Introduction

Major depressive disorder is one of the most common psychiatric diseases with a lifetime prevalence that has been estimated at 16.2%, with rates almost twice as high for women as for men. It is frequently associated with substantial symptom severity and role impairment. In recent decades, pharmacological and psychological treatments are increasingly developed but inadequate treatment is a serious concern since the remission rate hovers somewhere between 35% and 70%, varying with the type of depression and its chronicity. This implies that a substantial amount of our patients do not respond to treatment. For all of them, we are in need of better treatment programs and a better understanding of what works for whom.

Psychodynamic Psychotherapy

There is no clear definition of what psychodynamic psychotherapy is, despite its practice all over the world. It stems from psychoanalytic theory on a continuum with psychoanalysis (expressive technique, classical parameters such as frequent sessions, therapist neutrality and abstinence, focus on the past and on resistance, on transference and counter transference and the use of interpretation) on the one end and supportive psychotherapy (ego support, advice, guidance, focus on the present and on the encouragement of neurotic defense, understanding and containing of transference and counter transference) on the other. The current practice of psychodynamic psychotherapy as an amalgam can be summarized as consisting of the following features:

- Use of exploratory, interpretative, and supportive interventions as appropriate
- Frequent sessions
- Emphasis on uncovering painful affects, understanding past painful experiences
- Goal is to facilitate emotional experience and increase understanding
- Focus on the therapeutic relationship, including attention to transference and counter transference
- Use of a wide range of techniques, with variability in application by different practitioners

Psychodynamic psychotherapy for depression

Because psychodynamic psychotherapy aims at reducing the psychological vulnerabilities that may predispose patients to psychopathology, psychodynamic psychotherapy should be considered as an approach to reduce this vulnerability.

One form of such a psychodynamic psychotherapy for depression is Short-term Psychoanalytic Supportive Psychotherapy (SPSP). SPSP comprises 16 sessions within half a year (the first eight sessions weekly followed by eight sessions fortnightly). SPSP aims at the remission of depressive symptoms by exploring eight levels of psychological insight: 1) symptoms and complaints, 2) the life circumstances at times of the onset of the depression or those life events that maintain the depression in the present, 3) current interpersonal problems or conflicts, 4) patterns in these interpersonal problems or conflicts, 5) own attribution to these patterns, 6) the echo’s of external interpersonal relationships from the in the present, 7) the intrapersonal relationship one has with oneself, 8) the manifestations
of the problems or conflicts of the former levels in the relationship with the psychotherapist. Its core technique is Adequate Psychoanalytic Support (APS) which is the adequate gratification of the patient’s developmental needs that have been met inadequately in the first years of his life and that have therefore persisted into adulthood in their infantile forms, manifesting themselves in the primary aspects of the therapeutic relationship. It concerns all infantile wishes, desires and fears that manifest themselves in the relationship with the therapist through non-conscious behavior and affects states that present themselves in the transference – counter transference dyad. SPSP defines support as adequate when the following 4 criteria are met: 1) the therapist intends to emaptically validate, 2) the patient affectively experiences the validation as such, 3) it fosters ego progression and counters regression, 4) it evokes the experience of two (or more) dissonant external-interpersonal relationships.

5 randomized clinical trials

The Arkin Depression Research Group conducted five randomized clinical trials in a row from June 1993 until November 2009 on the relative efficacy and effectiveness of SPSP, Cognitive Behavioral Therapy (CBT) and pharmacotherapy. The data for this thesis were drawn from the second, third and fifth RCT.

The thesis started with the results of the third trial in chapter 2 concerning the relative efficacy of psychotherapy (SPSP) and combined treatment (psychotherapy plus pharmacotherapy) in the treatment of depression. In a six month randomized clinical trial, SPSP (n=106) was compared with combined therapy (n=85) in outpatients with mild or moderate severe DSM IV defined depressive disorder. Antidepressants were prescribed according to a protocol, which provided for four successive steps in case of intolerance or inefficacy: venlafaxine, an SSRI, nortriptyline and nortriptyline plus lithium. Efficacy was assessed using the Hamilton Depression Rating Scale (HAM-D-17), the Clinical Global Inventory of Severity and Improvement (CGI-S and CGI-I), and the depression subscale of the Symptom Check List (SCL-90). At week 24, the SCL-depression subscale did, while the other subscales did not show statistically significant inter-group differences, favoring combined therapy. We concluded that the patients experience clear advantages of combining antidepressants and psychotherapy in the treatment of depression.

In chapter 3, a factor analytic study on the questionnaire that was used in this thesis to measure the therapeutic relationship: The Helping Alliance Questionnaire I (HAQ I), was described. The psychometric properties of the HAQ I were analyzed at two times in SPSP for outpatient depression. Exploratory factor analysis conducted in 142 patients generated a model that was confirmed in a different validation sample (n=106) using confirmatory factor analysis. Two factors were found with satisfactory psychometric properties and a consistent structure over time: factor I: relationship and factor II: internal change. These factors are in line with the literature on the empirical concepts of alliance. Our study suggests that patients view supportiveness and helpfulness as separate elements of the alliance. We recommend that reporting on the HAQ I with separate scores for these individual aspects of alliance offers a more precise assessment and is preferable to using a single general alliance score. This enables the therapist to adjust either the therapeutic stance in the relationship or
the therapeutic technique when a problem is detected in one of the items of the internal change factor.

The relative impact of therapeutic technique on personality structure and outcome in SPSP was described in chapters 4 and 5. There is a lively debate regarding the elements that may optimize outcome in psychodynamic therapies. The clinical assumption is that expressive technique when utilized in patients with stronger ego capacities, lead to better outcome. The chapters report a study involving secondary analysis from the third randomized clinical trial comparing psychotherapy and combined therapy for outpatient depression. Therapists evaluated the patients’ defense style and applied therapeutic technique on the Therapist Evaluation Form (TEF). The main outcome measure was the HAM-D-17. We found no association between therapeutic technique, socio-demographic variables and severity or duration of the depression. Insight facilitating supportive technique was related to better outcome. However, defense style, as evaluated by the therapist, was the strongest independent predictor of outcome. Unlike our hypothesis, we did not find an association between expressive technique with patients who utilize mature defense styles and treatment success. This indicates, in line with recent literature that patients with a primitive defense style may profit from insight promoting supportive interventions.

In the next two chapters, the impact of personality pathology on the quality of the therapeutic alliance was investigated. In chapter 6, the predictive value of object relational functioning (ORF) for the therapeutic relationship was investigated in an exploratory study. The concept of ORF has been shown to be relevant for the process and outcome of psychodynamic psychotherapies. However, little is known about its relevance for the psychotherapeutic treatment of depression. The ORF of 81 patients from the second randomized clinical trial comparing antidepressants and SPSP in mild to moderate severe outpatient depression was rated using the Developmental Profile. The overall maturity of ORF measured at baseline was higher in patients who showed a better treatment response. Patients with a recurrent depression showed less mature levels of ORF, lower adaptive levels and a higher score on the symbiotic level of the Developmental Profile. No association was found between ORF and the therapeutic alliance, as measured with the HAQ I. In contrast to the single measure of alliance early in therapy, the growth of the alliance was related to outcome. This study indicated the relevance of ORF for the treatment and outcome of depression and established that it is a separate concept, distinctive from the therapeutic alliance.

There is a dearth on studies concerning DSM IV axis II disorders related to the alliance. This is a shortcoming to the clinician who deals mainly with the DSM classification as a starting point for treatment without a guideline, other than clinical judgment, as to what technique is required to foster the alliance in case of personality pathology. Therefore in chapter 7 we explore the predictive value of personality pathology on the early therapeutic alliance in SPSP for moderately severe depressed outpatients. The study concerned secondary analyses of the fifth RCT comparing SPSP and cognitive behavioral therapy (CBT) for depression. The study group consisted of 98 patients for whom the measures of interest were available: personality pathology was measured with dimensional scores of the Questionnaire on Personality Traits (VKP) and the therapeutic alliance was measured with the Relationship factor of the HAQ I. Surprisingly and unlike clinical lore as well as the mounting evidence
from developmental studies on the complexity of structural personality organization, we did not find an association between personality pathology and early alliance in SPSP. The results are interpreted in the context of Adequate Psychoanalytic Support (APS) as the assumed mechanism of structural change in SPSP. APS requires monitoring of the alliance and interventions are tailored to the specific personality pathology of the patient. Thus support in SPSP is an alliance fostering technique. We concluded with the hypothesis that because technique and alliance go hand in hand in SPSP, we do not find any prediction of personality pathology on the therapeutic alliance.

The following chapters concern the predictive value of the therapeutic alliance on subsequent symptom change. Without a doubt the therapeutic alliance is the most studied process factor in psychotherapy. It has a relatively small but consistent impact on outcome across different types of treatment, with average effect sizes of .28, accounting for 7.5% of the variance in treatment outcome. However, this relation between alliance and success does not imply causation. It has been questioned whether a good early alliance during therapy causes improvement or whether early symptom improvement accounts for a good alliance. Many authors call for a better understanding of both the concept of the alliance and its role as a possible causal factor for change during psychotherapy because the evidence for a direct relationship between alliance and subsequent symptom improvement is scarce.

In chapter 8 we investigated the predictive value of the alliance in the middle of SPSP on subsequent symptom change and we explored four issues related to conflicting findings in alliance – outcome research. We used data from the third RCT comparing SPSP and SPSP plus medication in mild to moderate severe outpatient depression. 117 patients completed the Relationship factor of the HAQ I (measured twice, middle and late during treatment). Alliance did not predict subsequent symptom change as measured by the HAM-D-17 beyond prior symptom change and the alliance course was not predicted by early symptom change. We concluded that further research is needed to explore the role of the alliance in the middle of therapy on symptom change but we may not be able to isolate and track down alliance as a single curative mechanism of change by predicting it over the full course of therapy. Future alliance research should focus more on session-by-session alliance prediction within patients. Unconscious intra and interpersonal processes as they emerge and unfold in the psychotherapeutic process should be addressed more. Finally, the development of uniformity in the conceptualization of the alliance, its measure, assessment timing and statistical methods is needed. Notwithstanding the robust clinical and empirical importance of a solid alliance in the psychotherapy process, current evidence leads to the question whether alliance directly accounts for subsequent change or moderates change via technique, transference phenomena, therapist competences and patient characteristics.

In chapter 9 we investigated the predictive value of early alliance in SPSP on subsequent symptom change and the influence of therapist variables on both symptom change and the alliance course. Among 94 outpatients with a depression, from the fifth RCT comparing SPSP and CBT, the therapeutic alliance was assessed with the HAQ I Relationship factor at week 5 of treatment. Alliance in the first phase of treatment did predict symptom change from week 5 onward. Alliance was not predicted by prior symptom change. Therapist and patient variables did not predict symptom change or the alliance course. In contrast to the previous
chapter, the results of this study provided support for the role of early alliance as a mediator of change in short-term psychodynamic therapy for depression. It stresses the importance of optimizing the quality of the alliance in the first phase of therapy.

A clinical vignette is presented in chapter 10 that aims at demonstrating to the clinician the usefulness of Adequate Psychoanalytic Support as the core technique and assumed mechanism of change in SPSP. It is argued that in doing so, a firm and solid therapeutic alliance can be established and maintained even in patients with depression and severe personality pathology. The vignette of Peter, a vulnerable narcissistic young man, serves as a clinical demonstration of APS as an alliance fostering technique.

This thesis is concluded with a general discussion in chapter 11, which results in the following 7 conclusions regarding the contribution to our understanding of the theoretical, empirical and clinical puzzle of what makes psychodynamic psychotherapy work.

1) This thesis provided indications that combined treatment (psychotherapy plus medication) is the best option for moderately severe depressed patients but that patients should offer a choice in the treatment they prefer.

2) Selecting basic patient- or therapist characteristics in order to optimize alliances or outcome is on the basis of this thesis not necessary for this treatment modality.

3) SPSP is suitable for all kinds of personality pathology as it tailors its interventions according to the ego strengths and weaknesses of the individual patient. Costly and time-consuming selection processes are on the basis of this thesis not necessary to start treatment.

4) Therapists systematically have to use their clinical judgment on defense style and therapeutic technique in order to tailor their APS interventions to the individual patient level. Insight facilitating interventions can be used, also in patients with weaker ego strengths but we have to keep in mind that the use of dynamic technique and their role on outcome and structural change in psychodynamic psychotherapy needs further empirical underpinning. The classical hypotheses should not be used as a straitjacket, instead psychodynamic psychotherapy needs to open its window and review its valuable theory and practice in light of psychotherapy process-outcome research. For there is a world to win in the better treatment of our patients.

5) The HAQ I or HAQ II should be added to every Routine Outcome Monitoring battery. Its evaluation and feedback to the patient should be incorporated in the treatment manual of SPSP and clinicians should be aware of the importance of a solid therapeutic bond early in treatment. This bond reduces dropout and enhances treatment success. The ROM should be benchmarked in the Netherlands on the level of alliance en we should use one instrument to do so.
6) In SPSP, APS is an alliance fostering technique. From this it follows that technique is relationship and relationship is technique. There is no schism between technique factors or relationship factors as APS incorporates these two into one alliance fostering technique.

7) It is worthwhile to consider transforming the SPSP manual into an Alliance Fostering Short-term Psychodynamic Supportive Psychotherapy (AFSPSP). And this should not be restricted to SPSP only.