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General introduction
Chapter 1

Introduction

This thesis aims at contributing to the theoretical, empirical and clinical puzzle of what makes psychodynamic psychotherapy work? How does it work? What elements of it are prerequisites for change and for whom does it work? In this first chapter, a general background is provided and the research questions and aims of this thesis are stated.

Depression

Depression 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 (Kessler et al., 2003). In recent decennia, 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 (Lambert, 2013). 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 (Roth & Fonagy, 2005).

In the practice guideline of the American Psychiatric Association (APA, 2010) are six psychotherapeutic modalities listed varying in their evidence base for the treatment of depression: 1) Cognitive Behavioral Therapies, 2) Interpersonal Psychotherapy, 3) Psychodynamic Psychotherapy, 4) Problem-solving Therapy, 5) Marital Therapy and Family Therapy, 6) Group Therapy.

Psychodynamic Psychotherapy

Psychodynamic psychotherapy is widely practiced all over the world and there is a great variation in its exact definition and content. 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 (Dewald, 1994; Summers & Barber, 2010). Kernberg (1999) draws a firm line between psychodynamic therapies on psychoanalytic lines and supportive therapies. De Jonghe et al. (1994) locate the various expressive and supportive techniques on a continuum with quantitative rather than qualitative differences. Summers & Barber (2010) regard the terms psychoanalytic and psychodynamic as synonymous and summarize the current practice of psychodynamic psychotherapy as an amalgam 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
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- 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

Throughout this thesis the terms psychoanalytic and psychodynamic will be considered synonymous and both are used.

Psychodynamic psychotherapy aims at personality change or the transformation of some aspect of the personality structure. It aims at reducing the psychological vulnerabilities that may predispose patients to psychopathology. Thereby reducing symptoms and preventing recurrence of symptoms, thus improving the quality of life, interpersonal functioning and self-esteem. Depending on the length of treatment and the frequency of sessions, more or less structural change can be expected but even when the changes in the intrapsychic structure are small, little transformations can make a world of difference when it comes to internal freedom, the ability to make choices and the enhancement of self-esteem.

The two main presumed mechanisms of change are the therapists’ technical tools and the relationship between patient and therapist. The more expressive therapies on the supportive-expressive continuum traditionally focus more on the (transference) interpretation as the gold pathway to insight and consequently structural change (Kernberg, 1999). The more supportive therapies use the relationship and the intersubjective dyad between patient and therapist as a vehicle for structural change of which self-insight can be a consequence but not prerequisite for long lasting change (Greenberg, 1986; Schechter, 2007; Stern et al., 1998; Summers & Barber, 2010).

**Psychodynamic psychotherapy for depression**

Because psychodynamic psychotherapy aims at reducing the psychological vulnerabilities that may predispose to psychopathology, Gabbard et al. (2002) argued that psychodynamic psychotherapy should be considered as an approach to reduce this vulnerability. Busch et al. (2004) developed five overarching theoretical dynamics underlying depression that is extracted from existing psychoanalytical models from the first psychoanalytic writers to more current theorists and researchers. These are 1) narcissistic vulnerability, 2) self-directed rage, 3) shame and guilt stemming from severe superego pathology, 4) idealization and devaluation (of self and others) and 5) other primitive defense mechanisms.

One form of such a psychodynamic psychotherapy for depression is Short-term Psychoanalytic Supportive Psychotherapy (SPSP). Frans de Jonghe developed this form of psychotherapy in the early 1990’s in an outpatient psychiatric clinic in the center of Amsterdam. (De Jonghe, 2005; De Jonghe et al., 2013). His goal was to bring the practice of psychoanalysis to those patients that need it most: those who suffer from a DSM axis I disorder with or without co morbid personality pathology. The Arkin Depression Research Group conducted five randomized clinical trials in a row and SPSP to date is an evidence-based psychotherapy for major depression (Driessen et al., 2013).

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 behaviour 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 emphatically validate (Lachmann, 2008; Schechter, 2007), 2) the patient affectively experiences the validation as such (Lachmann, 2008; Schechter, 2007), 3) it fosters ego progression and counters regression (e.g. Dewald, 1994), 4) it evokes the experience of two (or more) dissonant external-interpersonal relationships (e.g. Greenberg, 1986; Strachey, 1934).

Results of 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. In the first trial De Jonghe et al. (2001) found that combined treatment (SPSP plus pharmacotherapy) was significantly more acceptable than pharmacotherapy alone. Also there were significantly fewer dropouts in the combined therapy arm and, ultimately, there were significantly more patients recovered in the combined therapy arm. Thus, combined therapy seemed preferable to pharmacotherapy in the treatment of depressed outpatients. In the second trial, Dekker et al. (2004) found that 8 or 16 psychotherapy sessions in addition to 8 sessions of pharmacotherapy over a period of 6 months would appear to be equally effective in terms of dealing with symptoms. That was true for both moderately and severely depressed patients. In the third trial De Jonghe et al. (2004) concluded that SPSP alone was more acceptable than combined therapy (SPSP plus pharmacotherapy). The 6-month feasibility of SPSP was fair, that of combined therapy was good: 25% of the patients in the psychotherapy condition broke off their therapy; 16% did so in the combined therapy group. Nonetheless, both therapies were efficacious in reducing the symptoms of depression. The advantages of combining antidepressants with SPSP appeared equivocal. In the fourth trial, Dekker et al. (2008) have determined which sequence is preferable for the acute treatment of depression: starting with SPSP or with pharmacotherapy. This trial started with a randomised clinical trial of 8 weeks, making a direct comparison possible between antidepressants (AD) and SPSP. To our knowledge, a psychodynamic psychotherapy was never before compared directly to treatment with antidepressant medication. The efficacy of SPSP and AD in the first 8 weeks was not equivalent. We found slightly better results for AD by week 4. This benefit had almost disappeared by week 8. The final conclusion was that SPSP has a somewhat slower start than pharmacotherapy alone in the first 8 weeks of treatment, but that SPSP prevailed on most assessments in the end. In the final trial, Driessen et al. (2013) found that SPSP was as efficacious as CBT. No statistically differences were found for any of the outcome measures. The findings extended the evidence base for psychodynamic therapy but also
measures. The findings extended the evidence base for psychodynamic therapy but also indicated that short-term treatment was insufficient for a substantial number of patients. The data for this thesis were drawn from the second, third and fifth RCT.

**Background of this thesis**

From the very beginning I was interested in what makes psychotherapy work? Why does it work, how and for whom? The patient, therapist, technique and/or relationship triad fascinated me although I had no clue of how to address these matters research wise yet.

As a psychoanalytic psychotherapist in training, I learned about interpretation as the gold pathway to insight in the neurotic patient. I also learned about the interpersonal psychoanalysis and the relational views on development, deficits and how therapy and the therapeutic encounter itself could transform arrested personality growth. Not only did I read about all this for years and years. More importantly, I came to see and feel what psychotherapy could do, that it could bring real change and transformation even in very disturbed and traumatized patients. I was fascinated by all of this. Reading Freud, it felt as coming home, looking at patients and my inner self in such a depth. But I increasingly wondered about the lack of attention in the extensive psychoanalytic training programs on process research in the psychodynamic field on the supposed mechanisms of change and their association with outcome.

I started with the therapeutic relationship: what is it that I do with my patients that makes them feel understood and listened to? What is it that they do to me that makes my work meaningful and one of the most special things in my life? Can it be measured? How useful is the concept of the therapeutic relationship to the clinician and our patients? Is it something you can learn in order to improve yourself to become a better therapist? Can you teach it to your colleagues and improve their skills? How do different patients experience the therapeutic relationship? Is the quality of the relationship between patient and therapist in any way related to personality pathology? In further conceptualizing SPSP, Adequate Psychoanalytic Support (APS) became the main technique and I wanted to know more about the association between technique, outcome and the therapeutic relationship.

**Aims and research questions**

**Aim 1 Efficacy of SPSP**

According to clinical lore, combined therapy (antidepressants plus psychotherapy) is preferable to psychotherapy alone in the treatment of depression. However controlled studies conducted in the 1970s and 1980s did not consistently find a significant advantage for routinely combining therapies, compared with one or the other treatments provided alone. However the empirical evidence is conflicting. Some studies find a superior efficacy of combined therapy (Keller et al., 2000), other studies report equal efficacy of both treatment modalities (Thase et al., 1997). Results of meta-analyses indicate the advantage of combining pharmacotherapy and various forms of time-limited psychotherapies (Pampallona et al., 2004).
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The first aim of thesis was to address the relative efficacy of psychotherapy (SPSP) and combined treatment (psychotherapy plus pharmacotherapy) in the treatment of depression. We hypothesized that combined treatment was more acceptable, more feasible and more effective than SPSP alone.

Q 1. What is the relative acceptability of psychotherapy and combined treatment?
Q 2. What is the relative feasibility of psychotherapy and combined treatment?
Q 3. What is the relative efficacy of psychotherapy and combined treatment?

Aim 2 Psychometric properties of the HAQ
The definition of the therapeutic relationship or alliance concept involves interaction and working on the tasks and targets of therapy in the context of an affective bond. But studies on the predictive value of alliance on outcome use different alliance measures, limiting the generalization of research findings. There is a need for unification of the theoretical concepts underlying the alliance measures (Horvath, 2005).

In this thesis, the therapeutic relationship was measured with the Helping Alliance Questionnaire I (HAQ I; Alexander & Luborsky, 1986). The HAQ I consists of two theoretically derived subscales: 1) the patients’ experience of the therapist as warm, helpful and supportive; and 2) the alliance based on the sense of working together in a joint effort with emphasis on agreement regarding therapy goals. However, the HAQ I was never factor analyzed in a clearly defined population of depressed outpatients or in short-term psychodynamic psychotherapy. Before investigating the impact of the alliance on outcome and change in our trials, we first aimed at the psychometric properties of one of our main process measures.

The second aim of this thesis was therefore to examine the factor structure of the HAQ I in depressed patients treated with psychodynamic psychotherapy.

Our main hypothesis was that the distinction of two theoretically derived factors in the alliance would be confirmed: supportiveness and working together on goals. We further hypothesized that the factor structure would show consistency during treatment, that the factors would be reliable, intercorrelated, not sensitive to patient characteristics and predictive for outcome.

Q 4. Can the theoretical derived distinction between two factors (supportiveness and working together on goals) be confirmed?
Q 5. Is this factor structure consistent during treatment? In other words: is the alliance concept constant over time?
Q 6. Are the HAQ I factors reliable, intercorrelated, sensitive to baseline patient characteristics and predictive of outcome?

Aim 3 Technique: supportive or expressive?
There is a lively debate regarding the elements that may optimize outcome in psychodynamic therapies (Driessen et al., 2010). Psychodynamic technique can be placed on a continuum from supportive to expressive. Expressive interventions are related to better outcome across diagnostic groups, even for patients with poor object relational functioning.
(Högland et al., 2008) but supportive interventions might be as effective (Piper et al., 1999).

The third aim of this thesis was to investigate the relationship between type of intervention style (supportive or more insight facilitating) and outcome in SPSP for depression. We hypothesized that expressive technique would be associated with a better outcome when utilized in patients with stronger ego capacities, operationalized as a more mature defense style.

Q 7. Is there an association between socio-demographic variables, severity and duration of symptoms, personality pathology and defense style?
Q 8. Is supportive or more insight facilitating technique associated with outcome?
Q 9. Is expressive technique associated with better outcome for patients with stronger ego capacities?

Aim 4 Personality and alliance
Personality pathology is a possible moderator for the alliance – outcome relationship (Horvath & Luborsky, 1993). There is a dearth on studies concerning DSM IV axis II disorders related to the alliance and this scarcity on studies 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 (Barber, 2009). The level of object relational functioning (ORF) is an indicator for personality pathology (Greenberg & Mitchell, 1993). It has been shown to be relevant for the process and outcome of psychotherapy but little is known about its relevance for the psychotherapeutic treatment of depression. Furthermore, evidence points at an association between the quality of ORF and the quality of the therapeutic relationship. The basic capacity for patients and therapists to form healthy objects relations, characterized by mutuality, trust and regulation of emerging relational affects, may contribute to the development of a solid therapeutic alliance (Piper et al., 2004).

The impact of personality pathology on the quality of the therapeutic relationship in SPSP for depression was the fourth aim of this thesis.

We hypothesized that alliance is negatively related to axis II personality disordered patients, that the quality of ORF predicted outcome and that there was a significant correlation between ORF and the therapeutic alliance.

Q 10. Does DSM IV defined personality disorders predict alliance scores during therapy?
Q 11. Is the alliance related to the quality of object relational functioning?

Aim 5 Alliance and 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 (e.g., Horvath et al., 2011). However, this relation between alliance and success does not imply causation (e.g., Barber et al., 2000). It has been questioned whether a good alliance during therapy causes improvement or whether early symptom improvement accounts for a good alliance. The evidence for a direct relationship between
alliance and subsequent symptom improvement is scarce (Barber et al., 2010).

Therefore the fifth aim of this thesis was to investigate the impact of the therapeutic alliance on subsequent symptom change.

The following hypotheses were tested: 1) alliance at week 5 and 12 is predictive of subsequent symptom change beyond prior symptom change and 2) early symptom change does not predict the course of the alliance and 3) therapist variables do not directly influence symptom change or the alliance course.

Q 12. Is the alliance predictive of subsequent symptom change beyond prior symptom change?
Q 13. Does early symptom change predict the course of the alliance during SPSP?
Q 14. Is there a difference between early alliance and alliance in the middle of therapy regarding its effect on symptom change over time?
Q 15. What is the impact of therapist characteristics on symptom change?
Q 16. What is the impact of therapist characteristics on the alliance?

Aim 6 Case study and APS
How can all this empirical knowledge be useful to the clinician in order to improve our treatments for our patients? This case study is based on a real therapy but facts, statements and interventions are altered and sometimes mixed with other therapies in order to protect the privacy of the patient.

Q17: How is Adequate Psychoanalytic Supportive (APS) technique in SPSP suitable for patients with depression and co morbid personality pathology?
Q18: Can the clinician learn tools to establish and maintain a firm therapeutic alliance with patients with severe personality pathology?

The thesis ends with a general discussion of the main findings, their clinical implications and a summary of the content in chapter 11.
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