Personality disorders and the therapeutic alliance in short-term psychodynamic therapy for depression

This chapter is submitted as:
Abstract

**Background:** Although the causal role of alliance on outcome is equivocal, the evidence on the alliance strengthens arguments for its mediating role on change. Personality pathology is a possible moderator of the alliance-outcome relationship.

**Methods:** Among 98 outpatients with a major depression receiving short-term psychodynamic therapy, therapeutic alliance was assessed with the Helping Alliance Questionnaire I Relationship factor at week 5 of treatment. Personality Pathology was assessed by means of the Questionnaire on Personality Traits at baseline. Depression severity was assessed by means of the Hamilton Depression Rating Scale at week 5, 10 and 22 (end of treatment). In a linear regression analysis, the prediction of socio-demographic variables, symptom severity and personality pathology on the alliance was investigated.

**Results:** We did not find an association between personality pathology and early alliance.

**Conclusions:** Axis II personality pathology does not effect early alliance building in short term PDT for depression. The technique of Adequate Psychoanalytic Support is flexible and tailors interventions to the ego strength and prevailing object relational dyads of the patient. In this sense, APS is an alliance fostering technique.
Introduction

Although the causal role of alliance on outcome is equivocal (Barber et al., 2010; Barber et al., 2000; De Bolle et al., 2010), the evidence on the alliance strengthens arguments for its mediating role on change. Focusing on the alliance contributes to optimize treatment effects of psychotherapy (Lambert, 2013). Optimizing alliance calls for moderators of the alliance-outcome relationship (Beutler et al., 2012) and alliance-fostering techniques can be developed and trained as a consequence. There is evidence that training therapists in alliance improving behavior, which is emphatically co creating treatment goals (Crits-Christoph et al., 2006; Crits-Christoph et al., 2010), enhances the alliance and reduces dropout (Roos & Werbart, 2013). Personality pathology is such a possible moderator (Horvath & Luborsky, 1993; Minonne, 2008). There is a dearth on studies concerning DSM IV axis II disorders related to the alliance, and to our knowledge, there are five studies that investigated this topic (Gerstley et al., 1989; Hirsch et al., 2012; Lingiardi et al., 2005; Muran et al., 1994; Strauss et al., 2006). Cluster A en B personality disorders seem negatively related to alliance while cluster C pathology is more positively associated with alliance. 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; Castonguay et al., 2006; Westen & Weinberger, 2005). Therefore the aim of this study was to examine the impact of personality disorders on the quality of the therapeutic alliance in short-term psychodynamic therapy (PDT) for depression. Based on the current literature we hypothesized that alliance is negatively related to axis II personality disordered patients.

Methods

Participants and setting
This study concerns secondary analyses that were drawn from a randomized clinical trial comparing the efficacy of psychodynamic therapy (PDT) and cognitive behavioral therapy (CBT) in the outpatient treatment of major depression. We refer to Driessen et al. (Driessen et al., 2007; Driessen et al., 2013) for further details. Patients were referred by their general practitioner to one of three psychiatric outpatient clinics of Arkin Mental Health Care in Amsterdam, The Netherlands. The sample consisted of 177 patients who were originally allocated to the PDT arm. Written informed consent was obtained from all patients. The study group consisted of 98 patients for whom the measure of interest (VKA P & HAQ I) was available. This group did not differ from the total PDT sample with the exception of two variables. In the subsample, more patients were treated with PDT only \((x^2(1, n=177) = 4.722, p=.030)\) and more patients started with pharmacotherapy \(< 22\) weeks \((x^2(1, n=177) = 6.497, p=.011)\).

Treatment
PDT comprises 16 sessions of Short-term Psychoanalytic Supportive Psychotherapy (SPSP) within 22 weeks (the first eight sessions weekly and the final eight sessions were fortnightly), conducted according to a published treatment manual (de Jonghe, 2005; de Jonghe et al., 2013). SPSP involves an open patient-therapist dialogue that uses supportive and insight-facilitating techniques to address the emotional background of the depression focusing at
current relationships, internalized past relationships and intrapersonal patterns. The assumed therapeutic action of SPSP consists mainly of Adequate Psychoanalytic Support (APS), which is the proper gratification of unmet developmental needs that can lead to experiencing ‘relational dissonance’ or friction between two contradictory relationships (an old and a new one) simultaneously felt in the therapeutic situation. APS fosters ego growth, not regression. The techniques used in SPSP can be situated mainly on the supportive half of the supportive—expressive continuum (Barber et al., 2013; Gabbard, 2005). SPSP recognizes the manifestations of transference and transference traces but only intervenes on them when it obstructs the therapeutic alliance and without making in depth interpretations. Severely depressed patients (HAM-D > 24 at baseline; n=28) and moderately depressed patients at baseline that developed severe symptoms during treatment (n=9) were offered additional antidepressant medication administrated by (resident) psychiatrists according to a protocol starting with venlafaxine XR 75 mg/day that could be raised to a maximum of 225 mg/day. In case of intolerance or complete nonresponse venlafaxine was switched to either citalopram or nortriptyline. Pharmacotherapy consults addressed symptom evaluation, side effects and adherence. Three research psychiatrists supervised the pharmacotherapy.

Therapists
Psychotherapists were psychiatrists or psychologists with at least a master’s degree who completed a 3-day course in SPSP. Moreover, all therapists adequately conducted at least one intensively supervised therapy case in accordance with the treatment manual as judged by a study supervisor. Although no formal assessments were conducted, manual fidelity was checked by means of biweekly supervision sessions, chaired by a study supervisor, in which audio taped material was discussed. All study supervisors were registered supervisors with the Dutch Association of Psychoanalytic Psychotherapy.

Measures
The Questionnaire on Personality Traits (VKP) (Duijsens, 1993) is a self-report version of the International Personality Disorder Examination (IPDE; Loranger et al., 1994) and assessed the DSM IV classified personality disorders at baseline. The VKP consists of 212 questions that can be scored on a three-point scale: true/not true/not applicable. The VKP yields categorical (number of affirmed criteria per personality disorder) as well as dimensional scores (sum score per personality disorder of both the true and not applicable answers). Internal consistency is reasonable (α=.66) and the VKP is moderately stable over time (Duijsens, 1993).

Alliance was measured with the Relationship factor of the Helping Alliance Questionnaire I (HAQ) (Alexander & Luborsky, 1986; Hendriksen et al., 2010). It consists of five items and captures the feeling of being understood by the therapist and the feeling of working together in the same direction (α=0.93; maximum score is 35). The HAQ measurement concerned the alliance with the psychotherapist at week 5.

Severity of depression was measured with the Hamilton Depression Rating Scale (HAM-D; Hamilton, 1967). This is a 17-item semi structured interview that was assessed by trained research assistants (master’s-level graduate students in clinical psychology) according to the Dutch scoring manual (de Jonghe, 1994). The average intraclass correlation coefficient over
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46 audio taped assessments scored by multiple assessors was 0.97. Reliability at baseline was good (Cronbach’s alpha: 0.75). The HAM-D was assessed at baseline, week 5, 10, and 22.

**Statistical analysis**
Stepwise linear regression analysis with forced entry was performed to determine which variables were associated with alliance. First, gender and age, next HAM-D baseline and change and finally VKP dimensional scores were added to the model. The tests were two-tailed.

**Results**

The majority (68%) of the patients was female and 47% was younger than 40. Mean baseline HAM-D score was 22.4 (sd=5.1), 66% of the patients were classified with one or more personality disorders, mean early alliance scores overall were fairly high (M=27.6, sd=6.9) and did not differ between patients with or without personality pathology (t=0.70, df=96, p=0.49). Table 1 shows the predictors of early alliance. Being female predicted higher alliance scores in the second model. After adding depression severity, change and personality pathology to the model, no variable predicted the alliance. However, none of the models was significant with a low $R^2$ in all three models.

<table>
<thead>
<tr>
<th>Models</th>
<th>B (95% CI)</th>
<th>$p$</th>
<th>$R^2$</th>
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<tbody>
<tr>
<td>I</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender (female)</td>
<td>2.93 (.01 ~ 5.86)</td>
<td>NS</td>
<td>R$^2$ = 4%</td>
</tr>
<tr>
<td>Age (&gt; 40)</td>
<td>.36 (-3.09 ~ 2.37)</td>
<td>NS</td>
<td></td>
</tr>
<tr>
<td>II</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender (female)</td>
<td>3.18 (.16 ~ 6.20)</td>
<td>.04</td>
<td>R$^2$ = 5%</td>
</tr>
<tr>
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<td>-.36 (-3.16 ~ 2.44)</td>
<td>NS</td>
<td></td>
</tr>
<tr>
<td>HAM-D baseline</td>
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<td>NS</td>
<td></td>
</tr>
<tr>
<td>ΔHAM-D 0-5</td>
<td>.09 (-.16 ~ .36)</td>
<td>NS</td>
<td></td>
</tr>
<tr>
<td>III</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender (female)</td>
<td>2.95 (-.12 ~ 6.02)</td>
<td>NS</td>
<td>R$^2$ = 6%</td>
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<tr>
<td>HAM-D baseline</td>
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<td>NS</td>
<td></td>
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<tr>
<td>ΔHAM-D 0-5</td>
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<tr>
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<td>Dimensional score</td>
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<td>NS</td>
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**Discussion**

Unlike our hypothesis, the present study demonstrated no effect of personality pathology on early alliance. The prevalence of 66% comorbidity of personality disorders among depressed patients is high but in line with studies that have shown similar percentages (Dolan-Sewell et al., 2001; Greenberg et al., 1995; Kool et al., 2000). It demonstrates the relevance to measure personality pathology in depressed patients that are referred to second line services. However it is problematic to determine to what extent personality pathology needs
to be taken into account. Despite the assumption that patients with personality pathology are likely to develop more untoward outcomes due to the alliance building that is often more challenging, this study did not confirm this. The evidence on DSM axis II pathology related to alliance is scarce and to our knowledge, there are four studies that investigated this topic. Three studies, in supportive expressive therapy, Dialectical Behavior Therapy (DBT) and CBT found no associations between patient-rated alliance and personality pathology (Hirsch et al., 2012; Lingiardi et al., 2005; Strauss et al., 2006). In contrast, cluster A pathology was negatively related to the alliance in supportive expressive therapy and in drug counseling in two studies (Gerstley et al., 1989; Lingiardi et al., 2005). According to clinical lore, cluster B personality pathology in particular, puts a strain on the building and maintenance of a solid therapeutic relationship. The initial alliance building with these patients can be challenged by their reluctance or hunger to come to treatment, to engage in a relationship with the therapist, their grandiosity or self loathing, their perfectionistic or self destructive traits, their splitting nature of perceiving self and others. These personality dynamics challenge both patients and therapists in the management of transference and counter transference feelings (Busch et al., 2004; Blatt et al., 2002; Gabbard & Wilkinson, 1994; Levy & Scala, 2012; Yeomans et al., 1994). To date, on DSM IV axis II level however, no associations with alliance were demonstrated. On a more structural level however, associations between personality, object relational functioning, attachment and alliance was frequently found (Eames & Roth, 2000; Yeomans et al., 1994). The clinical utility of the DSM axis II has been questioned and there is limited evidence that the current personality disorder categories predict response to treatment (Livesley, 2001). Furthermore, the overlapping broad categories seem insensitive to discriminate the relative influence of complex and subtle process variables such as the therapeutic alliance. This is a shortcoming to the clinician, who deals primarily with DSM axis II classifications as other more structural personality descriptions such as identity diffusion or integration, objects relational functioning or attachment style, is costly and often not available to the clinician at the onset of treatment. Although a number of reasons can explain our findings, including some limitations of statistical power, the VKP measurement itself and few assessments of alliance, the technique of SPSP can be of importance in the interpretation our findings. Its main technique is Adequate Psychoanalytic Support. We define 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 (Greenberg, 1986; Strachey, 1999). To date it remains unknown, as it is for every psychotherapy modality, which elements of SPSP work for whom (Roth & Fonagy, 2005). APS is the supposed mechanism of structural change, albeit small in short-term treatment but nevertheless clinically relevant regarding prevention of recurrence and increasing freedom of choice (Kool et al., 2003). In order to meet the four above-mentioned criteria, the technique of APS is adjusted to the specific personality pathology of the patient. For criterion 2) to be adequately met, the therapist has to be flexible in using specific supportive techniques. Depending on the individual intrapsychic structure and object relational quality, patients experience the intended support very differently. The quality of the alliance has to be constantly monitored and the techniques are tailored to the ego strength and prevailing object relational dyads as they manifest themselves inside the therapy room as well as outside. Indeed Van et al. (2008) found no associations between
object relational functioning and the quality of the therapeutic alliance in SPSP. In another study we found that insight facilitating supportive interventions in SPSP lead to better outcome compared to solely supportive interventions (Hendriksen et al., 2011) indicating the importance of the flexible use of optimal supportive technique within the context of APS. The effect of supportive versus expressive techniques on outcome, are mixed (Diener et al., 2007; Hendriksen et al., 2011; Hogland et al., 2008) and the role of the alliance in this complex interplay is not yet well understood but might appear crucial. There might be a technique by patient characteristic interaction in the context of the magnitude of the alliance (Beutler et al., 2012; Levy & Scala, 2012). Notwithstanding the fact that the effect of alliance on outcome is modest across treatments, accounting for 7.5% of the variance (e.g., Horvath et al., 2011), alliance could emerge as the crucial missing link between therapeutic technique and treatment success in an individual patient. Therefore therapists should be trained in building and maintaining qualitatively firm alliances.

**Strengths and limitations**

This study had a number of strengths. First, the patient population in this study resembles regular clinical practice with treatment provided in a non-academic outpatient setting. General practitioners referred patients and no selection criteria with regard to suitability for psychotherapy were applied. Second, the treatment provided was an evidence based standardized form of psychodynamic psychotherapy for depression, thus limiting the possible influence of treatment variations. Third, demographic patient characteristics that could potentially confound the results were controlled for in the analyses. This study also had a number of limitations. First, alliance scores in this study were fairly high with minor deviations from the mean. Alliance measures in general are rated high (Barber, 2009) and this may obscure the finding of variables that predict its quality throughout studies. Third, the conclusions are restricted to PDT. To date there is no reason to believe that the effect of alliance on change differs across treatment modalities (Flueckiger et al., 2012). However, the specific mechanisms by which change occurs may diverge on a session-to-session basis and distinctive alliance patterns may be present in different modalities (Horvath et al., 2011). Finally, SPSP adherence to the manual was not evaluated by means of a standardized form. However, therapists were well trained and closely supervised by experienced supervisors on the bases of audio taped material, thus a sufficient level of SPSP adherence and competence could be guaranteed.

**Implications and conclusions**

In conclusion, axis II personality pathology does not effect early alliance building in short term PDT for depression. Clinically this implies that SPSP can be indicated and started without the investigation of personality pathology prior to treatment. The technique of APS is flexible and tailors interventions to the ego strength and prevailing object relational dyads of the patient. In this sense, APS is an alliance fostering technique.
References


Is the alliance always a predictor of change in psychodynamic psychotherapy for depression?