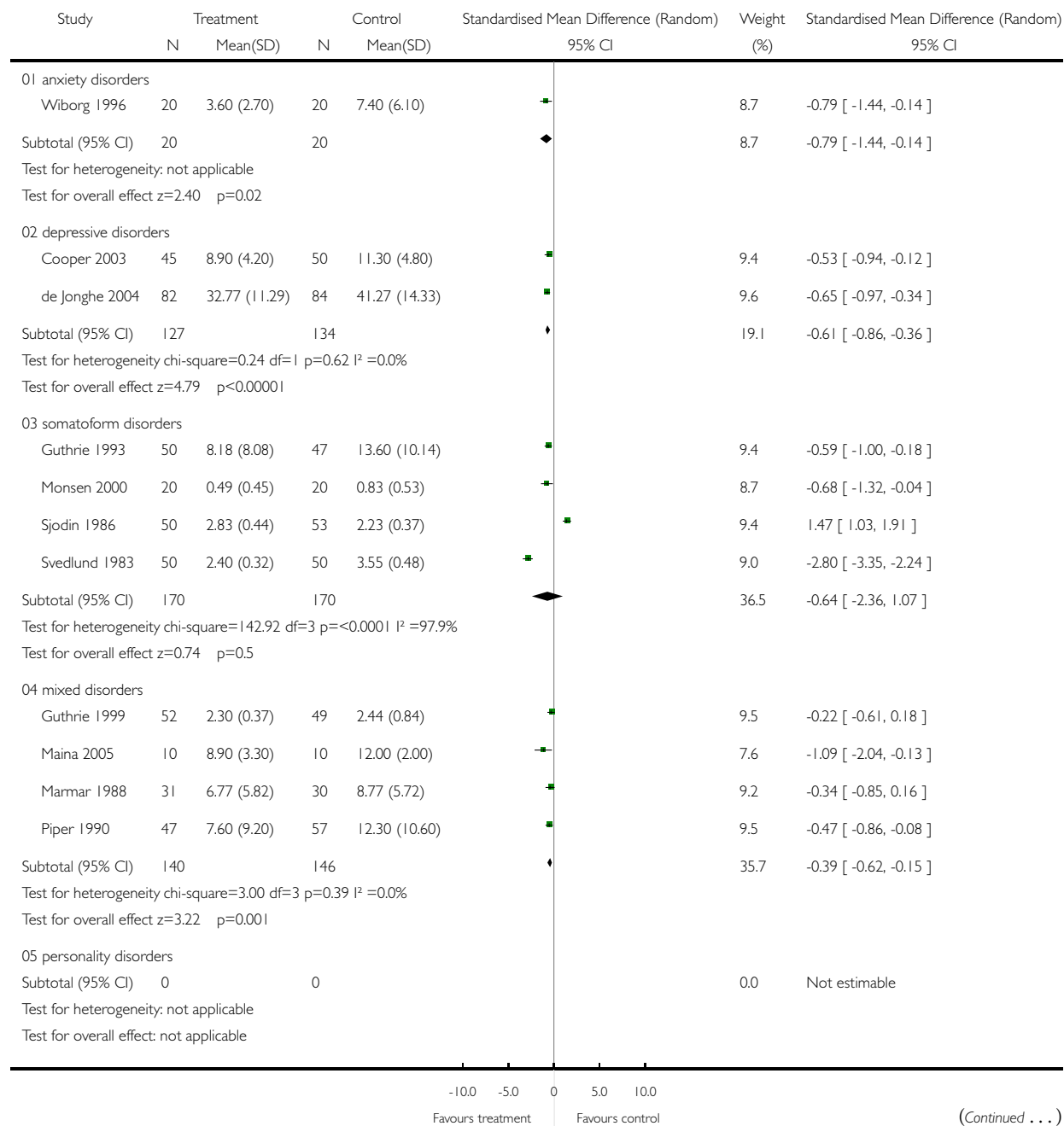


### Analysis 01.10. Comparison 01 STPP vs wait-list/TAU/minimal treatment, Outcome 10 Reduction in depressive symptoms: short-term

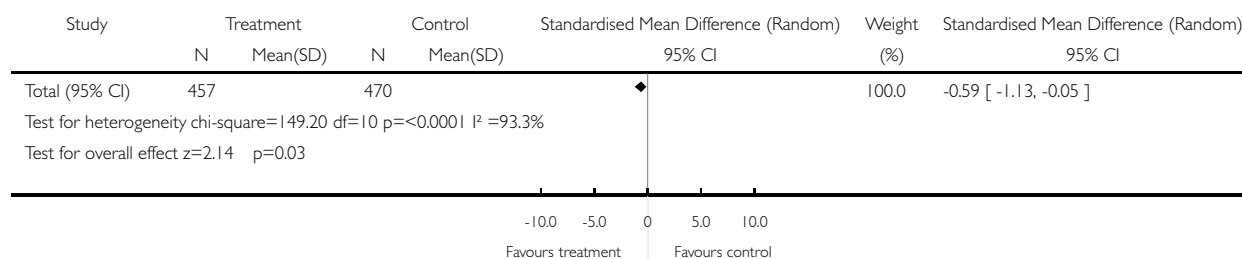
Review: Short-term psychodynamic psychotherapies for common mental disorders

Comparison: 01 STPP vs wait-list/TAU/minimal treatment

Outcome: 10 Reduction in depressive symptoms: short-term



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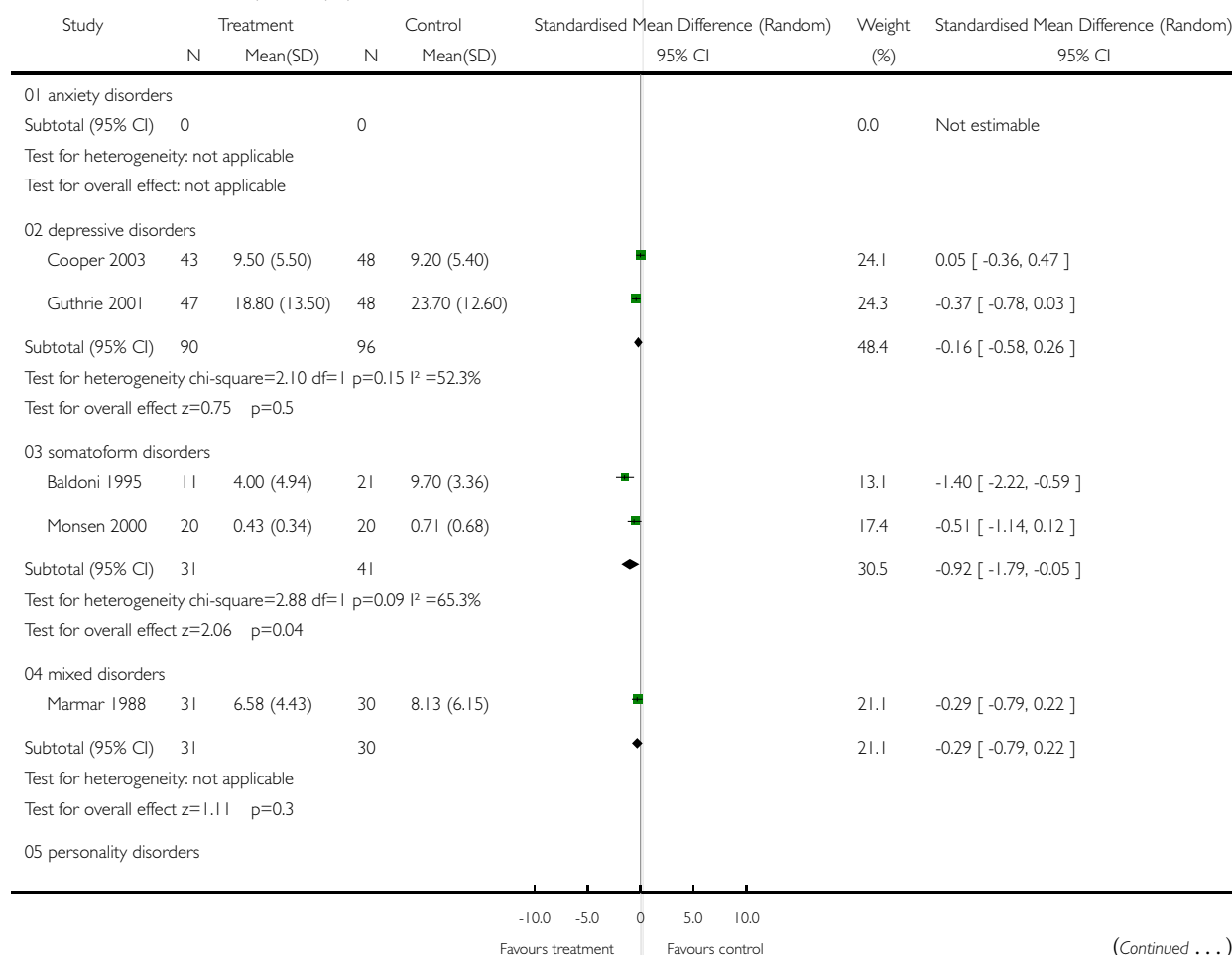


### Analysis 01.11. Comparison 01 STPP vs wait-list/TAU/minimal treatment, Outcome 11 Reduction in depressive symptoms: medium-term

Review: Short-term psychodynamic psychotherapies for common mental disorders

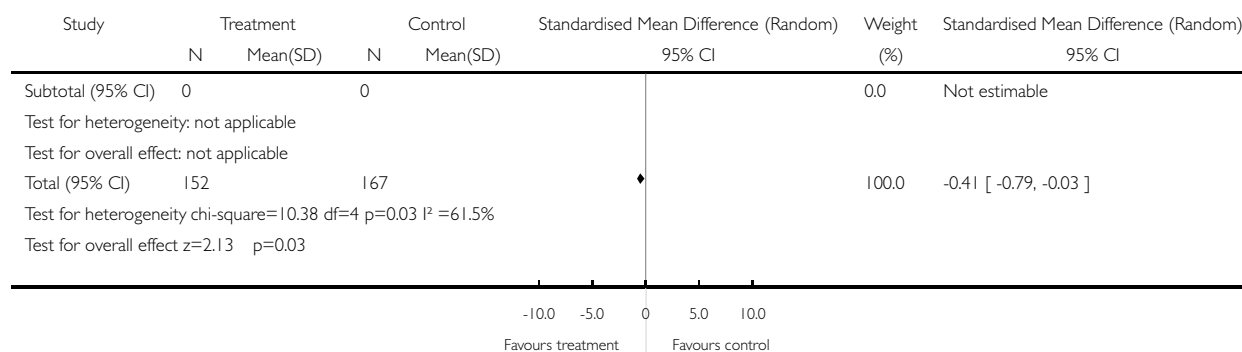
Comparison: 01 STPP vs wait-list/TAU/minimal treatment

Outcome: 11 Reduction in depressive symptoms: medium-term



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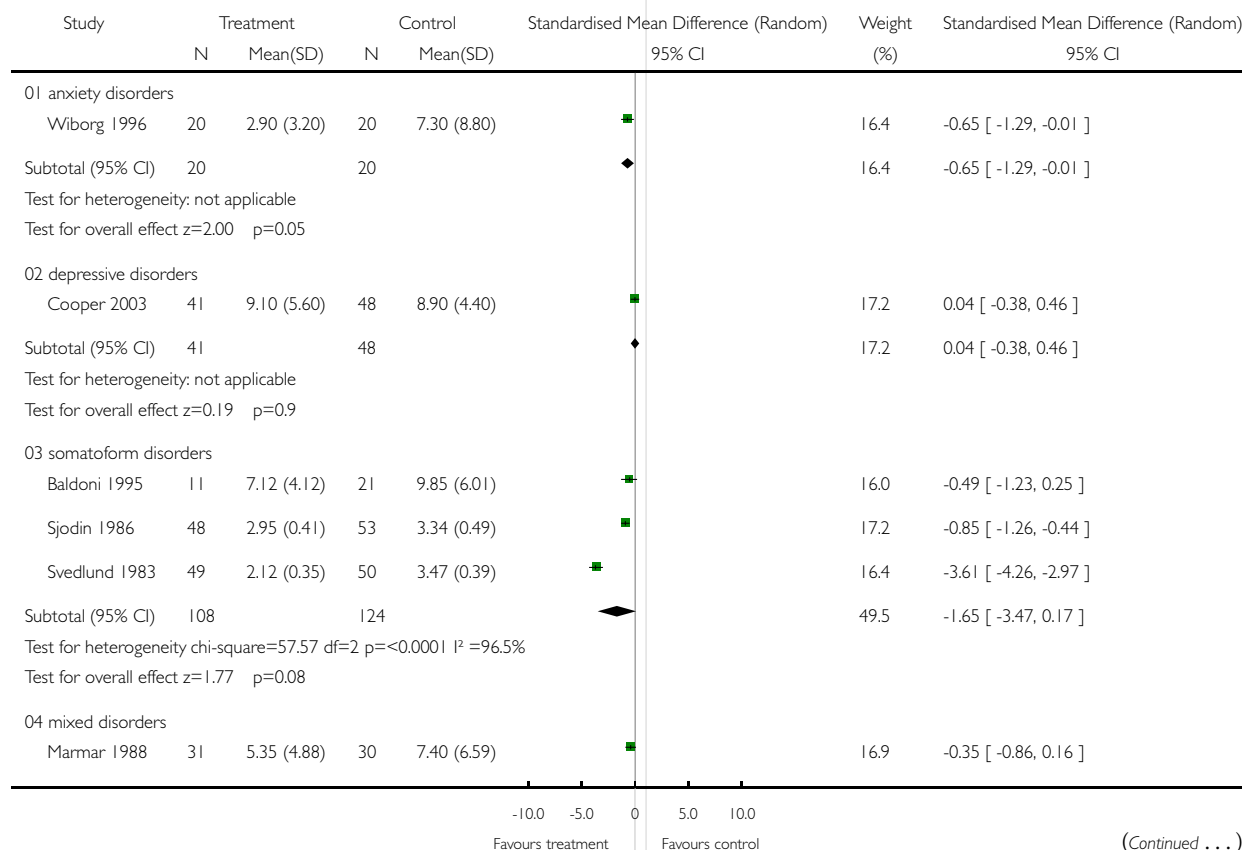


### Analysis 01.12. Comparison 01 STPP vs wait-list/TAU/minimal treatment, Outcome 12 Reduction in depressive symptoms: long-term

Review: Short-term psychodynamic psychotherapies for common mental disorders

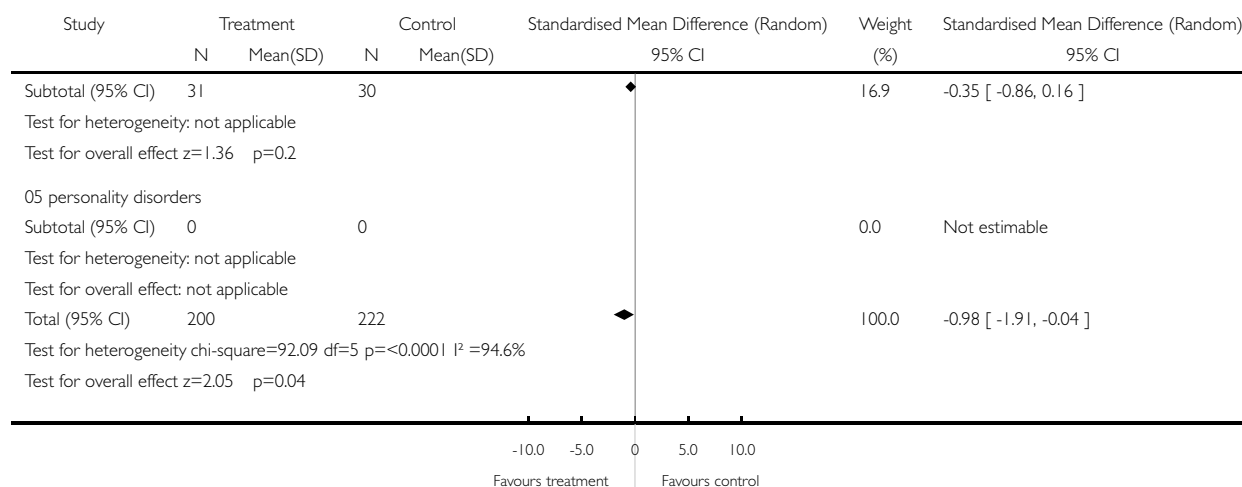
Comparison: 01 STPP vs wait-list/TAU/minimal treatment

Outcome: 12 Reduction in depressive symptoms: long-term



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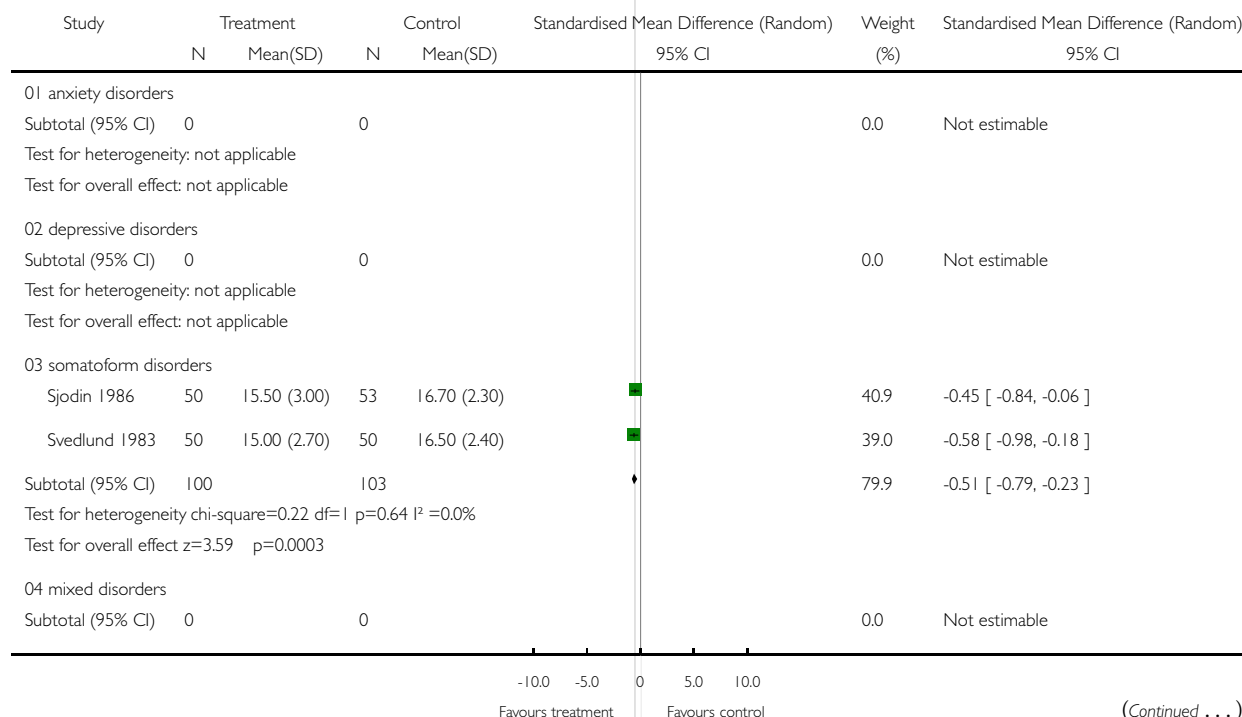


**Analysis 01.13. Comparison 01 STPP vs wait-list/TAU/minimal treatment, Outcome 13 Social adjustment: short-term**

Review: Short-term psychodynamic psychotherapies for common mental disorders

Comparison: 01 STPP vs wait-list/TAU/minimal treatment

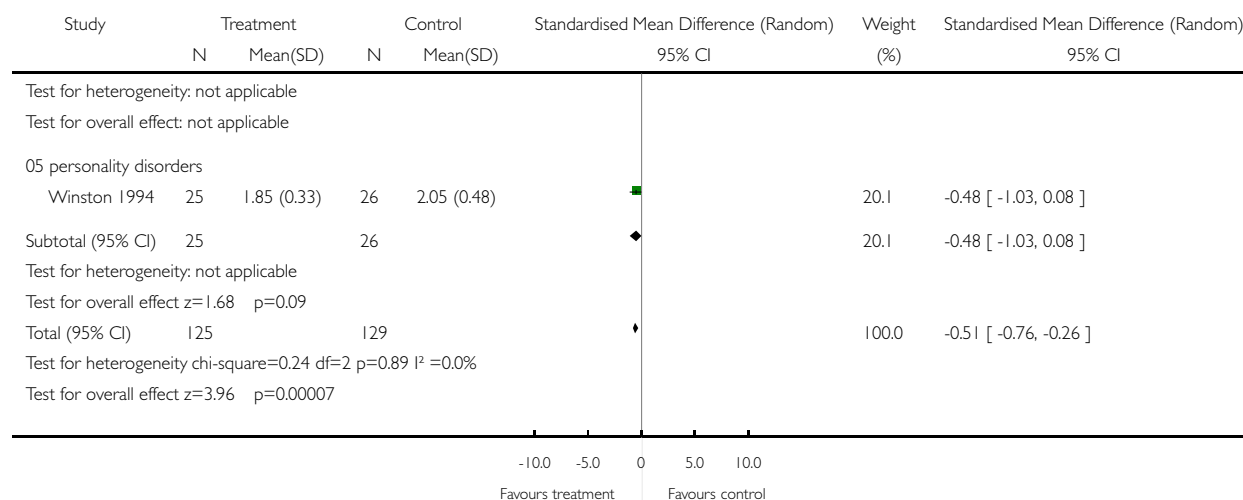
Outcome: 13 Social adjustment: short-term



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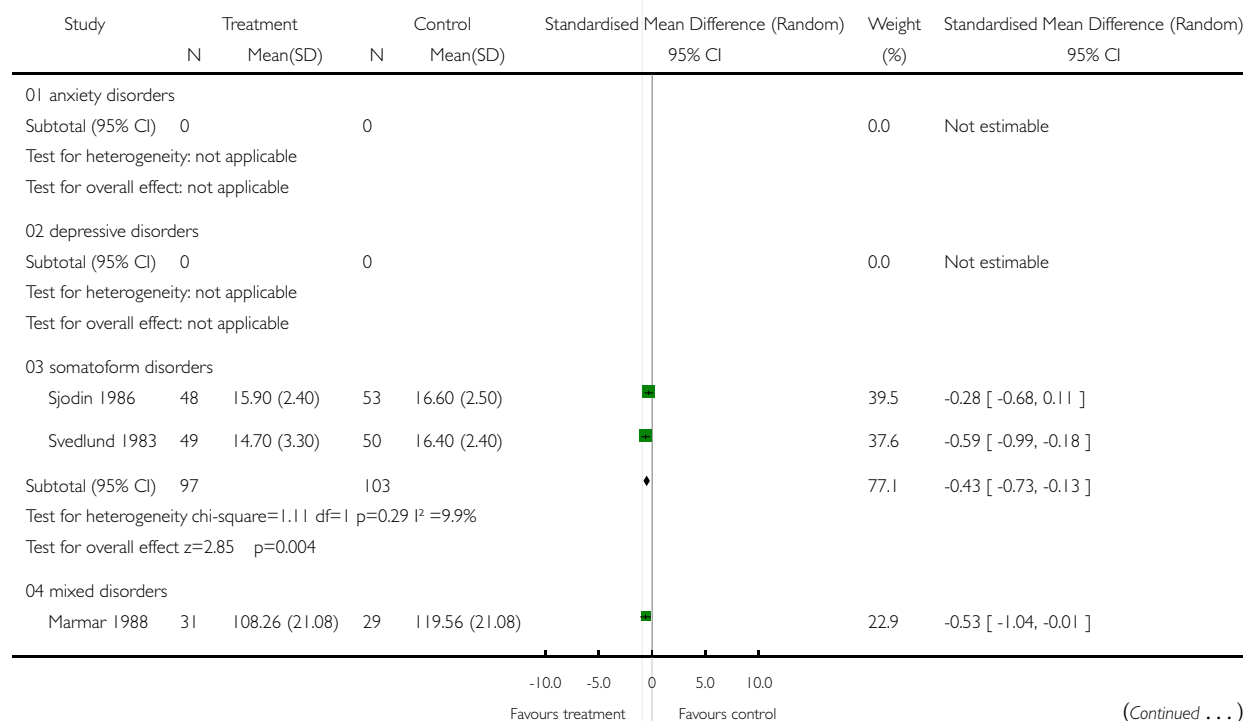


### Analysis 01.14. Comparison 01 STPP vs wait-list/TAU/minimal treatment, Outcome 14 Social adjustment: long-term

Review: Short-term psychodynamic psychotherapies for common mental disorders

Comparison: 01 STPP vs wait-list/TAU/minimal treatment

Outcome: 14 Social adjustment: long-term



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