

A Two-Year Follow-up of Psychodynamic Psychotherapy for Internalizing Disorders in Children

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ABSTRACT

Objective: To evaluate short- and long-term effects of time-limited psychodynamic psychotherapy (PP) for children with internalizing disorders. **Method:** Fifty-eight outpatient children (6.3–10.9 years old), seen in a process of routine care and meeting *DSM-IV* criteria for depressive or anxiety disorder, were assigned to either active treatment or community services. Subjects were measured at baseline, after 6 months, and at a 2-year follow-up, by Children's Global Assessment Scale (C-GAS) and Child Behavior Checklist (CBCL). **Results:** Major improvements in the experimental group were found in C-GAS and CBCL. These differences are noted at different times, with the C-GAS findings seen at 6 months and the CBCL findings at 2-year follow-up. Significant differences were found also for externalizing syndrome scales. **Conclusions:** PP is effective in treating internalizing disorders in routine outpatient care. The benefits of treatment are manifest both immediately and with delayed onset (sleeper effect). The finding that PP patients sought mental health services at a significantly lower rate than comparison conditions represents an important economic impact of PP. *J. Am. Acad. Child Adolesc. Psychiatry*, 2003, 42(3):331–339. **Key Words:** child psychiatry, psychodynamic psychotherapy, internalizing disorders, efficacy.

Epidemiological works suggest that broadly termed internalizing disorders (ID) are the most common problems in childhood, even if less frequently referred for psychiatric consultation than disruptive disorders (Kashani and Orvaschel, 1990; Last et al., 1992; Ollendick and Neville, 1994). Community and clinically referred samples suggest a high comorbidity of ID with externalizing disorders, and such an overlap tends to indicate different developmental pathways and responsiveness to various treatment regimens (Cantwell and Baker, 1989; Kendall et al., 2001). In addition, cross-sectional and longitudinal studies point out ID as malleable, but more persistent, disorders than once thought (Harrington et al., 1990; Mattison and Spitznagel, 1999; Offord et al., 1992).

Research in psychotherapy of ID has advanced considerably in the last few decades (Fonagy, 1997). A considerable body of studies found short-term efficacy of behavioral treatments for childhood ID, and some studies investigated the long-term outcome (Kendall et al., 1997; Ollendick and King 1998; Weisz et al., 1995). Follow-up studies are critically important because the effects that become evident immediately after treatment are not always the same as those evident over time. Recent studies (Weiss et al., 2000), through quite long follow-up assessment, have revealed the presence of “sleeper effects” (delayed effect of treatment) of psychotherapy. As far as the factors related to psychotherapy outcome are concerned, several studies tend to support that outcomes are better for brief child psychotherapy, where specific problems are targeted (Dulcan, 1984; Hoagwood et al., 1995; Weiss et al., 1999). Some studies on “dose effect” in child psychotherapy conclude that children receiving substantial amounts of treatment showed no better mental health outcomes than those receiving less treatment (Andrade et al., 2000). Similar studies are required in psychodynamic psychotherapy (PP) because it is widely used in mental health services (Roth and Fonagy, 1996; Weiss et al., 2000) and because it is not

Accepted October 1, 2002.

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This study was supported by grant RC 6/01 from the National Institute of Health, Italy. The authors thank Benedetto Vitiello of the NIMH for the useful comments on the manuscript.

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0890-8567/03/4203-0331©2003 by the American Academy of Child and Adolescent Psychiatry.

DOI: 10.1097/01.CHL.0000037033.04952.7F

accurate to always consider PP a long-term treatment. Indeed, several studies (Horowitz et al., 1996; Levenson et al., 1997; Smyrniotis and Kirkby, 1993) have shown that PP for children for as few as 12 sessions has been beneficial and cost-effective for selected children. Target and Fonagy (1994), in a retrospective study of the outcome of psychoanalytic treatment of 352 children with emotional disorders, have underlined that in less severe cases the improvement is not enhanced by greater length or intensity of treatment. Hoagwood (2000) has underlined that greater therapeutic precision and a careful sculpturing of treatments to children's clinical needs are necessary before the existence of dose response can be established.

We have hypothesized that brief psychodynamic treatments, with a target on a circumscribed set of symptoms, could be both efficacious and cost-effective for moderate ID (Sigal et al., 1999). The purpose of this article was to evaluate short- and long-term efficacy of a time-limited combined individual and parent-focused PP for children with ID in a clinical, naturalistic setting.

METHOD

Participants

Fifty-eight children (35 male and 23 female) between the ages of 6.3 and 10.9 years (mean age 8.8 years; SD = 1.3) were enrolled among those referred from multiple community sources to the Division of Child and Adolescent Neuropsychiatry, a suburban public academic hospital providing care to patients of all socioeconomic levels. Thirty of these participants were included in a pilot study (Muratori et al., 2002); on the basis of this previous study we have projected a sample size of 58 cases to achieve a statistical power of 85%; such a sample size is larger than an average one (40.5) indicated in meta-analytic studies of child psychotherapy (Weisz et al., 1995). Inclusion criteria were a *DSM-IV* diagnosis of depressive or anxiety disorder, which we classified as ID. Subjects met criteria for dysthymia (38), anxiety disorder (36), and oppositional defiant disorder (ODD, 19); 16 children met criteria for both anxiety disorder and dysthymia; 20 children met criteria for both ODD and dysthymia (18) or anxiety disorder (2). Anxiety disorders included generalized anxiety disorder (GAD, 5), separation anxiety disorder (SAD, 17), obsessive-compulsive disorder (2), and specific phobia (12). Other inclusion criteria were symptoms and difficulties lasting 1 year at least and circumscribed to a single or to several areas (but not to all social areas); a Children's Global Assessment Scale (C-GAS) under 70, which indicates a symptomatology interfering in global functioning that cannot simply be defined as an adjustment disturbance.

Exclusion criteria was IQ below 90; we also excluded adoptive families and families with active divorce process because the time-limited work with parents and the focus on child symptoms might be hampered by adoption-related problems or by parental conflicts. Two single, divorced-parent families were included; no "blended families" were present. The socioeconomic status of included families has been evaluated according to Hollingshead and Redlich (1958). The mean

socioeconomic status (69.57; SD = 21.8) corresponds to class III, which describes a middle socioeconomic and educational level. All subjects were medication-free.

Measures

To determine the categorical diagnosis, an independently trained child and adolescent psychiatrist separately interviewed the child and the parents with the Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS) (Chambers et al., 1985), a semi-structured psychiatric interview according to the diagnostic criteria of *DSM-III-R*. Reliability, validity, administrative characteristics, and use of the K-SADS were recently reviewed (Ambrosini, 2000). *DSM-III-R* diagnosis was converted to a *DSM-IV* diagnosis with the consideration that diagnostic criteria for dysthymia, ODD, SAD, obsessive-compulsive disorder, and specific phobia do not differ from the *DSM-III-R* criteria and that GAD subsumes *DSM-III-R* over-anxious disorder, which is indistinguishable from GAD (Kendall and Warman, 1996).

To evaluate change in behavior and global functioning, two instruments were used:

1. Child Behavior Checklist (CBCL-Parent Form). The CBCL (Achenbach, 1991) is one of the most frequently used empirically based assessment instruments for outcome research used to obtain standardized reports of children's behavior as observed by parents; its validity and reliability are described in the literature (Crijnen et al., 1999). The CBCL allows for the evaluation of a Total Problem score (TP), eight syndrome scales, and two broad-band groups of syndromes designated as Internalizing and Externalizing.
2. Children's Global Assessment Scale (C-GAS-Clinician Form). The C-GAS (Shaffer et al., 1983) is a single-point rating scale based on a continuum of 1 to 100, in which higher scores suggest better levels of functioning. Its validity and reliability and its use as a follow-up measure are described in the literature (Green et al., 1994). In our study, the interrater reliability of the C-GAS scores was computed on the basis of the ratings of two senior child and adolescent psychiatrists (intraclass *R* values = 0.76 for T₁, 0.81 for T₂, and 0.80 for T₃).

Design and Procedures

At baseline, referred parents and children received a total number of three assessment interviews (to update clinical status, to administer the K-SADS, to collect CBCL and C-GAS, and to observe the child in an individual play session) and a feedback session in which results of the assessment were discussed and treatment indications were posed. If inclusion criteria were satisfied, eligible participants were informed about the research project and signed informed consent was obtained.

Included children were assigned either to active PP treatment (experimental group) or to community services (comparison group). Because the study was conducted in a setting of routine clinical care, the group assignment was nonrandom: all admitted patients were sequentially allocated to the treatment group if a condition of therapeutic availability was given. If no therapeutic vacancy was available, the patient was allocated to the comparison group and the clinician suggested goals for the families to achieve and addressed them to community services. No other clinical criteria were used for group assignment. The comparison between the two groups at baseline showed no statistical differences for the sociodemographic and clinical variables (Table 1).

Outcome measures for the two groups were administered at baseline (T₁), after 6 months (T₂), and at 2 years follow-up (T₃).

TABLE 1
Baseline Demographic and Clinical Characteristics of Children in the Two Groups

Characteristic	Experimental (<i>n</i> = 29)	Comparison (<i>n</i> = 29)	<i>p</i>
Gender: male/female	19/10	17/12	$\chi^2_1 = 0.28; p > .05$
Age (mean and SD)	9.1 (1.3)	8.7 (1.2)	$t = 0.89; df = 56; p > .05$
SES (means and SD)	68.34 (21.45)	70.31 (21.63)	$t = 0.26; df = 56; p > .05$
Intact families	28	28	
C-GAS (means and SD) <i>DSM-IV</i>	61.37 (6.66)	59.90 (10.22)	$t = 0.65; df = 56; p > .05$
Anxiety disorder	20/29	16/29	$\chi^2_1 = 1.16; p > .05$
Dysthymic disorder	18/29	20/29	$\chi^2_1 = 0.3; p > .05$
Oppositional defiant disorder	9/29	10/29	$\chi^2_1 = 0.08; p > .05$
School: regular/special	29/0	29/0	

Note: SES = socioeconomic status; GGAS = Children's Global Assessment Scale.

Attrition

Of the 72 interviewed child–parent dyads, 6 were excluded because the child did not meet inclusion criteria for depression or anxiety disorder, 4 because parents were in an active divorce process, and 2 because parents declined to participate in the study. Of the 60 assigned participants, 2 families did not participate in the 2-year follow-up assessment.

Active Treatment

Patients and their families participated in an 11-week psychotherapy based on the protocol *La Pratique des Psychothérapies Mères-Bébés* (Cramer and Palacio Espasa, 1993), a psychotherapy protocol originally developed for infants and toddlers including only parent–child sessions and focused on the representational world of parents. We adapted this protocol from infancy to childhood, and we added several child sessions to parent–child sessions. The treatment goal is to point out the nature of the core conflictual theme and to elucidate its links to the child's symptom and to the representational world of the parents. The model schedules three consecutive phases to be carried out by the same therapist: (1) Five parent–child sessions in which the therapist allows the parent's representations to emerge and recognizes the link between parent's reconstruction of self-history with child behavior. The child's symptom is understood for its role in providing parents with defenses against anxiety, guilt, and depressive affects. The formulation of the focus is verbalized in the form of confrontation with transgenerational conflicts that could distort parents' perceptions of their child. The final aim of these sessions is to clarify the present parent–child interactions in relation to the parents' past (Cramer, 1998), to modify parents' misconceptions, and to improve empathy with the child. (2) Five sessions with the child in which the same therapist, by means of play and verbal intervention, works to focus the child's perception of the symptom and his/her defensive style. The therapist tries to give select attention to the link between the defensive style and the actual symptoms. The initial interventions are designed to give words to feelings; the therapist then tries to articulate these feelings with thoughts, memories, and wishes. Third, the therapist pays attention to mental contents (oedipal, aggressive, and regressive wishes), and, finally, a connection between feelings, mental contents, and specific symptoms is proposed. Use of play materials is essential in preparing verbal interventions that remain in the line of confrontation and clarification. (3) A final parent–child session in which the therapist points out the shared core conflictual

theme, its relationship with the child's symptom and with parents' representations.

Psychotherapists were practitioners with a degree in psychology or in child and adolescent psychiatry; all received specific training on the PP model during the year before the beginning of the research. All sessions were videotaped and later discussed in a weekly supervised group to monitor the therapists' adherence to the protocol and to ensure that core features of the treatment were delivered.

Usual-Care Control Condition

No limitation was posed for treatments of the comparison group. Information about the type and the degree of usual-care treatment sought between T₁ and T₂ was collected at T₂: 15 subjects (51.7%) did not follow any treatment; 14 subjects (48.3%) followed various kinds of treatment (individual psychotherapy, 7 cases; supportive therapy for parents, 3 cases; school tutoring, 2 cases; medication for enuresis, 1 case; speech therapy, 1 case), with a mean number of 12 sessions at T₂.

Data Analysis

To check for possible baseline differences between the two groups, a χ^2 test for categorical variables and a two-tailed *t* test (probability level $p < .05$) for continuous variables were performed on sociodemographic and clinical variables. Longitudinal data were submitted for statistical elaboration using a 2 (group: experimental versus comparison) \times 3 (time: T₁, T₂, T₃) repeated-measures analysis of variance for each outcome variable (the group means of CBCL and C-GAS) to investigate the interaction between time and group. Time effect was also evaluated to investigate changes within groups. In case of an overall, significant group by time or time effect, we performed a two-tailed *t* test (probability level $p < .05$) to investigate significance between group differences or significance within group changes over time, respectively.

To assess clinical impact of treatment, we evaluated the degree to which the means of both groups shifted from dysfunctional to functional range at T₂ and T₃ using the cutoff scores for C-GAS and CBCL. Significant differences between groups in the ratio of cases moving from clinical to nonclinical range were calculated using a χ^2 test.

To assess the alternative service use, we compared the frequency with which treatment and comparison families sought mental health services during the 2-year follow-up using a χ^2 test. The data were analyzed with SPSS 9.0 for Windows.

TABLE 2
Rates of Improvement in the Two Groups for C-GAS and CBCL Summary Scales

	Experimental		Comparison		ANOVA (<i>df</i> = 56)		Time Comparison	<i>t</i> Test	
	Mean	(SD)	Mean	(SD)	Time	G × T		Within Group (<i>df</i> = 28)	Between Groups (<i>df</i> = 56)
C-GAS					78.24***	6.58**	T ₁ →T ₂	E: <i>t</i> = 10.56***	<i>t</i> = 0.65ns
T ₁	61.37	(6.66)	59.90	(10.22)				C: <i>t</i> = 4.65***	
T ₂	75.34	(7.31)	66.68	(12.38)			T ₂ →T ₃	E: <i>t</i> = 1.84ns	<i>t</i> = 3.24**
T ₃	78.51	(9.90)	69.93	(13.52)			T ₁ →T ₃	C: <i>t</i> = 1.93ns	
T ₁ →T ₃								E: <i>t</i> = 10.36***	<i>t</i> = 2.75**
C: <i>t</i> = 5.69***									
Total problems					21.291***	6.608**	T ₁ →T ₂	E: <i>t</i> = 2.065*	<i>t</i> = 0.735ns
T ₁	63.00	(8.44)	64.86	(10.71)				C: <i>t</i> = 3.202**	
T ₂	60.57	(10.03)	61.00	(12.30)			T ₂ →T ₃	E: <i>t</i> = 4.036***	<i>t</i> = 0.144ns
T ₃	54.75	(7.84)	61.62	(11.15)			T ₁ →T ₃	C: <i>t</i> = 0.587ns	
T ₁ →T ₃								E: <i>t</i> = 6.500***	<i>t</i> = 2.708**
C: <i>t</i> = 2.781*									
Internalizing					17.881***	6.087**	T ₁ →T ₂	E: <i>t</i> = 2.164*	<i>t</i> = 0.153ns
T ₁	64.37	(8.02)	63.96	(12.16)				C: <i>t</i> = 1.334ns	
T ₂	61.64	(10.43)	61.68	(11.22)			T ₂ →T ₃	E: <i>t</i> = 4.326***	<i>t</i> = 0.016ns
T ₃	54.62	(8.84)	61.00	(12.01)			T ₁ →T ₃	C: <i>t</i> = 0.645ns	
T ₁ →T ₃								E: <i>t</i> = 6.868*	<i>t</i> = 2.302*
C: <i>t</i> = 1.710ns									
Externalizing					3.407*	3.104*	T ₁ →T ₂	E: <i>t</i> = 0.952ns	<i>t</i> = 0.668ns
T ₁	57.38	(9.79)	59.17	(10.61)				C: <i>t</i> = 1.545ns	
T ₂	56.35	(10.83)	57.24	(11.53)			T ₂ →T ₃	E: <i>t</i> = 2.153*	<i>t</i> = 0.298ns
T ₃	52.86	(9.78)	58.55	(9.56)			T ₁ →T ₃	C: <i>t</i> = 0.913ns	
T ₁ →T ₃								E: <i>t</i> = 3.179**	<i>t</i> = 2.240*
C: <i>t</i> = 0.526ns									

Note: C-GAS = Children's Global Assessment Scale; CBCL = Child Behavior Checklist; ANOVA = analysis of variance; E = experimental; C = control; ns = not significant.

* $p < .05$; ** $p < .01$; *** $p < .001$.

RESULTS

Means, standard deviations, and values of significance on each of the outcome measures are presented in Tables 2 and 3.

Changes on CBCL Total, Internalizing, and Externalizing Scales

For TP, Internalizing and Externalizing significant group by time and time effects were found. Regarding the significant interaction between time and group, *t* tests between groups showed no significant differences at T₁ and T₂, whereas at follow-up, major improvements in the experimental group appeared. As far as time effect is concerned, *t* tests within groups showed a significant change from T₁ to T₂ in both groups for TP but only in the experimental group for Internalizing. From T₂ to T₃, significant changes for all the three summary scales were found only in the experimental group; this indicates that, from the end of treatment to follow-up, only the experimental group

improved significantly in these scales. The effect size was 0.72 for TP, 0.59 for Externalizing, and 0.61 for Internalizing.

Changes on CBCL Syndrome Scales

A group by time effect was found for two internalizing syndromes: Somatic and Anxious/Depressed. A *t* test between groups showed no significant differences at T₁ and T₂, whereas at T₃, the experimental group had a lower mean score in Withdrawn and Anxious/Depressed, but also in Attention, Delinquent, and Aggressive scales. Regarding time effect, *t* tests within groups indicated that, from T₁ to T₃, the experimental group had significant lower mean scores in all syndrome scales whereas the comparison group improved only in the Withdrawn scale.

The analysis of clinical impact for CBCL TP and Internalizing scales (Fig. 1) showed a transition to a borderline range from T₁ to T₂ for both groups; a further improvement to the nonclinical range was observed from T₂ to T₃ in the experimental group only, whereas the comparison group remained in the borderline range. Regarding

TABLE 3
Rates of Improvement in the Two Groups for CBCL Syndrome Scales

	Experimental		Comparison		ANOVA (<i>df</i> = 56)		Time Comparison	<i>t</i> Test	
	Mean	(SD)	Mean	(SD)	Time	G × T		Within Group (<i>df</i> = 28)	Between Groups (<i>df</i> = 56)
Withdrawn	61.13	(7.50)	62.31	(10.07)	15.156***	2.650ns	T ₁ →T ₂	E: <i>t</i> = 2.084*	<i>t</i> = 0.503ns
T ₁								C: <i>t</i> = 2.165*	
T ₂	58.92	(7.82)	59.34	(9.33)			T ₂ →T ₃	E: <i>t</i> = 3.782**	<i>t</i> = 0.182ns
								C: <i>t</i> = 0.367ns	
T ₃	54.34	(5.51)	58.86	(7.62)			T ₁ →T ₃	E: <i>t</i> = 6.035***	<i>t</i> = 2.585*
								C: <i>t</i> = 2.511*	
Somatic Complaints					2.647ns	4.606*	T ₁ →T ₂	E: <i>t</i> = 0.419ns	<i>t</i> = 0.095ns
T ₁	59.10	(8.51)	58.89	(8.13)				C: <i>t</i> = 2.173*	
T ₂	58.35	(8.79)	56.58	(6.79)			T ₂ →T ₃	E: <i>t</i> = 3.038**	<i>t</i> = 0.853ns
								C: <i>t</i> = 1.238ns	
T ₃	54.79	(6.81)	58.58	(7.62)			T ₁ →T ₃	E: <i>t</i> = 2.710*	<i>t</i> = 1.725ns
								C: <i>t</i> = 0.194ns	
Anxious/Depressed					7.655**	3.838*	T ₁ →T ₂	E: <i>t</i> = 0.375ns	<i>t</i> = 0.262ns
T ₁	64.68	(9.61)	65.44	(12.27)				C: <i>t</i> = 0.752ns	
T ₂	64.03	(10.59)	64.06	(11.00)			T ₂ →T ₃	E: <i>t</i> = 3.74***	<i>t</i> = 0.012ns
								C: <i>t</i> = 0.36ns	
T ₃	57.34	(7.65)	63.62	(10.13)			T ₁ →T ₃	E: <i>t</i> = 4.74***	<i>t</i> = 2.660**
								C: <i>t</i> = 0.45ns	
Social					5.172**	1.502ns	T ₁ →T ₂	E: <i>t</i> = 0.076ns	<i>t</i> = 1.547ns
T ₁	59.41	(8.57)	63.58	(11.72)				C: <i>t</i> = 2.16*	
T ₂	59.85	(9.43)	61.06	(11.08)			T ₂ →T ₃	E: <i>t</i> = 3.309**	<i>t</i> = 0.444ns
								C: <i>t</i> = 0.608ns	
T ₃	56.00	(6.65)	60.13	(11.98)			T ₁ →T ₃	E: <i>t</i> = 2.729*	<i>t</i> = 1.626ns
								C: <i>t</i> = 2.020ns	
Thought problem					7.011**	2.397ns	T ₁ →T ₂	E: <i>t</i> = 1.164ns	<i>t</i> = 0.546ns
T ₁	59.51	(7.91)	58.37	(7.96)				C: <i>t</i> = 1.016ns	
T ₂	57.92	(9.01)	56.82	(7.81)			T ₂ →T ₃	E: <i>t</i> = 2.793**	<i>t</i> = 0.493ns
								C: <i>t</i> = 0.296ns	
T ₃	53.65	(5.73)	56.51	(7.02)			T ₁ →T ₃	E: <i>t</i> = 3.855***	<i>t</i> = 1.700ns
								C: <i>t</i> = 1.434ns	
Attention					7.161**	1.006ns	T ₁ →T ₂	E: <i>t</i> = 1.819ns	<i>t</i> = 1.851ns
T ₁	63.44	(8.41)	68.68	(12.71)				C: <i>t</i> = 2.463*	
T ₂	61.28	(9.31)	65.75	(11.76)			T ₂ →T ₃	E: <i>t</i> = 2.261*	<i>t</i> = 1.588ns
								C: <i>t</i> = 0.310ns	
T ₃	58.00	(6.97)	66.10	(10.71)			T ₁ →T ₃	E: <i>t</i> = 3.944***	<i>t</i> = 3.414***
								C: <i>t</i> = 1.758ns	
Delinquent					1.702ns	0.441ns	T ₁ →T ₂	E: <i>t</i> = 0.423ns	<i>t</i> = 0.921ns
T ₁	56.27	(7.16)	58.20	(8.72)				C: <i>t</i> = 1.755ns	
T ₂	55.21	(6.99)	56.44	(8.38)			T ₂ →T ₃	E: <i>t</i> = 1.339ns	<i>t</i> = 0.602ns
								C: <i>t</i> = 0.323ns	
T ₃	53.41	(4.90)	56.82	(7.37)			T ₁ →T ₃	E: <i>t</i> = 2.235*	<i>t</i> = 2.076*
								C: <i>t</i> = 1.090ns	
Aggressive					1.532ns	2.764ns	T ₁ →T ₂	E: <i>t</i> = 0.283ns	<i>t</i> = 0.748ns
T ₁	59.13	(9.34)	61.10	(10.63)				C: <i>t</i> = 1.787ns	
T ₂	59.10	(10.48)	59.06	(9.44)			T ₂ →T ₃	E: <i>t</i> = 1.968ns	<i>t</i> = 0.014ns
								C: <i>t</i> = 1.175ns	
T ₃	56.20	(6.98)	60.72	(8.61)			T ₁ →T ₃	E: <i>t</i> = 2.610*	<i>t</i> = 2.194*
								C: <i>t</i> = 0.251ns	

Note: CBCL = Child Behavior Checklist; ANOVA = analysis of variance; E = experimental; C = control; ns = not significant.

* *p* < .05; ** *p* < .01; *** *p* < .001.

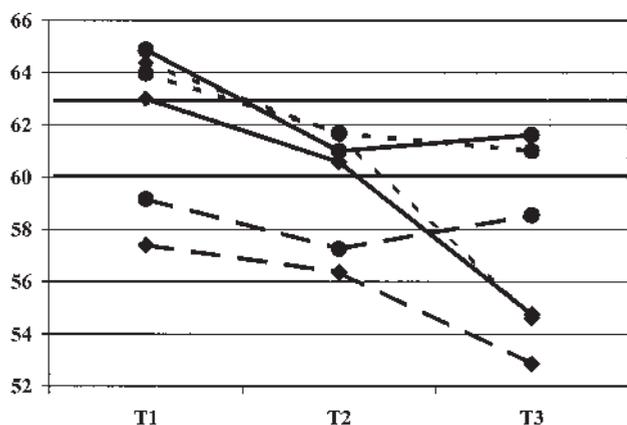


Fig. 1 Developmental course of Total (black lines), Internalizing (short-dotted lines), and Externalizing (long-dotted lines) problems on the Child Behavior Checklist summary scales before and after psychodynamic psychotherapy (PP) (squares) compared with comparison group (circles). The bold parallel lines indicate the cutoff ranges for borderline (above 60) and clinical (above 63) values. The figure shows a transition to a borderline range from T₁ to T₂ for both groups. A further improvement to the nonclinical range is observed from T₂ to T₃ only in the PP group, whereas the comparison group remains in the borderline range.

individual cases (Table 4), there were no significant group differences at T₁ and T₂. At follow-up, more PP children moved to the normal range in the TP scale ($\chi^2_1 = 4.42$; $p < .05$) and the Externalizing scale ($\chi^2_1 = 3.658$; $p = .06$). As far as syndrome scales are concerned, more PP children moved significantly to nonclinical range at the Withdrawn ($\chi^2_1 = 6.692$; $p < .05$), Attention ($\chi^2_1 = 10.07$; $p < .05$), Delinquent ($\chi^2_1 = 4.062$; $p < .05$), and Anxious/Depressed scales ($\chi^2_1 = 3.39$; $p = .07$).

Changes on C-GAS

Group by time and time effects were found. As regards group by time effect, tests between groups showed no significant difference at T₁, whereas at T₂ and at follow-up, the experimental group had higher mean scores. As concerns time effect, a *t* test within group showed significant improvements in both groups from T₁ to T₂ and no change from T₂ to T₃ for either group. This means that improvement appears in a short time in both groups, with maintenance at 2 years; the magnitude of the change is greater in the experimental group. The effect size for C-GAS was 0.73.

The analysis of clinical impact for C-GAS showed that, whereas at T₁ means of both groups were in the dysfunctional range (<70), at T₂ and T₃ only the mean of the experimental group had moved to the functional range (>70); more PP children (Table 4) had proportionally moved to the functional range at both T₂ ($\chi^2_1 = 9.03$; $p < .05$) and T₃ ($\chi^2_1 = 7.324$; $p < .05$).

Alternative Service Use

Between T₂ and T₃, 34.48% of the comparison-conditions patients and 10.34% of the treatment-conditions patients sought mental health services. These two rates differed significantly ($\chi^2_1 = 4.71$; $p < .05$).

DISCUSSION

The comparison between the experimental and comparison group allows us to point out some similarities and some significant differences in their courses. Briefly, there is evidence that conditions of treatment influence the rate of change, with major improvements in the experimental group.

On the C-GAS, both groups improved significantly in the first 6 months after the first evaluation, but only the experimental group showed a shift to the nonclinical range maintained at the 2-year follow-up. On the CBCL, no group difference emerged in the first 6 months, whereas at 2-year follow-up, only the experimental group improved significantly in all summary scales and in most related syndromes.

The finding of a significant improvement in global functioning for the whole sample is only partially unexpected. One interpretation could be linked to the fact that treatment is applied in the course of development and that changes are likely to result from developmental processes. This view is consistent with the concept of ID as being transient. In this view, it could be argued that treatment had no impact on outcome because the process of change was developmental rather than psychotherapeutic. An alternative hypothesis is that the positive changes result from the approach used during assessment. Several investigations report clinical improvements following brief assessment contacts (Barrett et al., 1978). This view is supported by several studies on brief therapy (Smyrniotis and Kirkby, 1993), concluding that it would be valid to consider "minimal control procedure" as a treatment because during the assessment the clinician establishes a therapeutic relationship and provides feedback to children and their parents. Suggesting to the families in the feedback session that they can work somewhere on their problems and giving them a follow-up appointment could engender a sense of self-efficacy that would facilitate change (Bandura and Cervone, 1983). A third explanation concerns the fact that 48.3% of the comparison group was under some kind of active treatment, and these treatments likely had a positive effect beyond the initial assessment period.

TABLE 4

Significant Differences Between Groups at T₁, T₂, T₃ in Ratio of Cases Moving to Nonclinical Range for C-GAS and CBCL

Measures	Experimental: n (%)			Comparison: n (%)			<i>p</i>		
	T ₁	T ₂	T ₃	T ₁	T ₂	T ₃	T ₁	T ₂	T ₃
C-GAS	6 (20.69)	24 (82.76)	23 (79.31)	5 (17.24)	13 (44.83)	13 (44.83)	<.05	<.05	<.05
CBCL-TP	11 (37.93)	13 (44.83)	19 (65.52)	10 (34.48)	11 (37.93)	11 (37.93)			<.05
CBCL-Int	7 (24.14)	11 (37.93)	18 (62.07)	10 (34.48)	12 (41.38)	13 (44.83)			
CBCL-Ext	17 (58.62)	17 (58.62)	22 (75.86)	17 (58.62)	17 (58.62)	15 (51.72)			.07
Withdrawn	22 (75.86)	22 (75.86)	29 (100)	17 (58.62)	22 (75.86)	23 (79.31)			<.05
Anxious/Depressed	21 (72.41)	18 (62.07)	25 (86.21)	18 (62.07)	17 (58.62)	19 (65.52)			.06
Attention	17 (58.62)	19 (65.52)	26 (89.65)	13 (44.83)	15 (51.72)	15 (51.72)			<.05
Delinquent	23 (79.31)	25 (86.21)	28 (96.55)	22 (75.86)	23 (79.31)	23 (79.31)			<.05

Note: Syndrome scales with no significant difference are not reported. C-GAS = Children's Global Assessment Scale; CBCL = Child Behavior Checklist; TP = Total Problem score; Int = Internalizing score; Ext = Externalizing score.

Even if the two groups improved significantly, the analysis of clinical impact showed that only the experimental group passed to a functional range; this means that children who received the PP became less impaired by their symptoms. Such different patterns of change could indicate that PP produces a better improvement in global functioning than the routine support received by the comparison group.

Changes on the CBCL have a different trend, showing a significant major improvement of the experimental group only at the 2-year follow-up. These data seem to provide evidence of the "sleeper effect." Weiss et al. (2000) summarized different hypotheses that explain the sleeper effect for child psychotherapy. One is that in nonbehavioral approaches like ours that can be defined as representation-oriented, changes in insight and self-awareness may produce more of a delayed treatment effect than in behavioral treatments that work directly on behavioral patterns (Kendall, 1991). We can hypothesize that changes in the shared representational world, promoted by our type of PP, are able to first prime changes in parent-child interaction and only after a period of time in the child's behavior.

The different timing of the improvement of the experimental group on C-GAS and CBCL sheds light on the importance of nonlinear treatment outcomes. We hypothesize that the rate of improvement in global functioning tends to decrease when the children's functioning approaches normal cutoff. We can also hypothesize that the lack of consistency of results depended on the use of two different informants: the clinician who rates the C-GAS could be more sensitive in appreciating the child's improvement in global functioning when symptomatology is not yet reduced from the point of view of the parents. As pointed out in

several treatment supervisions, parents need time to accept changes in the behavior of their child (Weiss et al., 2000).

CBCL results indicate that PP acts not only on internalizing symptoms, as expected, but also on externalizing dimensions with significant lower mean scores at follow-up of experimental group in attention, delinquent, and aggressive scales. This finding deserves attention because it seems that the PP may affect both of these two dimensions, can reduce comorbidity, and could also be responsible for the less frequent use of mental health services in the experimental group during long-term follow-up. The important finding that patients in the comparison condition sought mental health services at a significantly higher rate than PP patients seems to indicate that an intensive, focused, relationship-based psychotherapy has a more enduring effect than a collection of services that are likely to be poorly coordinated.

Limitations

Several limitations restrict the findings of the present study. First, the lack of totally random assignment of subjects could have introduced bias into patient allocation; this bias, determined by the setting of routine clinical care for referred children, is mitigated by the fact that no differences between groups were identified on demographic and clinical variables at baseline.

Second, children of the comparison group are not homogeneous on treatment condition. Given that 51.3% of the comparison group did not receive any kind of treatment, the results may be indicative of nonspecific treatment effects as opposed to effects specific to psychodynamic treatment. The lack of homogeneity must be ascribed to the fact that the study was carried out in a naturalistic

clinical setting in which ethical considerations prevented us from having children without any form of treatment. The continuation of the research will try to deepen the assessment of PP efficacy through more precise comparisons between experimental conditions, no treatment, and specific active comparison conditions. Nevertheless, that part of the comparison group had some form of therapy does not undermine our findings because it reduces a negative Hawthorne effect for the comparison group.

Third, even if all children reached full criteria for one or more categorical diagnosis, the CBCL score means appear lower compared with other clinical samples (Kendall et al., 2001). This is probably due to the composition of our sample, where SAD and specific phobias often occur with no comorbidity and represent 80.5% of total anxiety disorders, which is a higher percentage compared with the Kendall sample, where SAD represents only 22.2% and the internalizing mean score is higher (66.6). The increase of the whole sample will allow us to carry out further studies on subgroups to verify which kind of ID are more suitable for this specific treatment and whether the severity of the disorder measured through the CBCL could be related to the efficacy of our treatment.

Fifth, we have not developed a multiple-level outcome to evaluate the appropriateness of the PP model for a larger set of characteristics of patients in accordance with the current methodological literature (Jensen et al., 1996; Kazdin, 2000). In the present study, we have considered symptoms, diagnosis, and adaptation to the psychosocial environment, without extending the evaluation to transactional level, mechanism-process level, and change in the family. In particular, the assessment of changes in family and child functioning, which probably underpin both symptomatology and adaptation, seems to be highly important and congruent with our PP model, where the focus is oriented to parental and child representations. By developing this area, it may be possible to become more aware of how PP achieves change.

Finally, families in our sample reflect specific aspects of Italian society, and this poses the question of which modifications are needed to extend our therapeutic model to other countries where intact families are rarer and where single-parent and blended families are much more represented.

Clinical and Research Implications

Despite these limitations, the finding that, in addition to symptom reduction and functioning improvement,

PP reduces the risk of relapse and addresses treatment of comorbid conditions, has broad implications. First, our findings permit us to propose PP as a useful therapeutic tool in ID. Second, the improvements in the externalizing dimension of ID could suggest new research on efficacy and effectiveness of PP for externalizing disorders. Third, a time-limited and structured treatment was applied to routine clinical care, making research not too far removed from real-world clinical conditions. Fourth, effectiveness of PP is shown by means of the less frequent use of mental health services, and the prevention of relapse represents an important economic impact of psychotherapy. Finally, our study illustrates the importance of developing empirical research on psychodynamic-oriented treatment widely applied in clinical practice but less frequently studied through careful, long-term outcome evaluation. Moreover, considering the intensive involvement of the parents in our combined PP, an area of future research could concern differences between PP which do not work intensively with the parents' representations, addressing the question of which kinds of ID are more suitable for this specific treatment.

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