

Combined Brief Dynamic Therapy and Pharmacotherapy in the Treatment of Major Depressive Disorder: A Pilot Study

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Key Words

Major depressive disorder · Brief dynamic therapy · Supportive psychotherapy

Abstract

Background: The relative efficacy of supplemental psychotherapy in the treatment of depression is still a matter of debate. Moreover, the superiority of brief dynamic therapy (BDT) over supportive psychotherapies is not well established. The aim of this study is to compare the efficacy of BDT added to medication with that of brief supportive psychotherapy (BSP) added to medication in the treatment of major depressive disorder. **Method:** A 12-month randomized clinical trial compared BDT (n = 18) with BSP (n = 17) combined with antidepressants in outpatients with major depressive disorder. Both psychotherapies were added during the first 6 months of the trial; all patients continued to be treated with only pharmacotherapy (paroxetine or citalopram) in the following 6-month continuation phase. Efficacy was assessed using the 17-item Hamilton Rating Scale for Depression (HAM-D), the Hamilton Rating Scale for Anxiety and the Clinical Global Impression (CGI). The data analysis was conducted on two samples: the per-protocol (PP) sample and the observed-cases (OC) sample. **Results:** Thirty-two patients completed the study. Although at the end of the combined therapies (T2) no differences emerged between the two treatment approaches, the group of patients treated with BDT showed a further clinical improvement at the end

of the study (T3): a significant reduction in symptomatology emerged on the HAM-D (PP sample: $F = 75.154$, $p = 0.03$; OC sample: $F = 67.149$, $p = 0.022$) and on the CGI total scores (PP sample: $F = 78.527$, $p = 0.016$; OC sample: $F = 74.104$, $p = 0.007$). The difference in remission rates on the HAM-D (75 vs. 12.5% at T3) is statistically significant favoring BDT. **Conclusions:** BDT combined with antidepressants is preferable to supportive psychotherapy combined with medication in the treatment of outpatients with major depression.

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Background

According to many clinicians' opinion, the combination of antidepressants and psychotherapy should be the treatment of choice in outpatients with major depression. These views are partially supported by empirical evidence. Although some previous reviews have suggested that combined treatments offer no benefit over single treatment [1–4], the majority of authors concluded that the effect of combined therapy in treating major depression shows some superiority [5–8]. The most recent meta-analytic and qualitative reviews suggested that combined treatment could be particularly beneficial in severer, recurrent depressions [9]. Concerning the different methods in psychotherapy, interpersonal psychotherapy may improve interpersonal functioning, whereas cognitive-behavioral therapy (CBT) appears to have an enduring

effect that reduces the subsequent risk following treatment termination. Treatment with the combination of medication and interpersonal psychotherapy or CBT retains the specific benefits of each and may enhance the probability of response over either monotherapy, especially in severer recurrent depressions [10]. Although various meta-analyses have addressed the efficacy of short-term psychodynamic psychotherapies in psychiatric disorders [11–15], the most recent meta-analysis concluded that further research in specific psychiatric disorders is needed [16].

The efficacy of brief dynamic therapy (BDT) in monotherapy has already been suggested by some randomized controlled trials performed on different clinical populations and in comparison with different other forms of psychotherapy [17–22]. A meta-analysis on the efficacy of short-term psychodynamic psychotherapy in depression concluded in 2001 that short-term psychodynamic psychotherapy, CBT and behavioral therapy seem to be equally effective in the treatment of depression [23].

A group from Holland has recently compared the efficacy of antidepressants with that of antidepressants plus short psychodynamic supportive psychotherapy in the acute treatment of major depression: they found that combined treatment was significantly more acceptable for patients, that they were significantly less likely to drop out of combined therapy and that they were significantly more likely to recover [24]. In a second study they tested the efficacy of the same combined treatment with short psychodynamic supportive psychotherapy alone: they concluded that the advantages of combining antidepressants with psychotherapy are equivocal, because neither the treating clinicians nor the independent observer were able to ascertain them, but the patients experienced them clearly [25]. Furthermore, comparing a combination of clomipramine and psychodynamic psychotherapy with clomipramine alone in a randomized controlled trial among patients with major depression, another group from Switzerland found that provision of supplemental psychotherapy is cost-effective [26].

This study is part of a long-term depression research project on psychotherapy, which studies the relative value of BDT in comparison to nonspecific supportive psychotherapy. In our previous single-blind controlled study on minor depressive disorders, although BDT requires additional resources in comparison to brief supportive psychotherapy (BSP), the results suggested the efficacy of both psychotherapies in treating minor depressions with a superiority of BDT in improving the long-term outcome [27]. The present study reports on the results of a

randomized clinical trial comparing the efficacy of BDT combined with antidepressants with that of BSP combined with antidepressants in a 12-month treatment program for outpatients with major depressive disorder.

Method

Sample

Subjects were recruited from the outpatient waiting list for BDT at the Mood and Anxiety Disorders Unit, Department of Neuroscience of the University of Turin, Italy. The criteria used for being included in the BDT waiting list were (a) patients requesting a psychotherapeutic approach, (b) the presence of a focal problem and/or of a recent precipitant life event (as suggested by Malan [28, 29] and Horowitz et al. [30]) and (c) age 18–65 years. Exclusion criteria were (a) evidence of mental retardation, lifetime history of organic mental disorders, psychotic disorders, bipolar disorders or substance abuse and (b) severe axis II psychopathology (cluster A personality disorders, antisocial personality disorder and borderline personality disorder according to DSM-IV-R).

Patients for the study were consecutively selected from the BDT waiting list, according to the two following inclusion criteria: (1) main diagnosis of major depressive disorder according to DSM-IV-R; (2) a baseline score on the 17-item Hamilton Rating Scale for Depression (HAM-D) ≥ 15 . The exclusion criteria from the investigation were: (1) evidence of severe or unstable or active neurological or physical diseases, (2) drug abuse, (3) any contraindication for one of the antidepressants prescribed by the pharmacotherapy protocol, (4) before the possible start of the trial, the patient had been already treated adequately by antidepressants during the present depressive episode, (5) the patient used psychotropic medication other than the one prescribed by the pharmacotherapy protocol, (6) the patient was pregnant or there was a risk of pregnancy during the study, (7) suicidal risk that contraindicated the participation in a clinical trial (e.g. hospitalization was recommended).

152 subjects of the waiting list were screened consecutively for the inclusion in this study: 111 were excluded (25 affected by minor depressive disorder, 12 alcohol abusers, 8 females that were at risk of pregnancy, 66 already treated adequately with antidepressants) and 41 were considered because they fulfilled the requirements.

Procedure

The question of the relative 6-month efficacy of the 2 combined treatments was addressed in a randomized parallel-group design. Patients were allocated randomly to antidepressants plus BDT or antidepressants plus BSP by the study recruiter, who drew one of two colored balls from a bag, the assignment of each therapy to a different colored ball having been defined at the start of the study and maintained until the end of the recruitment period.

The trial was preceded by a 2-week period in which the diagnosis was assessed by means of the Structured Clinical Interview for DSM-IV axis I and II disorders [31, 32], the inclusion and exclusion criteria were checked, and the baseline assessments were

made. If necessary, this period was used as a drug washout period (without placebo). The psychotherapies started within 2 weeks after the initiation of pharmacotherapy; at the end of the 6-month trial with combined treatments, the patients entered in a continuation treatment period with antidepressants (same drug at the same dose). Patients were treated by a psychiatrist (or advanced, supervised resident in psychiatry) who provided medication and by a psychotherapist (who was not the psychiatrist providing medication). Two raters assessed all patients: they were 2 psychiatrists who did not participate in the study as therapists and were kept blind with respect to the treatment assignment.

Pharmacotherapy

All patients were treated according to the following antidepressant protocol: a selective serotonin reuptake inhibitor, paroxetine or citalopram, was provided at the minimum daily dose of 20 mg/day. Dosage adjustments were made on the basis of individual responsiveness and tolerability; the daily dose could be increased up to 60 mg/day. Other psychiatric treatments were not permitted throughout the treatment period. The intended medication period was 12 months. The psychiatrist makes 12 appointments of 20 min each with his patient, the first 4 weekly, the following 5 monthly, the last 3 every 2 months. Furthermore, the patients were informed to contact their psychiatrist every time they experienced a worsening of symptoms. The task of the psychiatrist was to provide pharmacotherapy and clinical management. The latter consisted of providing psychoeducation, discussing the effects and side effects of medication, and motivating the patient to comply with the medication regimen.

Brief Dynamic Therapy

The primary objective of BDT is to enhance the patient's insight into repetitive conflicts (intrapsychic and interpersonal) and trauma that underlie and sustain the patient's problems. The principal instruments of BDT are interpretation and clarification: the therapist makes use of the actual relationship and attends to linkages with past significant relationships. The time limitation and the focal exploration of the patient's life and emotions distinguish the treatment from many current psychoanalytic psychotherapies. Compared to supportive therapy, BDT is more demanding and anxiety arousing: the therapist is more active and he urges the patient to explore uncomfortable emotions with holding immediate praise and gratification. The psychotherapeutic technique we apply in our Department as BDT derives from Malan's focused, short-term psychoanalytic psychotherapy [28]. In the initial phase of BDT, the clinical picture is assessed and identified as part of a treatable disorder, as the primary problem area is defined as a focus. Symptoms, conflicts or crises may represent primary problem areas. In the middle phase, the identified focus is addressed. In the terminal phase, the end of the treatment is explicitly discussed, progress is reviewed and gains are consolidated. Patients are told from the outset that their treatment will be time limited and the final session is established beforehand.

Two graduate therapists provided the BDT; they were both psychiatrists who had completed a personal training in psychodynamic psychotherapy. Sessions were weekly, lasting 45 min, individually administered and in a face-to-face interview. The number of sessions ranged from 15 to 30. Any missed session was included as part of the psychotherapeutic protocol. An experi-

enced BDT therapist who reviewed case notes and supervised treatment adherence according to manuals weekly monitored each BDT therapist.

Brief Supportive Psychotherapy

The primary objective of supportive therapy is to improve the patient's immediate adaptation to his/her life situation. Principal instruments are reassurance and encouragement and the treatment involves advice, praise and emphasis on strengths and talents. Anxiety and regression are minimized in the sessions; the therapist is active but noninterpretative and nonurging.

Two experienced psychiatrists provided the BSP; each therapist had been trained in supportive therapy and the treatment adherence was facilitated by strict compliance with manuals [33]. Treatment adherence was also enhanced by case discussions conducted by an experienced therapist on a weekly basis. Sessions were weekly, lasting 45 min, individually administered and in a face-to-face interview. The patients were told from the outset that their treatment would be time limited with a number of sessions ranging from 20 to 30 but without a time limitation strictly established (some flexibility was allowed).

Clinical Assessment

Patients assigned to the two treatment strategies were assessed by two raters while they were in the waiting list condition [time 0 (T0): pretest condition], at the start of the treatment [time 1 (T1): baseline], at the end of the combined treatment [time 2 (T2)] and at the end of the 6-month continuation phase [time 3 (T3)].

At each evaluation time, the primary outcome measure employed was the 17-item HAM-D; moreover, patients were assessed by the Clinical Global Impression for Severity (CGI-S) and the Hamilton Rating Scale for Anxiety (HAM-A). From T1, the Clinical Global Impression for Improvement was also rated. Two raters assessed all patients: they were 2 psychiatrists who did not participate in the study as therapists and were kept blind with respect to the treatment assignment. The patients were advised not to talk to the evaluators about the type of psychotherapy they were undergoing. In the early phase of the study, interrater agreement on the diagnosis as well as the classification regarding the clinical features of major depressive disorder were ascertained.

The interrater reliability of DSM-IV diagnosis was good ($k = 0.79$, 95% confidence interval = 0.71–0.87). To determine the interrater reliability, the two raters simultaneously assessed 10 depressed subjects before the start of this study; the score obtained by our raters on HAM-D and on HAM-A correlated above 0.90.

Additional information was obtained from patients by interviews at the conclusion of the combined treatments (T2): they were asked if they liked their treatment, if they liked their therapist, if they thought that the treatment was helpful or not and if they were interested in further psychotherapy. For each of these 4 questions, the patients had to select 1 of the following responses: not at all, a little bit, moderately, quite a bit, extremely.

Statistical Analysis

Analysis of variance was performed to test the comparability of continuous variables in the two groups (index age, educational level, HAM-D, HAM-A, CGI-S). Pearson χ^2 calculations were used to compare among groups: sex ratio, marital status, number of previous depressed episodes and duration of the present episode.

Table 1. Characteristics of the PP study sample

	BDT (n = 18)	BSP (n = 17)	Total (n = 35)
Sex, n			
Males	6 (33)	6 (35.3)	12 (34.3)
Females	12 (66.7)	11 (64.7)	23 (65.7)
Age, years	33.50±8.34	38.53±13.23	35.94±11.17
Marital status, n			
Married	6 (33.3)	7 (41.2)	13 (37.1)
Divorced	1 (5.6)	2 (11.8)	3 (8.6)
Never married	10 (55.6)	7 (41.2)	17 (48.6)
Widowed	1 (5.6)	1 (5.9)	2 (5.7)
Educational level	14.72±3.51	12.88±4.22	13.83±3.92
Duration of present episode, n			
<1 year	10 (55.6)	11 (64.7)	21 (60.0)
1–2 years	8 (44.4)	5 (29.4)	13 (37.1)
>2 years	0 (0.0)	1 (5.9)	1 (2.9)
Depressed episodes within previous 5 years, n			
0	9 (50.0)	9 (52.9)	18 (51.4)
1	4 (22.2)	5 (29.4)	9 (25.7)
2	4 (22.2)	3 (17.6)	7 (20.0)
≥3	1 (5.6)	0 (0.0)	1 (2.9)
HAM-D	20.94±3.244	19.41±1.805	20.20±2.72
HAM-A	16.00±4.627	13.82±4.680	14.94±4.71
CGI-S	4.39±0.502	4.29±0.470	4.34±0.48

Figures in parentheses indicate percentages. Educational level is expressed as study years.

A comparison of treatment duration and mean number of sessions among BDT and BSP groups was performed after treatment by using the Student *t* test; mode and median were also calculated.

Two data analysis methods for outcome were conducted on the two subgroups of patients:

- 1 the per-protocol (PP) sample for the design: the sample consisted of all patients who started with the treatment to which they were allotted; a last observation carried forward approach was applied to the missing data;
- 2 the observed-cases (OC) sample: the sample included all patients who started with therapy and for whom the data had been gathered at the relevant assessment points; in other words, we used only the real observed data, the patient becomes a study dropout if, for whatever reason, he/she cannot or should not be treated further on the basis of the protocol (e.g. clinical condition deteriorates), no longer shows up for the assessments or refuses further participation in the study.

Analysis of covariance, including the initial measures as covariants, and multivariate analyses of variance were used to test intragroup and intergroup differences.

Pearson χ^2 calculations (two-sided, level of significance $p < 0.05$) were used to compare the three different outcome measures of the qualitative evaluation: (a) HAM-D response (HAM-D reduction of at least 50% from base rate); (b) HAM-D remission (HAM-D end score of 7 points or less); (c) CGI success (CGI-S score 1–2).

Results

A total of 41 participants were randomly assigned to combined BDT ($n = 21$) or BSP ($n = 20$) with medication. Of the randomized patients, 35 gave their written informed consent to participate and 6 refused consent (2 for scheduling problems and 4 refused a study treatment). There was no significant difference between those who refused and those who accepted the study, whether in clinical variables or demographic characteristics.

The characteristics of the 35 patients (BDT plus antidepressants $n = 18$; BSP plus antidepressants $n = 17$) in the PP sample at baseline (T1) are given in table 1. There was no significant difference between the two treatment conditions.

In the group treated with BDT, the dropout rate was higher ($n = 2$) than in the group treated with BSP ($n = 1$; 11.1 and 5.9%, respectively) but the difference was not statistically significant. All withdrawals from the study were within T2; in both subgroups, the dropouts were due to the fact that patients stopped attending the psychotherapy sessions (from the fifth and from the sixth sessions in the BDT combined treatment, from the fifth session in the BSP combined treatment). No statistically significant differences were found between the two treatment groups (OC) in demographics or baseline rates.

As shown in table 2, BDT and BSP did not differ in number of sessions and duration of treatment.

Table 3 presents the efficacy results, expressed in mean HAM-D, HAM-A and CGI scores: intergroup differences at the end of the study (T3) were statistically significant in both PP and OC samples, according to all mean rating scale scores. No difference between the two treatment groups was found at any other point by any assessment method.

Intragroup differences between baseline and discharge assessments (T3) were statistically significant in both treatment conditions for both the PP and OC samples. Although the differences were not statistically significant, the group treated with BSP combined with medication exhibited lower mean rating scale scores at the end of the combined treatment phase (T2) than at T3. Interestingly, the group of patients treated with BDT showed a further clinical improvement at the end of the continuation treatment with medication (T3) in comparison with T2: a significant reduction in symptomatology emerged on the HAM-D (PP sample: $F = 75.154$, $p = 0.03$; OC sample: $F = 67.149$, $p = 0.022$) and on the CGI total scores (PP sample: $F = 78.527$, $p = 0.016$; OC sample: $F = 74.104$, $p = 0.007$).

Table 2. Comparison between BDT and BSP with respect to treatment characteristics: number of sessions and duration of the acute and continuation treatments (OC)

Type of psychotherapy	Sessions, n			Duration of acute treatment, months			Duration of continuation treatment, weeks		
	mean ± SD	mode	median	mean ± SD	mode	median	mean ± SD	mode	median
BDT (n = 16)	15.50±4.97	20	15.50	5.06±2.18	6	5.50	25.13±1.109	25	25.00
BSP (n = 16)	15.35±8.53	17	16.00	6.12±2.11	5	6.00	24.81±0.806	25	25.00
Statistics (Student t test)	n.s.			n.s.			n.s.		

Table 3. Mean HAM-D, HAM-A, CGI-S and CGI Improvement (CGI-I) scores in the OC and PP samples (BDT vs. BSP)

	BDT		BSP		F	p
	mean ± SD	n	mean ± SD	n		
<i>OC sample</i>						
HAM-D						
T0	20.94±3.244	18	19.41±1.805	17	2.933	0.096
T1	20.67±4.256	18	19.53±2.035	17	0.997	0.325
T2	10.19±3.468	16	9.63±4.080	16	0.177	0.677
T3	6.19±3.920	16	12.75±4.420	16	19.746	0.000
HAM-A						
T0	16.00±4.627	18	13.82±4.680	17	1.913	0.176
T1	16.17±4.528	18	14.06±5.080	17	1.683	0.203
T2	8.75±4.107	16	8.25±3.804	16	0.128	0.723
T3	5.13±3.324	16	11.69±4.285	16	23.428	0.000
CGI-S						
T0	4.39±0.502	18	4.29±0.470	17	0.332	0.568
T1	4.39±0.502	18	4.35±0.493	17	0.046	0.832
T2	2.56±0.814	16	2.81±0.911	16	0.670	0.419
T3	1.81±0.655	16	3.31±1.014	16	24.686	0.000
CGI-I						
T1	4.11±0.471	18	4.06±0.429	17	0.117	0.734
T2	2.25±0.683	16	2.50±0.816	16	0.882	0.355
T3	1.50±0.516	16	3.00±0.816	16	38.571	0.000
<i>PP sample</i>						
HAM-D						
T0	20.94±3.244	18	19.41±1.805	17	2.933	0.096
T1	20.67±4.256	18	19.53±2.035	17	0.997	0.325
T2	9.83±3.417	18	9.47±4.002	17	0.083	0.774
T3	6.28±3.691	18	12.41±4.501	17	19.534	0.000
HAM-A						
T0	16.00±4.627	18	13.82±4.680	17	1.913	0.176
T1	16.17±4.528	18	13.88±4.794	17	2.102	0.157
T2	9.00±3.941	18	8.41±3.743	17	0.205	0.654
T3	5.78±3.671	18	11.65±4.152	17	19.681	0.000
CGI-S						
T0	4.39±0.502	18	4.29±0.470	17	0.332	0.568
T1	4.39±0.502	18	4.35±0.493	17	0.046	0.832
T2	2.44±0.865	18	2.71±0.985	17	0.705	0.407
T3	1.78±0.647	18	3.18±1.131	17	20.464	0.000
CGI-I						
T1	4.11±0.471	18	4.06±0.429	17	0.117	0.734
T2	2.06±0.725	18	2.47±0.800	17	2.591	0.117
T3	1.50±0.514	18	2.94±0.827	17	38.808	0.000

Table 4. Success rates on the three outcome measures

Time	BDT		BSP		Pearson, χ^2 (2-sided)	p
	%	n	%	n		
<i>PP sample</i>						
HAM-D response						
T2	55.6	18	52.9	17	0.24	0.877
T3	88.9	18	29.4	17	12.887	0.000
HAM-D remission						
T2	27.8	18	35.3	17	0.229	0.632
T3	77.8	18	17.6	17	12.665	0.000
CGI-S success						
T2	55.6	18	47.1	17	0.253	0.615
T3	88.9	18	29.4	17	12.887	0.000
<i>OC sample</i>						
HAM-D response						
T2	50.0	16	50.0	16	0.000	1.000
T3	87.5	16	25.0	16	12.698	0.000
HAM-D remission						
T2	18.8	16	31.3	16	0.667	0.685 ¹
T3	75.0	16	12.5	16	12.698	0.000
CGI-S success						
T2	50.0	16	43.8	16	0.125	0.723
T3	87.5	16	25.0	16	12.698	0.000

¹ Fisher's exact test.

The success rates (HAM-D response, HAM-D remission, CGI-S success) of the PP and of the OC samples are shown in table 4. Comparing the two different combined treatment methods, a significant difference emerged at T3 between the groups in both PP and OC samples: 6 months after the end of psychotherapy, the addition of BDT to medication was more effective than the addition of BSP. The statistical analysis of the success rates showed no difference at the end of the combined therapies (T2), but during the continuation phase with only medication, a consistent group of patients who had been treated with BDT achieved remission while some patients of the other group lost their positive results.

Concerning the additional information obtained by interviewing all treated patients at the conclusion of treatments, patients tend to like BSP more than BDT (the treatment was 'extremely liked' by the 29.4% of BSP patients but by none of the BDT patients), but 50% of BDT patients thought the therapy was extremely helpful (only 17.6% in the BSP group).

Discussion

This study addresses the pragmatic question of the different clinical utility of two fully operational psychotherapeutic techniques added to medication in the treatment of depressive symptoms.

During both acute and continuation phases, the patients were all treated with antidepressants; they were randomly assigned to receive BDT or BSP in addition to medication in the acute phase and they were all assessed by blind investigators. The randomization in our study appeared successful.

In the two groups, the success rates at the end of combined treatments (T2) were comparable; moreover, the average rates were not impressive and lower than those reported by the two studies of de Jonghe et al. [24, 25]. The characteristics of the subjects that we recruited from the waiting list for BDT may explain the lower success rates: major depressive patients with a focal problem and/or with a recent precipitant life event could be less responsive to treatments.

During the continuation phase, the group of patients who had been treated with BDT showed a further clinical improvement whereas the success rates in the group of

patients who had been treated with supplemental supportive psychotherapy decreased: statistically significant intergroup differences appeared at T3 on all efficacy results in both the PP and OC samples. Moreover, BDT was found to produce higher response rates and higher remission rates (over 85 and over 75%, respectively) in comparison with adding BSP to medication (under 30 and under 20%, respectively).

Although this study is limited by the small sample size, two interesting findings emerged: first, the results obtained from the patients who were treated with the addition of BDT to medications were satisfactorily improved during the continuation phase with pharmacotherapy alone; second, the gains measured in the group of patients treated with the addition of BSP were not completely maintained during the continuation phase. These findings may depend on the characteristics of the treatment groups that were recruited from a waiting list for BDT: patients with a specific request for psychotherapy and with a focal problem and/or with a recent precipitant life event could be much more responsive to a psychodynamic treatment than to a nonspecific and brief supportive intervention. It can be argued that the BDT can produce such large differences in efficacy in selected patients with major depression associated with actual psychosocial stressors; as some recent meta-analytic and qualitative reviews suggest [7–9], the identification of the specific cases in which a psychotherapy is indicated is of great interest. There is a need to develop better criteria for

the identification of major depressed patients suitable for the addition of BDT to pharmacotherapy.

In conclusion, our preliminary findings suggest that supplemental BDT in the treatment of patients with major depression who are receiving effective medication has some significant advantages in comparison with BSP principally after the end of treatment sessions. Our current data do not definitely demonstrate the superiority of BDT over supportive psychotherapy which would require a much larger sample size. However, they do suggest potential benefits for BDT which appears to have an enduring effect that lasts and increases beyond the end of treatment as it has already been demonstrated for CBT.

As we previously pointed out, the primary objective of BDT, which is to enhance the patient's insight into repetitive conflicts (intrapsychic and interpersonal) and trauma, appeared to be a specific therapeutic factor: it underlies and sustains the patient's problems not only during the treatment sessions [27].

Further studies with longer follow-up periods and on larger samples of subjects should be conducted to confirm these results and to test the effectiveness of BDT in monotherapy for the treatment of major depressive disorder. Moreover, as the length of BDT might be a problem for its applicability in a public health care system, future randomized controlled trials to compare BDT with shorter forms of psychotherapy (CBT) in terms of efficacy and cost-effectiveness are needed.

References

- 1 Conte HR, Plutchik R, Wild KV, Karasu TB: Combined psychotherapy and pharmacotherapy for depression: a systematic analysis of the evidence. *Arch Gen Psychiatry* 1986; 43:471–479.
- 2 Robinson LA, Berman JS, Neimeyer RA: Psychotherapy for the treatment of depression: a comprehensive review of controlled outcome research. *Psychol Bull* 1990;108: 30–49.
- 3 Hollon SD, Shelton RC, Loosen PT: Cognitive therapy and pharmacotherapy for depression. *J Consult Clin Psychol* 1991;59:88–99.
- 4 Wexler BE, Cicchetti DV: The outpatient treatment of depression: implications of outcome research for clinical practice. *J Nerv Ment Dis* 1992;180:277–286.
- 5 Weissman MM: The psychological treatment of depression: evidence for the efficacy of psychotherapy alone, in comparison with, and in combination with pharmacotherapy. *Arch Gen Psychiatry* 1979;36:1261–1269.
- 6 Miller IW, Keitner GI: Combined medication and psychotherapy in the treatment of chronic mood disorders. *Psychiatr Clin North Am* 1996;19:151–171.
- 7 American Psychiatric Association: APA issues practice guideline for major depressive disorder in adults. *Am Fam Physician* 1993; 48:1312–1313.
- 8 Friedman MA, Detweiler-Bedell JB, Leventhal HE, Horne R, Keitner GI, Miller IW: Combined psychotherapy and pharmacotherapy for the treatment of major depressive disorder. *Clin Psychol* 2004;11:47–68.
- 9 Thase ME, Greenhouse JB, Frank E, Reynolds CF 3rd, Pilkonis PA, Hurley K, Grochocinsky V, Kupfer DJ: Treatment of major depression with psychotherapy or psychotherapy-pharmacotherapy combinations. *Arch Gen Psychiatry* 1997;54:1009–1015.
- 10 Hollon DS, Jarrett RB, Nierenberg AA, Thase ME, Trivedi M, Rush AJ: Psychotherapy and medication in the treatment of adult and geriatric depression: which monotherapy or combined treatment? *J Clin Psychiatry* 2005;66:455–468.
- 11 Svartberg M, Stiles TC: Comparative effects of short-term psychodynamic psychotherapy: a meta-analysis. *J Consult Clin Psychol* 1991;59:704–714.
- 12 Crits-Christoph P: The efficacy of brief dynamic psychotherapy: a meta-analysis. *Am J Psychiatry* 1992;149:151–158.
- 13 Grawe K, Donati R, Bernauer F: *Psychotherapie im Wandel: von der Konfession zur Profession*. Göttingen, Hogrefe, 1994.
- 14 Anderson EM, Lambert MJ: Short-term dynamically oriented psychotherapy: a review and meta-analysis. *Clin Psychol Rev* 1995; 15:503–514.

- 15 Wampold BE, Mondin GW, Moody M, Stich F, Benson K, Ahn HA: Meta-analysis of outcome studies comparing bona fide psychotherapies: empirically, 'all must have prizes'. *Psychol Bull* 1997;122:203–215.
- 16 Leichsenring F, Rabung S, Leibling E: The efficacy of short-term psychodynamic psychotherapy in specific psychiatric disorders: a meta-analysis. *Arch Gen Psychiatry* 2004; 61:1208–1216.
- 17 Thompson LW, Gallagher D, Breckenridge JS: Comparative effectiveness of psychotherapies for depressed elders. *J Consult Clin Psychol* 1987;55:385–390.
- 18 Gallagher D, Thompson LW: Effectiveness of psychotherapy for both endogenous and nonendogenous depression in older adult outpatients. *J Gerontol* 1983;38:707–712.
- 19 Steuer JL, Mintz J, Hammen CL, Hill MA, Jarvik LF, McCarley T, Motoike P, Rosen R: Cognitive-behavioral and psychodynamic group psychotherapy in treatment of geriatric depression. *J Consult Clin Psychol* 1984; 52:180–189.
- 20 Arean PA, Perri MG, Nezu AM: Comparative effectiveness of social problem-solving therapy and reminiscence therapy as treatments for depression in older adults. *J Consult Clin Psychol* 1993;61:1003–1010.
- 21 Gallagher-Thompson D, Steffen AM: Comparative effects of cognitive-behavioral and brief psychodynamic psychotherapies for depressed family caregivers. *J Consult Clin Psychol* 1994;62:543–549.
- 22 Cooper PJ, Murray L, Wilson A, Romaniuk H: Controlled trial of the short- and long-term effect of psychological treatment of post-partum depression. I. Impact on maternal mood. *Br J Psychiatry* 2003;182:412–419.
- 23 Leichsenring F: Comparative effects of short-term psychodynamic psychotherapy and cognitive-behavioral therapy in depression: a meta-analytic approach. *Clin Psychol Rev* 2001;21:401–419.
- 24 de Jonghe F, Kool S, van Aalst G, Dekker J, Peen J: Combining psychotherapy and antidepressants in the treatment of depression. *J Affect Disord* 2001;64:217–229.
- 25 de Jonghe F, Hendricksen M, van Aalst G, Kool S, Peen V, Van R, van den Eijnden E, Dekker J: Psychotherapy alone and combined with pharmacotherapy in the treatment of depression. *Br J Psychiatry* 2004;185: 37–45.
- 26 Burnand Y, Andreoli A, Kolatte E, Venturini A, Rosset N: Psychodynamic psychotherapy and clomipramine in the treatment of major depression. *Psychiatr Serv* 2002;53:585–590.
- 27 Maina G, Forner F, Bogetto F: Randomized controlled trial comparing brief dynamic and supportive therapy with waiting list condition in minor depressive disorders. *Psychother Psychosom* 2005;74:43–50.
- 28 Malan DH: *A Study of Brief Psychotherapy*. London, Tavistock, 1963.
- 29 Malan DH: *Toward a Validation of Dynamic Psychotherapy: A Replication*. New York, Plenum Press, 1976.
- 30 Horowitz M, Marmar C, Krupnik J, Wilner N, Kaltreider N, Wallerstein R: *Personality styles and brief psychotherapy*. London, Aronson, 1997.
- 31 First MB, Spitzer RL, Gibbon M, Williams JBW: *Structured Clinical Interview for DSM-IV Axis I Disorders*. Washington, American Psychiatric Press, 1997.
- 32 First MB, Gibbon M, Spitzer RL, Williams JBW, Benjamin Smith L: *Structured Clinical Interview for DSM-IV Axis II Disorders*. Washington, American Psychiatric Press, 1997.
- 33 Novalis PN, Rojcewicz SJ, Peele R: *Clinical Manual of Supportive Psychotherapy*. Washington, American Psychiatric Press, 1993.