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The Efficacy of a Brief Supportive Psychodynamic Therapy in Treating Anxious-Depressive Disorder in Daily Hospital

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A B S T R A C T

Study objective is to determine the efficacy of brief supportive psychodynamic therapy in treating anxious-depressive disorder in Daily hospital wwithin the Psychological Medicine Clinic. The study comprised a total of 45 male subjects, in which an admission to the Daily Hospital was indicated. On the occasion of the hospital admission, as well as following the completion of a one month-lasting partial hospitalisation within the Daily Hospital, the subjects had undergone testing using a number of psychological instruments. There weren't established statistically significant differences in clinical presentations of the treated patients. A partial, one month-lasting hospitalisation, did not yield any changes in clinical presentation an anxious-depressive disorder. Due to the fact that this psychotherapeutic method should be applied for quite some time in order to yield results, and is not expected to be effective in a close range, a one-month lasting treatment is definitely not long enough to be effective.

Key words: *supportive psychodynamic therapy, anxiety, depression*

Introduction

The forms of treatment carried out in Daily Hospital settings, irrespective of their location either on somatic, or psychiatric wards' premises, have recently become a world trend. As regards psychiatric patients, the organisational pattern of daily in-hospital treatment is intended to limit patients' regression. Partial hospitalisation is cost-effective and, from a medical standpoint, represents the therapeutic method of choice. Patients and their families express a high level of satisfaction with a partial hospitalisation; the latter leaves the patients under the impression that they are not under so much coercion as with conventional hospitalisation, and leaves them less alienated and closer to reality, since a partial hospitalisation aims at creating as realistic images of life as possible. The concept of partial hospitalisation has been developed for the last fifty years. It is founded on the principles of decreasing coercion, increasing the reality of the situation, and creating a non-hospital setting[1]. Partial hospitalisation provides for a coordinated, intensive and multidisciplinary approach to the patient. During the course of an in-hospital stay, the role designation and the differentiation of characters into the active physician and an inactive patient, contributes to the regression towards the treating physician. Organisation of the treatment in the daily hospital, in which all efforts are made to encourage the patients to actively participate in their treatment to the greatest possible extend, is less motivating in terms of developing regression. In addition, patients remain in a daily contact with their families, and are consequently less regressive towards the institution[2]. There existed the idea that some of the patients could continue attending to their professional duties even during the course of the treatment; however, a real-life practice revealed this idea to be unfeasible. With psychiatric patients, partial hospitalisation (a Daily Hospital treatment) was proven to be warranted beyond a shadow of doubt; however, the efficacy of such a treatment depends on the nature of the disorder and patient's state of illness[3].

Partial hospitalisation has been proven efficient in cases of a major depressive episode, depressive disorder,

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dysthimia, anxiety disorder, and adaptation disorder. The improvements have also expressed themselves in lowering of the distress level, mood improvements, improvements in social functioning, rise in self-confidence, the establishment of adequate challenge-confronting mechanisms, and the improvement in organisational skills[4]. Partial hospitalization has demonstrated its efficiency in personality disorders as well, and led to the improvement in social and family functioning, the increase in the establishment of inter-personal relationships, the increase in life satisfaction and self-esteem, and resulted in the decrease in psychical complaints' intensity. Not all patients respond well to partial hospitalization treatments. Partial hospitalization failed to demonstrate its efficiency in patients suffering from an acute stress disorder (characterized by a psychotic clinical presentation). However, the mechanism underlying the reactions to partial hospitalization treatments, expressed by certain categories of psychiatric patients, hasn't been fully clarified yet[5].

The most common patient populations hospitalized within the Daily Hospital hosted on the premises of the Psychological Medicine Clinic, are those diagnosed with anxiety or depressive disorder, and anxiety-depressive disorder, even though, when it comes to anxiety disorders, they are lately often out-numbered by PTSD patients. The high level of efficacy in treating the above-mentioned disorders in daily hospital settings, have been shown in a number of studies. Daily Hospital environment enables the patient to preserve his/her individuality and autonomy, which is exactly the primary goal of the treatment, as well as the growth and development of each person[1]. The studies have revealed the existence of changes in persons suffering from an anxiety disorder, hospitalized within a Daily Hospital; however, it should be noted that the psychotherapeutic treatments in questions were based on the interventions falling within the category of cognitive-behavioral psychotherapeutic approach[6]. In addition, cognitive-behavioral treatment carried out on a group level, and employed in partially hospitalized persons suffering from a panic disorder, has yielded fair, satisfactory results[7].

Unlike psychotherapies carried out in outpatient health care settings, brief supportive psychodynamic therapy in Daily Hospital has demonstrated its successfulness in patients suffering from a borderline personality disorder. Individual and group psychotherapy, initiated within the frame of a partial hospitalisation, were carried out for not more than 18 months[8].

The anxiety is a state of diffuse and unpleasant tension, accompanied by fretfulness of a vague nature, as well as trepidation[9]. It is often accompanied by somatic sensations, which reflect the excitation of the autonomous nervous system (both symphatic and parasymphatic). Everyday-functioning is characterised by a lower level of efficacy, and the affected persons are constantly worrying about something, which prevents them from relaxing in an adequate manner, and release tension[10].

Depressive neurotic reactions are typically manifested by a bad mood, and the feeling of hopelessness and inadequacy; self-confidence and self-esteem are both lowered, vital dynamics (appetite, libido, sleep) is disturbed, and the level of emotions and vitality is low. The affected persons are overwhelmed with the feelings of guilt, inadequacy and uselessness[9]. Unlike other depressive disorders, a depressive reaction does not necessarily imply the retreat from emotional relationships; however, the affected persons show no interest in other people, things and activities. Depressive neurotic reactions are essentially mood disorders, in which tension and anxiety demonstrate themselves through self-undervaluation, somatic complaints, and the feelings of worthlessness and guilt. Depressive persons are sensitive and vulnerable to everything that undermines or seriously jeopardises their ability to satisfy their basic needs. They are also vulnerable to everything that diminishes their self-confidence and self-esteem.

An anxious-depressive disorder is a diagnostic category applicable to patients who present with the symptoms of anxiety and depression, but lack the prevalence of any of the two. In other words, when analysed separately, none of the symptoms falling into any of these two categories does not prevail to the extend that allows for the establishment of an individual diagnosis[9]. Bearing in mind the previous research that had demonstrated satisfactory effects of partial hospitalisation in treating psychic disorders, the aim of this study was to investigate the efficacy of brief supportive psychodynamic therapy in Daily Hospital carried out within the Psychological Medicine Clinic, and applicable to the persons suffering from a pronounced anxious-depressive disorder.

Subjects and Methods

Patients

The study was carried out in 2004, and comprised the subjects hospitalised in the Daily Hospital, hosted on the premises of the Psychological Medicine Clinic. The study embraced a total of 72 subjects, but, due to a substantially high drop-out rate, only the outputs of 45 subjects had been processed within its frame. The subject recruitment was limited to males only, while females represent a smaller portion of the patient population hospitalised in the Daily Hospital, so that the sample could not be adequately balanced as regards the subjects' gender. Only the patients exhibiting the symptoms falling within the anxious-depressive circle, or those diagnosed with an anxious-depressive disorder on the occasion of their psychiatric visit, were considered eligible for this research. Patients suffering from other psychic discomforts, as well as co-morbid anxious-depressive patients, were considered ineligible. Patients who were pre-morbidly adjudicated as inadequately structured, as well as markedly regressive patients, such as those presenting with severe psycho-organic alterations, florid psychosis, proneness to suicide and homicide, were also excluded from the study sample. All of the subjects had been adequately medi-

cated as prescribed by the treating psychiatrist. The diagnoses were established based on the International Classification of Diseases and Disorders-10th Edition (ICD-10), and left to the discretion of the treating psychiatrist. All the examinees embraced by this study, originated from the Zagreb Prefecture, and had completed a high school education. The majority of them (77%) were employed, but on long-term sick-leaves, while 23% were unemployed. Their age ranged from 35 to 56.

The daily routine of the Daily Hospital located on the premises of the Psychological Medicine Clinic, is organised in conformity with the therapeutic community patterns and principles, supplemented by the elements of the milieu therapy. The treatment is carried out in small and large group settings, as well as in individual ones.

Group treatment has been demonstrated to be successful in various clinical settings and with various patient profiles. It aims at preventing a non-functional and non-adaptive pattern of behaviour, as well as the enhancement of a personal growth and the alleviation of behaviouristic and experiencing alterations[7]. The therapeutic team providing treatment within the Daily Hospital located on the premises of the Psychological Medicine Clinic consists of four psychiatrists, psychologists, a senior nurse, three junior nurses and a social worker. In an indirect manner, daily practice of the Daily Hospital in reference engages also other therapists affiliated with the Psychological Medicine Clinic, whose patients are provided treatment within the Daily Hospital, while during the course of such a treatment, the concurrent therapies are not supposed to be discontinued. The eligibility of the patients as to be treated within the Daily Hospital was assessed by an indicative interview, which, if necessary, may take place day after day. They are conducted by psychiatrists affiliated with the Daily Hospital. Patients are referred to such an interview by their treating psychiatrists or Family Medicine practitioners. The duration of the hospitalisation in the Daily Hospital is limited to a month. All patients were admitted on the same day, with no incomers within the next month. Their next therapeutic cycle could be scheduled in a six months' time, however, due to a great number of patients referred, this time-frame has to be extended. The milestone of psychotherapy provided within a Daily Hospital is group psychotherapy. Group séances were scheduled three times a week, and lasted for an hour, with a half an hour-break between the two of them. The first séance is chaired by a co-therapeutic couple, and the second by a nurse trained in group psychotherapy. Once a week, a dynamically--chaired large group is scheduled. All patients currently hospitalised in the Daily Hospital take part in this séance, which is also joined by some of the previously hospitalised patients, currently treated in the outpatient settings. The meeting of the therapeutic community takes place once a week. A socio-therapeutic group, chaired by a social worker, takes place once in two weeks. While in session, these groups discuss the problems faced by the patients in their everyday-life. Patients also make contacts with the social worker on an individual basis. On the occasion of their very first hospitalisation, the social worker summons each patient and conducts an individual interview, during which data on the patient's social background are collected. Every two weeks, a group therapy utilising a movie is carried out, chaired by a psychiatrist-psychotherapist.

Psychotherapeutic methods, exercised within the Partial Hospitalisation Ward, are individual and group psychotherapy, as well as predominantly supportively-led small group, supplemented by a certain dynamic elements, together with dynamically-led large group and socio-therapeutic group. Although the psychiatrists affiliated with the Daily Hospital are well-educated in group dynamics, the therapeutic procedure is predominantly characterised by the supportive therapeutic elements, targeted at the diminishment or elimination of anxiety.

Following the enlistment into the Daily Hospital, the patients were referred to a psychologist in order to undergo psychological evaluation based on the clinically--structured interview (in German: Strukturiertes Klinisches Interview; SKID I), and, in the event of meeting the criteria, the examinee (suffering from an anxious-depressive disorder), took tests employed in order to examine the personality features, the anxiety and the depression (PIE -Plutchik Emotional Profile Index; STAI – State-Trait Anxiety Inventory; and BDI – Beck Depression Inventory). The testing was carried out on a group and individual level, depending on the number of patients referring to the Daily Hospital on that very day; the patients had received detailed instructions and provided with the explanation as to the purpose of the study. The patients were asked to retake the tests following the completion of their treatment in the Daily Hospital, observing thereby the pre-set test term (scheduled at month 1).

Psychological instruments utilised

SKID I – Structured clinical interview targeted at DSM [Diagnostic and Statistical Manual of Mental Disorders] (IV) Axis I. disorders.

PIE (Plutchik Emotional Profile Index) – the personality questionnaire originating from the emotional theory founded on the multidimensional model, set off from the notion that the responses of an adult are based on eight basic or primary emotions (fear, anger, joy, sorrow, acceptance, reluctance, and expectation). The emotions vary in their intensity (for instance, panic is more intense than fear, while anger is more intense than agitation), their polarity i.e. controversy (for instance joy versus sorrow, anger versus fear). The questionnaire consists of a list of words put down in pairs, the words in reference thereby describing some of the human characteristics. The task put in front of an examinee, is to pick a word from a pair that better describes him/her. The questionnaire falls within the category of forced choice, and comprises 62 items, i.e. terms referring to different personality features. It measures the incorporation (i.e. the dimension that indicates the emotional state of acceptance), self-protection (implying the emotional state of fear), deprivation (indicating the emotional state of sor-

row), oppositionality (the emotional state of rejection), aggressiveness, reproduction (indicates the emotional state of joy), exploration (the emotional state of expectation and planning), uncontrollability (reflects the emotional state of impulsiveness, i.e. the urge for new experiences and adventures). The test-retest accuracy approximates 0.90, while the reliability of individual dimensions ranges from 0.61 to 0.90. The scores beyond 60 are interpreted as high, those between 40 and 60 as average, while the scores under 40 are interpreted as low. Only high and low PIE scores are subject to interpretation.

STAI (State/Trait Anxiety Inventory) – The questionnaire in reference consists of 40 items of the Likert type, with which the examinee is expected to circle one of the numbers offered on the menu (ranging from 1 to 4), his/her choice thereby being based on the pronouncement of the certain item (claim). The questionnaire refers to anxiety as the state (i.e. the intensity of the anxiety experienced by the person while completing the questionnaire) and anxiety as a feature (the usual level of anxiety experienced by the person in question). It has been translated into Croatian, and exhibits excellent metric characteristics.

BDI (Beck Depression Inventory) – This questionnaire represents a self-describing method, and consists of 21 items related to the symptoms of depression, while the task to be confronted by the examinee is to circle one of the numbers offered with each item (of the Likert type, ranging from 0 to 3). The questionnaire in reference exhibits good metric characteristics (alpha coefficient approximately 0.80), and has been translated into Croatian. It is sensitive to changes in intensity and structure of the symptoms induced by psychotherapy or pharmacotherapy. It measures changes week by week, and is capable of satisfactory discriminating a mild, moderate and profound depression.

Statistical analysis

For the purposes of data processing, SPSS 11.0 (SPSS Inc. Chicago, USA; 2003) had been employed. The obtained results do not statistically differ significantly from the normal distribution pattern, so that descriptive and parametric statistics were used accordingly.

Results

The average values of individual emotions, experienced prior and following the partial hospitalisation are shown in Table 1. Crude analysis revealed the lack of significant changes of emotions experienced prior and following the partial hospitalisation. The afore-stated is substantiated by the results of the t-test (Table 2). The obtained profile of the average emotional values encountered among 45 examinees comprised by this study, suggests their introvert profile and proneness to social retreat and distrust in other persons. They are characterised by pronounced depressive symptoms, the feeling of sorrow and emptiness, accompanied by non-satisfaction with their life prospective. The persons in question are prone to exhibit their aggressive pulsions in passive-aggressive, aggressive, but also self-aggressive patterns of behaviour. The obtained patient profile was interpreted by the authors having a multiyear experience in Clinical Psychology and psycho-diagnostic techniques. The profile was interpreted in accordance with the codes of practice applicable to the PIE test. Tables 1 and 2 reveal no shift in individual emotional values expressed in PIE scores obtained following the completion of the partial hospitalisation, which would otherwise result in a different kind of interpretation of the obtained profile. Table 3 shows average anxiety values expressed through STAI scores, as well as depressiveness expressed through BDI scores, applicable to the patients enrolled into the study, and taken prior and subsequent to the hospitalisation. The employed statistical procedure, applicable for related samples, indicates the lack of changes both in the anxiety as a state, and the anxiety as a feature, as well as the lack of changes in depressiveness, noted following the completion of a partial hospitalisation ($t=0.581$ $p=0.569$; $t=0.055$ $p=0.957$; $t=0.709$ $p=0.488$: Table 4).

TABLE 1
THE AVERAGE VALUES OF EIGHT EMOTIONS EXPERIENCED BY THE SUBJECTS INVOLVED INTO THE STUDY, OBTAINED PRIOR AND FOLLOWING THE PARTIAL HOSPITALISATION.

	Prior	Afterwards
Variable	M ± SD	M ± SD
Reproduction	13.43 ± 5.43	12.76 ± 4.35
Incorporation	12.56 ± 4.67	12.39 ± 5.05
Uncontrollability	53.06 ± 19.04	53.06 ± 19.04
Self-protection	39.78 ± 12.56	41.28 ± 11.34
Deprivation	73.89 ± 13.15	74.17 ± 13.9
Oppositionality	63.83 ± 12.04	64.11 ± 10.43
Exploration	52.56 ± 13.44	53.78 ± 13.85
Aggressiveness	73.33 ± 16.51	73.50 ± 16.51

TABLE 2
T-TEST VALUES OBTAINED WITH EIGHT EMOTIONES EXPRESSED THROUGH PLUTCHIK EMOTIONAL INDEX

Emotions	t	P
Reproduction	0.11	0.913
Incorporation	0.074	0.942
Uncontrollability	0.000	1
Self-protection	0.529	0.604
Deprivation	0.07	0.942
Oppositionality	0.108	0.915
Exploration	0.435	0.669
Aggressiveness	0.049	0.960

Discussion

The study discussed within the frame of this article, failed to demonstrate any changes in the clinical presen-

TABLE 3
THE AVERAGE VALUES OF ANXIETY AND DEPRESSION, ACCOMPANIED BY THE CORRESPONDENT STANDARD DEVIATIONS, OBSERVED IN THE STUDIED SUBJECTS PRIOR AND FOLLOWING THEIR PARTIAL HOSPITALISATION

	Prior Afterwards
	M ± SD M ± SD
Anxiety as a state	69.67 ± 7.348 70.67 ± 7.874
Anxiety as a feature	66.67 ± 8.752 66.56 ± 8.305
Depressiveness	31.89 ± 7.661 33.28 ± 8.435

TABLE 4
T-TEST VALUES OBTAINED WITH ANXIETY MEASURED ON THE STAI SCALE, AND WITH DEPRESSIVENESS MEASURED ON THE BDI SCALE

	t	P
Anxiety as a state	0.581	0.569
Anxiety as a feature	0.055	0.957
Depressiveness	0.709	0.488

$p<0.05$ is considered statisticallynt significa

tation prior and following the partial hospitalisation. No differences in emotional profiles, measured using PIE, and the presentational level of depressive symptoms, had been encountered. In addition, the differences in anxiety as a state, and the anxiety as a personal characteristic, adjudicated prior and subsequent to the partial hospitalisation, were also non-existent. The reasons underlying such findings could be of various natures. The very act of taking a battery of tests could be stressful on its own, so that the unchanged pattern of anxiety as a state could be anticipated. It can be assumed that the subjects embraced by the study, failed to develop adequate mechanisms of stress reduction, which would aid in more successful confrontation with frustrating and stressful situations (which certainly calls for psychological evaluation), but rather exhibit anxious reactions in response.

Previous studies had demonstrated satisfactory effects of partial hospitalisation targeted at persons suffering from an anxiety disorder, while the treatment carried out within this frame had been based on cognitive-behavioural principles. The subjects had been hospitalised in the Daily Hospital for 5 weeks (6). Other studies have shown some improvements in the clinical presentation of the persons suffering from a panic disorder, encountered after a two week-treatment[7]. In addition, the studies had demonstrated that partial hospitalisation grounded on the psychoanalytic therapeutic patterns, exhibits satisfactory efficacy in treating personality disorders (borderline personality disorder), provided that the treatment is carried on for a longer period of time[8].

There exist no investigations available to us, dealing with the impact of partial hospitalisation on the patients suffering from an anxious-depressive disorder, so that adequate comparisons of the findings could not be taken. We are unable to claim with certainty that the application of cognitive-behavioural psychotherapy would lead to the improvement in clinical presentation of our patients, as well; however, it should be noted that the practice exercised within the Daily Hospital is founded on therapeutic techniques that call for a long-lasting treatment, so that a one month-period, foreseen as a follow-up period within the frame of this study, is, beyond a shade of doubt, too short to allow for the partial hospitalisation to take effect. The goal aimed by the supportive psychotherapy alone (i.e. the psychotherapeutic methods often employed in the Daily Hospital settings), is often limited; it aims towards the achievement of certain changes in patient's behaviouristic pattern, i.e. at comprehension and acceptance of the inner conflicts and problems, and more realistic confrontation with the latter. Such a brass goal calls, beyond any doubt, for a treatment longer than partial hospitalisation, so it should be understandable why no changes in the patients' clinical presentations were observed. Psychological instruments utilised within the frame of this study, are sensitive to changes in clinical presentation occurring even after short-term psychotherapeutic interventions; however, they are incapable of measuring the level of comprehension and acceptance of inner conflicts and problems (no psychological instruments capable of objectively and, psychometrically speaking, satisfactory measuring the aforementioned are currently available on the market). Therefore, the objectification as to the improvement in clinical presentation, carried out on the basis of psychological instruments utilised herein, is limited. Several attempts had been taken as to compare the psychoanalytical and cognitive-behavioural approach to the treatment of psychic discomforts; however, the studies in question have never been completed due to the substantial duration of the treatment necessitated by the psychoanalytic approach. Due to the very nature of the psychotherapeutic approaches, the first author is of the opinion that its combined administration with cognitive-behavioural approach would yield satisfactory results. Cognitive-behavioural approach is not time-consuming, and aims at solving situational problems, having thereby a clearly defined goal. The skills that are particularly encouraged are the problem-solving ones [11]. The therapy provides a rapid feed-back. By virtue of solving situational problems, an individual is enhanced to better realise the causes underlying his/her own functioning, more easily perceive the deprived contents, and better focus to conflicts he/she is unaware of, which can, no doubt about it, unexceptionally be accomplished by psychoanalytical psychotherapy[11]. Cognitive-behavioural therapy represents a certain bond between psychoanalytical and behavioural therapy[12]. In recommendations proposed for various kinds of psycho-pathological disorders, the American Psychiatric Association suggests the observation of

behavioural-cognitive technique in as much as 80% of the different disorders[12].

By all means, the hypothesis proposed by the first author, should be verified during the course of further research. Regardless of the psychotherapeutic frame utilised in a particular case, in order to gain success during the course of a therapeutic procedure, the patients should be highly motivated to undergo treatment and eager to be cured. It would be highly inappropriate to presume that the patients embraced by this study were unmotivated to undergo treatment; nevertheless, taken that the majority of them is unemployed, existentially jeopardised, and lacking any perspectives to resolve the unemployment problem, they can hardly expected to exhibit any substantial changes in their behaviouristic and experiencing pattern. A psychological mastermind, Sam Maslow, the author of the hierarchic theory of human motivation, based on which he had arranged human needs in a hierarchical fashion, had pointed out that, in case the primary needs (the need for food and water, met on the account of steady job, and safe residence), are not met to a satisfactory extend, one could not even think of satisfying the needs for safety, love, and not to mention the need for self-actualisation, and even more so, curing. Unfortunately, the social climate is discouraging, with the majority of population being unemployed and, at the same time, the social demands are steadily increasing, while the illness itself prevents the person to adequately respond to the demands imposed on him/her day after day. The illness itself, irrespective of its psychical or somatic nature, often represents an obstacle to taking a job, even though it might be in a stage of remission. Being fully aware of their inability to find an appropriate employment, the patients seek various modes of ensuring their existence, so that they are often driven by secondary and tertiary benefits arising on the account of illness. Both secondary and tertiary benefits hardly pose as motivating factors for curing, which could be partially reflected also in the results obtained by this study. The studies conducted on this matter, have demonstrated the relevance of the secondary benefit concept, reflecting itself in the awareness of the hiding-behind-the illness--concept and pasivisation, as well as the significance of the secondary benefit in the limitation of therapeutic effects[13,14].

It should be noted that this study is characterised by certain limitations. The lack of control groups makes the conclusions somewhat difficult to draw, as do the lack of a long-term follow-up and the lack of the strict monitoring of/control over the compliance with the prescribed psycho-pharmacological therapy, the latter unquestionably representing an unavoidable part of each and every therapeutic process.

The follow-up studies of the effects gained by psychotherapy are scarce and rare, so that no adequate comparison with the current study could be made. Their rareness should come as no surprise, since they carry a burden of numerous methodological traps, already elaborated herein. However, this study scratches the surface, and leads the way to a more systematic research in this crucial field of interest.

Conclusion

A one month-lasting partial hospitalisation, based on psychodynamic principles, failed to yield any changes whatsoever in clinical presentations of the patients diagnosed with an anxious-depressive disorder. As a matter a fact, no shifts in depressiveness, anxiousness, or emotional profiles subsequent to the hospitalisation, had been noted. Due to the fact that the psychotherapeutic method in question calls for a longer treatment, and is unable to yield short-term results, a one-month lasting hospitalisation is, no doubt about it, too short to bring the patients to terms. The presence of secondary benefits (the unconscious process of hiding behind the illness, and pasivisation exercised in order to gain compassion, empathy and favour of the surroundings as regards psychical discomforts, alike the habit of seeking attention and more intense care), as well as the presence of tertiary benefits (the conscious process of benefiting from the illness, for instance, in form of a disability-supporting retirement), could have affected the results, and mask the actual effects of psychotherapeutic treatments undertaken during the course of the partial hospitalisation.

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EFIKASNOST KRATKE SUPORTIVNE PSIHODINAMSKE TERAPIJE U LIJEČENJU ANKSIOZNO-DEPRESIVNOG POREMEĆAJA U DNEVNOJ BOLNICI

S A Ž E T A K

U radu je ispitivana efikasnost kratke suportivne psihodinamske terapije u liječenju anksiozno-depresivnog poremećaja u Dnevnoj bolnici Klinike za psihološku medicinu. U istraživanju je sudjelovalo 45 muških pacijenata kod kojih je bilo indicirano liječenje u Dnevnoj bolnici. Na prijemu u Dnevnu bolnicu i pri završetku parcijalne hospitalizacije u trajanju od mjesec dana ispitanici su testirani brojnim psihološkim instrumentima.. Parcijalna hospitalizacija u trajanju od mjesec dana nije dovela do statistički značajnih razlika u kliničkoj slici anksiozno-depresivnog poremećaja kod ispitanika. Obzirom da psihoterapijske metode trebaju biti primjenjivane duže vremena te se ne očekuje brzo poboljšanje, liječenje u trajanju od mjesec dana je prekratko za postizanje terapijske efikasnosti.