The Efficacy of Short-term Psychodynamic Psychotherapy in Specific Psychiatric Disorders

A Meta-analysis

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Background: The efficacy of psychodynamic therapy is controversial. Previous meta-analyses have reported discrepant results.

Objective: To test the efficacy of short-term psychodynamic psychotherapy (STPP) in specific psychiatric disorders by performing a meta-analysis of more recent studies. We assessed outcomes in target problems, general psychiatric symptoms, and social functioning.

Design: We identified studies of STPP published between January 1, 1970, and September 30, 2004, by means of a computerized search using MEDLINE, PsycINFO, and Current Contents. Rigorous inclusion criteria, including randomized controlled trials, use of treatment manuals and evaluations of treatment integrity, therapists experienced or specifically trained in STPP, treatment of patients with specific psychiatric disorders, reliable and valid diagnostic measures, and data necessary to calculate effect sizes. Studies of interpersonal therapy were excluded. Seventeen studies fulfilled the inclusion criteria. The information was extracted by 3 raters. Effect sizes were calculated for target problems, general psychiatric symptoms, and social functioning using the data published in the original studies. To examine the stability of outcome, we assessed effect sizes separately for end of therapy and follow-up assessment. The effect sizes of STPP were compared with those of waiting-list control patients, treatments as usual, and other forms of psychotherapy.

Results: Short-term psychodynamic psychotherapy yielded significant and large pretreatment-posttreatment effect sizes for target problems (1.39), general psychiatric symptoms (0.60), and social functioning (0.80). These effect sizes were stable and tended to increase at follow-up (1.37, 0.95, and 1.10, respectively). The effect sizes of STPP significantly exceeded those of waiting-list controls and treatments as usual. No differences were found between STPP and other forms of psychotherapy.

Conclusions: Short-term psychodynamic psychotherapy proved to be an effective treatment in psychiatric disorders. However, further research of STPP in specific psychiatric disorders is needed, including a study of the active ingredients of STPP. Effectiveness studies should be included.

Arch Gen Psychiatry. 2005;62:1208-1216

The Place of Psychoanalytic and Psychodynamic Treatments within Psychiatry is Controversial: 1,2 For long-term psychoanalytic psychotherapy and psychoanalysis, convincing outcome research is urgently needed. 3 In the field of short-term psychodynamic psychotherapy (STPP), more evidence of efficacy is available. Various meta-analyses have addressed the efficacy of STPP. 4,5,6,7,8,9 Searberg and Salee found STPP to be superior to a no-treatment control condition, but inferior to alternative psychotherapies. According to Crits-Christoph, STPP achieved large effect sizes compared with untrained waiting-list control patients and was found to be equally effective as other forms of treatment such as cognitive-behavioral therapy (CBT) or psychopharmacological treatment. Although the effect sizes of STPP assessed by Andreassen and Lamberts were higher than those reported by Crits-Christoph, meta-analyses corroborated the findings of Crits-Christoph. One factor that heavily influences the outcome of a meta-analysis is the selection and the quality of the studies included. 10 Unlike Searberg and Salee, Crits-Christoph and Andreassen and Lamberts included studies of interpersonal therapy (IPT) as representative of STPP. However, the inclusion of IPT to STPP is controversial. 11 According to empirical results, IPT seems to be very close to CBT. 12 Furthermore, the methodological quality of the studies included in a meta-analysis plays an important role. As Messenger

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and Warren (1912) have pointed out, many studies included in the meta-analysis of Swannberg and Stiles showed severe conceptual and methodological flaws. This is also true for the meta-analysis of Grae and Stiles (1914) which compared STPP and CBT. To avoid these flaws, Crits-Christoph (1912) included in his meta-analysis only studies that fulfilled rigorous inclusion criteria (eg., use of therapy manuals, experienced therapists, minimum number of sessions). Wampold et al. (1915) assessed the efficacy of bona fide treatments and did not find differences between different methods of psychotherapy. Up to the present, 2 disorder-specific meta-analyses of STPP have been published. The meta-analysis of Leichsenring (1916), which used criteria similar to those of Crits-Christoph, found STPP and CBT to be equally effective in the treatment of depression. For the treatment of personality disorders, significant and large effect sizes for STPP and CBT were found in the meta-analysis of Leichsenring and Leibing (1917).

Randomized controlled studies (RCTs) are regarded as the gold standard for the demonstration that a treatment is effective. This applies not only to psychotherapy research but to the realm of evidence-based medicine in general. (1918) This assumption is reflected in the criteria proposed by the Task Force on Promotion and Dissemination of Psychological Procedures of Division 12 (Clinical Psychology) of the American Psychological Association for the definition of empirically supported treatments. (1919) According to these criteria, empirical support for psychotherapeutic methods can only be provided by RCTs in which a therapy group is compared with a control condition (waiting list or placebo group) or with an already established therapy. (1912) Furthermore, the use of therapy manuals and the treatment of a specific disorder are required.

Since the publication of the meta-analyses of Swannberg and Stiles, Crits-Christoph, Grae et al. (1913), and Anderson and Lambert (1913) and the report of the Task Force, (1914) several studies of STPP have been published that have not yet been included in meta-analyses of STPP. The most recent study included by Anderson and Lambert was published in 1993, i.e., more than 10 years ago. For this reason, we conducted a new meta-analysis that included the more recent studies of STPP. As the results of a meta-analysis depend on the quality of the studies included, we applied rigorous inclusion criteria.

This meta-analysis addressed the following questions:
1. What is the evidence of improvement in target problems, general psychiatric symptoms, and social functioning after STPP?
2. Do the effects of STPP exceed the effects of untreated control groups and treatments of usual (TAU) groups?
3. Are there differences in efficacy between STPP and other forms of psychotherapy?
4. How stable are the effects of STPP?
5. Is there a correlation between outcome and duration of treatment?

**METHODS**

**DEFINITION OF STPP**

Apart from conceptual and technical differences, there are some therapeutic elements that the different models of STPP have in common. (1915) With regard to formal characteristics, they are time limited (usually 16-30 sessions with a range of 7-40 sessions) and performed in a face-to-face setting, with 1 or 2 sessions a week. (1916) Therapies including 6 or fewer sessions are regarded as ultrabrief. (1917) The therapeutic techniques of STPP are elaborations and modifications of general principles of psychodynamic psychotherapy. Short-term psychodynamic psychotherapy is characterized by the following features. First, therapies are usually relatively active and foster the development of a therapeutic alliance and a positive transference. Second, STPP focuses on specific conflicts or themes that are formulated early in therapy. Third, attention is paid to adherence to the focus, the sorting of achievable goals, and termination issues. The focus is on the patient's experiences here and now, including their symptoms. With regard to transference, the emphasis is more on the here-and-now dimension, i.e., on the present relationship between the patient and the psychotherapist, which is not necessarily traced back to the past. In a review of empirical studies, Bögels and Hilsenroth (1918) identified 7 features that were observed significantly more frequently in STPP compared with CBT, thus focusing on affect, resistance, identification of consistent patterns (of relationships, feelings, and behaviors), past experiences, interpersonal experiences, the therapeutic relationship, and wishes, dreams, or fantasies.

**SELECTION OF STUDIES**

We collected studies of STPP that were published between January 1, 1970, and September 30, 2004. By performing a computerized search using MEDLINE, PsychINFO, and Current Contents, the following key words were used: psychodynamic therapy, psychodynamically oriented therapy, psychoanalytic therapy, and randomized controlled trial. A total of 141 partly overlapping journal articles were found. The only studies included in the meta-analysis fulfilled the following methodological requirements: (1) a randomized controlled design was applied; (2) a specific form of STPP was represented in a treatment manual or manual-like presentation; (3) outcome measure was presented for treatment integrity; (4) therapists were specifically trained and/or experienced in STPP techniques; (5) patient's specific psychodiagnostic treatments were created (no mixed samples or analogue studies); (5) the sample patient was clearly described; (6) diagnostic procedures and outcome measures for which reliability and validity have been demonstrated were used; and (7) data were reported that are necessary to calculate pre-treatment-posttreatment effect sizes.

Contrary to the meta-analysis of Crits-Christoph and Anderson and Lambert, studies of IPT were not included (eg., Fichten et al. (1919) and Willey et al. (1919)), because the relation of IPT to STPP is controversial, and empirical results suggest that IPT is very close to CBT. (1920) This very close relation exists if there is a general agreement that they represent models of STPP. As it is questionable to aggregate the results of very different outcome measures that refer to different areas of psychological functioning, we assessed the efficacy of STPP separately for target symptoms, general psychiatric symptoms (ie., comorbidity symptoms), and social functioning. (1921) This procedure is analogous to the meta-analysis of Crits-Christoph. As outcome measures of target problems, we included patient ratings of target problems and measures referring to the symptoms that are specific to the patient group under study, eg., measures of anxiety for studies investigating treatments of anxiety disorders. (1922) For the efficacy of STPP in general psychiatric symptoms, broad measures of psychiatric symptoms such as the Symptom Checklist-90 and specific measures that do not refer specifically to the disorders under study were included, eg., the Beck Depression Inventory. The Beck Depression Inventory applied in patients with personality disorders. (1923) For the assessment of social functioning, the Social Adjustment Scale and similar measures were included.
ASSESSMENT OF EFFECT SIZES

We calculated within-group effect sizes for all studies using the Cohen's *d* statistic. For each measure, we subtracted the pretreatment mean from the posttreatment mean and divided the difference by the pretreatment standard deviation, as suggested by *Cohen*. If necessary, *d* scores were reversed so that a positive effect size always indicated improvement. We assessed effect sizes separately for measures of target problems, general psychiatric symptoms, and social functioning. Whenever multiple measures were applied in a study, we assessed the effect size for each measure separately and calculated the mean effect size to assess the overall outcome of the study in the respective area of functioning. We computed effect sizes that were unweighted and those weighted by the sample size to yield unbiased estimators of effect sizes. *d* *d* *d* to examine the stability of psychotherapeutic effects, we assessed effect sizes separately for assessments at termination of therapy and follow-up.

Furthermore, between-group effect sizes were assessed according to the method described by *Cohen*. By calculating the difference between precurriculum and postcurriculum (follow-up) measures of the STPP group minus the difference between pre-assessment and postassessment (follow-up) measures of the comparison group, divided by the pooled standard deviation before-therapy. These between-group effect sizes give the difference in the magnitude of change between STPP and the comparison group in units of standard deviation. An effect size of zero indicates that STPP and comparison groups are equal in therapeutic effect. All *d* *d* d *d* d *d* d *d* d *d* were calculated so that a positive effect size indicates superiority of STPP.

The third rater extracted the following information from the articles: (1) name of the *authors*, (2) year of publication, (3) psychiatric disorder treated with STPP, (4) model of STPP, (5) duration of STPP, (6) comparison group, (7) sample size in each group, (8) means and standard deviations for each outcome measure. This information was checked by the second rater, and disagreements were resolved by consensus, including the ratings of the third rater.

RESULTS

DESCRIPTION OF STUDIES

Seventeen studies of STPP met the inclusion criteria. The studies are described in Table 1 (data necessary for the assessment of effect sizes were provided by Susan Boggs, PhD (written communication, January 21, 2004); Paul Czis-Chrystoph, PhD (written communication, November 11, 2003); and F. J. Cooper, PhD, and Helgo Romanuk, PhD (written communication, November 24, 2003)).

OVERLAP WITH OTHER META-ANALYSES

Of the 17 studies that we identified, 13 (76%) have not yet been included in other meta-analyses of STPP. Only 3 of the 19 studies that Stanberg and Taylor included in their meta-analysis met our inclusion criteria. Of the 20 studies in the meta-analysis of Anderson and Lambert, 4 could be included. Of the 11 studies included by Crits-Christoph, “we included 4 was by Crits-Christoph and Anderson and Lambert included studies of IJ, which we excluded. Only 2 studies of the meta-analysis of Leichsenring and Leibing were included and only 1 study of the meta-analysis of Leichsenring and Leibing. Accordingly, only a limited portion of the studies that were included in previous meta-analyses of STPP was included in our meta-analysis. Thus, most of the studies included in our meta-analysis have not been included in the previous meta-analyses.

Models of STPP

In the 17 studies included in our meta-analysis, different models of STPP were applied (Table 1). The most frequently applied concepts of STPP were the methods developed by Luborsky, *Horowitz*, *Shafrira* and *Firth*, and Davanloo.

Therapy Duration

In the 17 studies of STPP, the number of sessions conducted ranged from 7 to 40. Short therapies of 7 sessions were performed in the study of Hamilton et al., whereas longer therapies were performed in the studies of Wittsö et al. and Stanberg et al., who studied the treatment of personality disorders (Table 1). The mean number of sessions of STPP was 20.97 (SD, 10.93).

DURATION OF FOLLOW-UP

Mean length of follow-up was about 1 year (mean, 61.42 weeks; SD, 71.26 weeks).

PSYCHIATRIC DISORDERS

In the studies selected, the following psychiatric disorders were treated with STPP: major depression (2 studies), maternal depression (1), posttraumatic stress disorder (1), bulimia nervosa (2), anorexia nervosa (1), oppositional defiant disorder (2), cocaine dependence (1), cluster C personality disorders (3), borderline personality disorder (1), somatoform pain disorder (1), chronic functional dyspepsia (1), and social phobia (1). It is desirable to perform meta-analyses of STPP separately for specific psychiatric disorders, eg, for somatoform disorders or anxiety disorders. However, the number of RCTs of STPP is not yet large enough for that purpose. Nevertheless, it is still useful at the present state of research to evaluate the efficacy of STPP in psychiatric disorders in general, ie, across different psychiatric disorders.

EFFECT SIZES OF STPP

Within-group effect sizes of STPP, other forms of psychotherapy, TAU, and waiting list are presented in Table 2.

Target Problems

Short-term psychodynamic psychotherapy yielded an effect size of 1.04 after therapy and of 1.37 at follow-up (Table 2). To determine whether the effect sizes were different from zero, we performed unpaired, 2-tailed *t* tests. Both effect sizes differed significantly from zero (t1,9 = 6.94 [P<.001] and t1,0 = 7.11 [P<.001], respectively). The limits of a 95% confidence interval (CI) were 0.97 and 1.82.

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at the posttreatment assessment and 1.10 and 2.04 at the follow-up assessment. Adjustment for sample size yielded nearly identical results (1.31, 95% CI [0.96, 1.80]) and 1.54, 95% CI [1.15, 2.03]), respectively.

General Psychiatric Symptoms

Short-term psychodynamic psychotherapy yielded an effect size of 0.80 after therapy and 0.95 at follow-up. Both effects differed significantly from zero (t(12) = 2.25, p < 0.05 and t(12) = 2.88, p < 0.001), respectively. The limits of 95% CI were 0.59 and 1.17 at the posttreatment measurement and 0.65 and 1.25 at the follow-up assessment. Adjustment for sample size yielded nearly identical effect sizes of 0.81 (t(12) = 2.50, p < 0.05) and 0.95 (t(12) = 0.95, p < 0.05), respectively.

Social Functioning

Short-term psychodynamic psychotherapy yielded an effect size of 0.80 after therapy and 1.19 at follow-up. Both effects differed significantly from zero (t(12) = 3.24, p < 0.05 and t(12) = 2.88, p < 0.05), respectively.
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| Treatment/Control Group | No. of Studies | Mean (SD) | Range |
| Walking kit | 4 | 0.27 (0.33) | 0.00 to 0.72 |
| Target problems (pre-post) | 4 | 0.12 (0.13) | 0.00 to 0.24 |
| General psychiatric symptoms (pre-10) | 4 | NA | NA |
| General psychiatric symptoms (pre-10) | 4 | NA | NA |
| Social functioning (pre-10) | 2 | 0.21 (0.23) | 0.04 to 0.37 |
| Social functioning (pre-10) | 2 | NA | NA |

Abbreviations: CBT, cognitive-behavioral therapy; TAU, not available; pre, pre-treatment; post, post-treatment; post-h, post-hospitalization; STPP, short-term psychiatric psychotherapy; TAU, treatment-as-usual.

[Please note: Table 2 contains specific data and results related to the effects of different treatments on various outcome measures.]

**Effect Sizes of No Treatment**

Four studies provided data for waiting-list control patients (Table 1). No treatment yielded small effect sizes that ranged from 0.12 to 0.27 (Table 2). Because of the small number of studies (n = 4), we did not perform tests of significance for the between-group effect sizes of STPP and no treatment.

**Effect Sizes of TAU Patients**

Three studies provided data for TAU (Table 1). We decided to regard the control condition of the study of Gow et al. as TAU rather than as no treatment, because some of these patients had "received extensive treatment elsewhere." Treatment as usual yielded effect sizes that ranged from 0.22 to 0.95 (Table 2). Again, we did not perform tests of significance for the between-group effect sizes of STPP and TAU because of the small number of studies (n = 3).

**STPP vs No Treatment and TAU**

To compare STPP with no treatment and TAU, we tested whether the between-group effect sizes between STPP on the one hand and no treatment and TAU on the other significantly differed from zero (t tests for independent samples). According to the results, STPP was significantly superior to no treatment and TAU with regard to target problems, general psychiatric symptoms, and social functioning (Table 3). Because of the small number of studies, these tests were performed only for the posttherapy effect sizes. The between-group effect sizes were large for target problems and medium to large for general psychiatric symptoms and social functioning (Table 3).

**STPP vs Other Forms of Psychotherapy**

Fifteen studies included a comparison of STPP with other forms of psychotherapy (Table 1). For these comparisons we calculated between-group effect sizes (Table 3). They ranged from 0.02 to 0.23, thus corresponding to small effect sizes according to Cohen. To test for differences between STPP and other forms of psychotherapy in these 15 studies, we performed multiple analyses of variance (MANOVA). In a first MANOVA, we compared the pretreatment-posttreatment effect sizes between STPP and other forms of psychotherapy in target symptoms, general psychiatric symptoms, and social functioning. In a second MANOVA, we compared the pretreatment-posttreatment effect sizes between STPP and other forms of psychotherapy on the 3 outcome variables. Both MANOVA yielded an insignificant result at the posttherapy assessment (Wilks A = 0.92, F(3, 49) = 0.49 [P = 0.69]).
The place of psychoanalytic and psychodynamic treat-
ments within psychiatry is controversial. This meta-
analysis addressed the efficacy of STPP in specific psy-
chiatric disorders. As present, the number of RCTs is not
yet large enough to perform meta-analyses of STPP for
specific psychiatric disorders separately. For this rea-
son, our meta-analysis addressed the question of how ef-
fective STPP is in general in the treatment of psychiatric
disorders. We studied the effects in target problems, gen-
eral psychiatric problems, and social functioning.

The data presented herein corroborate the results re-
ported by Criés-Christoph,1 Anderson and Lambert,1 and
Leischnering. However, this meta-analysis adds to the
literature for several reasons. First, more rigorous inclu-
sion criteria were applied. As a consequence, only a mi-
nority of studies included in previous meta-analyses were
regarded as adequate for inclusion in this meta-analysis.
Second, studies of IFT were not included because the re-
lation of IPT to STPP is controversial. Empirical results
seem to support the exclusion of IPT from a meta-
analysis of STPP.10 Thus, the database of this meta-
analysis is different from those of previous meta-
analyses. Third, 76% of more recently published studies
included in this meta-analysis had not yet been in-
cluded in other meta-analyses of STPP. Fourth, the sta-
bility of effects of STPP was assessed by studying the pre-
treatment and posttreatment effects and the effects yielded
in follow-up studies.

According to the results, STPP yielded significant and
large effect sizes. With regard to between-group effect
sizes, which allow for a stricter test of efficacy and are
more appropriate to the fact that only RCTs were in-
cluded, STPP was significantly superior to no treatment
and TAU. No difference was found between STPP on the
one hand and CBT or other psychotherapies on the other
concerning changes in target problems, general psychi-
atric problems, and social functioning. These results dif-
f er in part from those reported by Svanberg and Stiles,8
who found STPP to be superior to no-treatment con-
trols but inferior to alternative psychotherapies.7 The dis-
crepant results can be explained by the selection of stud-
ies. In our meta-analysis, only studies were included that
fulfilled rigorous inclusion criteria that, among other
things, ensured that STPP was delivered competently.
The results of this meta-analysis are consistent with those of
the meta-analysis of Wampold et al.8 who did not find
differences between bona fide methods of psycho-

therapy. The insignificant differences in effect size be-
tween STPP and other forms of psychotherapy found in
this meta-analysis correspond in magnitude quite well to
the data reported by Grimmel,17 who found a mean dif-
f erence in effect size of 0.23 between different forms of
psychotherapy.

Effect sizes can be transformed into percentages of
treatment 70.12-14 According to these results, patients
treated with STPP are better off with regard to their tar-
gel problems than 92% of the patients before therapy. At
follow-up, which was on average 13 months after termi-
nation of therapy, they were better off than 95% of the
patients. As an effect size of 1.00 corresponds to a suc-
cess rate of 72%, clearly more than 72% of the patients
were successfully treated with STPP.12 These results are
highly relevant for clinical practice. This is true for an-
other result as well. Comparing the effect sizes yielded
at the end of therapy and follow-up, the effects of STPP
proved to be stable and even tended to increase. This re-
sult is consistent with that reported by Anderson and Lam-
bert,1 who found a slight superiority of STPP at fol-
low-up assessment. The effects of CBT also were
maintained to a high degree at follow-up.

For a valid estimation of the efficacy of STPP, fol-
low-up assessments seem to be necessary, as can be il-
lustrated by the following example. In 2 RCTs, signifi-
cant improvements in bulimia nervosa after STPP were
found.15-17 In the central measures specific to bulimia
nervosa (i.e., bulimic episodes and self-induced vomit-
ing), STPP was as effective as CBT.15-17,19 Apart from this,
CBT was superior to STPP on some other measures of
psychopathology.15,18 However, a follow-up study of the
sample of Feuerburn et al15 that used a longer follow-up
period found that both forms of therapy (STPP and CBT)
proved to be equally effective and partly superior to be-
havioral form of therapy.18 Results like this can only be
detected by long-term follow-up studies.
In this meta-analysis, TAU yielded effect sizes between those of psychotherapy and no treatment. These results are consistent with the overall findings according to which the "curing for therapeutic success is generally therapy, placebo, and control (do nothing or wait)." Treatment as usual generally can be expected to be superior to placebo and inferior to psychotherapy. The relatively large effect sizes of TAU found in this meta-analysis can be attributed to the study of Gowers et al., which reported large effect sizes in target problems (1-year follow-up, 1.20; 2-year follow-up, 1.71) and measures of social functioning (2-year follow-up, 0.95). These large effect sizes achieved by TAU may be explained by the fact that some of the control patients of this study had "received extensive treatment elsewhere." In this study, patients with anorexia nervosa were treated, and outcome was assessed by weight gain and physical, nutritional, social, and sexual adjustment and mental state (Morgan and Russell scores). In this case, an "extensive" TAU, as described by the authors, can be expected to be relatively effective. The studies reviewed herein refer to RCTs of STPP in specific psychiatric disorders (Table 1). However, for some specific psychiatric disorders, there are no RCTs of STPP at all. This is true for dissociative disorders, and for some specific forms of personality disorders (eg, compulsive, avoidant, and narcissistic). This is also true for CBT; however, to our knowledge, there are no studies of CBT in the treatment of dissociative and conversion disorder. With regard to personality disorders, only studies of CBT in avoidant and borderline personality disorder exist. Furthermore, for some forms of anxiety disorders, RCTs of STPP are needed. For panic disorder and agoraphobia, only RCTs in which STPP was combined with pharmacological treatment exist. This is also surprising, as anxiety is one of the central concepts of psychoanalytic and psychodynamic theory and therapy. With regard to generalized anxiety disorder, the study of Barlow and Thuras comparing STPP and CBT did not fulfill the inclusion criteria of this meta-analysis (no manual for STPP, no specific training of therapists, no checks of adherence to and competence for STPP). In addition, STPP and CBT were not equally carefully performed. In that study, STPP served as a kind of control group or "stress man." As Smith and Ablow put it: A comparison therapy might be set up as a kind of stress man over which the favored therapy would prevail. The comparison therapy (often an "insight" therapy) would be treated with fairly obvious disdain and would be given not much opportunity for success. This is known as the investigator-allegiance effect. Furthermore, studies of STPP in children and adolescents are urgently needed. Studies of STPP can be one aspect of what Kazdin defined as a research agenda for child and adolescent psychotherapy. In the studies reviewed herein, different models of STPP were applied. It is an interesting question if and how they empirically differ, as "brand names of therapy can be misleading. Studies addressing this problem are relevant for consideration if some of the different models of STPP are close enough to be lumped together. Ablon and Jones recently compared CBT and IPT as they were performed in the National Institute of Mental Health Treatment of Depression Study. According to the results, both forms of therapy adhered most strongly to the ideal prototype of CBT. In addition, adherence to the CBT prototype yielded more positive correlations with outcome measures across both types of treatment. However, STPP was not included in this comparison. Thus, it is not clear how STPP, CBT, and IPT empirically differ with regard to therapist behavior. Comparing prototypes sessions of different variants of STPP empirically would be a very interesting and promising project of research. Other forms of therapy (eg, CBT) should be included. The studies evaluated in this meta-analysis did not include comparisons with pharmacological treatments. There are only a few randomized controlled studies that examined the effects of a combination of STPP and pharmacological treatments. In the RCT of Zerin et al. and Klein et al. STPP and CBT were combined with imipramine hydrochloride in the treatment of phobias. According to the results, STPP and CBT were equally effective in the treatment of agoraphobia, mixed phobia, and simple phobia. In this study, however, no manual of STPP was used. In the study of Wiborg and Dahl, STPP combined with clomipramine hydrochloride was more successful in the treatment of panic disorder at follow-up than an exclusive treatment with clomipramine. In this study, 80% of the sample had panic disorder and agoraphobia. In 2 studies, the combined treatment of STPP and antidepressives was more successful than the pharmacological treatment alone. However, in the study reported by de Jonghe et al. and Kool and et al., this was true only for patients with a comorbid personality disorder. In the mega-analysis of DeRubeis et al., CBT was as effective as pharmacological therapy in the treatment of severe depression. According to the mega-analysis of Thase et al., the combined treatment of psychotherapy (CBT or IPT) and antidepressives was more successful in severe depression than was psychotherapy alone. In milder depression, psychotherapy and the combined treatment were equally effective. With regard to STPP, further studies of STPP are necessary that examine the combined treatment compared with STPP alone and pharmacological treatment alone. According to the results of this and other meta-analyses, STPP is an effective treatment of psychiatric disorders and yields stable results. Further research should study not only the effects of STPP in specific psychiatric disorders but also the active ingredients of STPP. In addition, the active ingredients of STPP should be compared with other forms of therapy, eg, CBT. Furthermore, effectiveness studies should address whether the methods of therapy that have proved to work in RCTs are effective in the field. Data on health economics also should be included. Submitted for Publication: March 9, 2004: final revision received May 25, 2004: accepted June 9, 2004. 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