General discussion


Chapter 11

Introduction

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 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. This thesis investigates one of these modalities: short – term psychodynamic psychotherapy.

Psychodynamic psychotherapy is widely practiced all over the world and there is a great variation in its exact definition and content. All forms stem from psychoanalytic theory and can be classified on a continuum with classical psychoanalysis (expressive technique, frequent sessions, open end, therapist neutrality and abstinence, focus on the past and on resistance, on transference and countertransference 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 (Gabbard, 2005). Therefore the current practice of psychodynamic psychotherapy can be seen as an amalgam but all share the following features (Summers & Barber, 2010):

- Use of both 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

One form of 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 and structural personality change, albeit small in 16 sessions. It explores eight levels of psychological insight depending on the psychological capacities of the patient: 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.
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. This thesis is based on three of these RCT’s:

1) The relative efficacy of psychotherapy (SPSP) and pharmacotherapy in the treatment of depression.
2) The relative efficacy of psychotherapy (SPSP) and combined treatment (psychotherapy plus pharmacotherapy) in the treatment of depression.
3) The relative efficacy of SPSP and CBT in the treatment of depression.

In this chapter, the main findings of this thesis are first summarized. Further on these findings will be discussed in light of the most important discussions in the research literature the past decennia. Next, methodological issues are discussed that need to be taken into account when interpreting the findings of this thesis. Finally, the implications of the findings for clinical practice and future research are discussed, and the conclusions are stated.

Main findings

Psychotherapy and combined therapy (pharmacotherapy plus psychotherapy) in the treatment of depression
The thesis started with the results of the first 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.

Psychometric properties of the Helping Alliance Questionnaire I in psychodynamic psychotherapy for major 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 was 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.

**Therapist judgment of defense styles and therapeutic technique related to outcome in psychodynamic psychotherapy for depression**

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.

**Predictive value of object relations for therapeutic alliance and outcome in psychotherapy for depression**

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.

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

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 explored 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 RCT comparing SPSP and cognitive behavioral therapy (CBT) for depression. The study group consisted of 98 patients who received SPSP and 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 and its impact on interpersonal functioning, 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.

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

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.

**The temporal relationship between alliance and change in psychodynamic therapy for depression**

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 RCT comparing SPSP and CBT, the therapeutic alliance was assessed in patients receiving SPSP 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.

**Adequate Psychoanalytic Support for patients with narcissistic personality pathology and comorbid depression**

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, served as a clinical demonstration of APS as an alliance fostering technique.

**Methodological considerations**

When interpreting the findings of this thesis, some methodological issues need to be taken into account.

1) The data for this thesis were drawn from three randomized clinical trials that were conducted by the Arkin Depression research Group. The aim of the trials was effectiveness and efficacy research on SPSP, CBT and pharmacotherapy and the trials were designed correspondingly. Alliance research was included as secondary explorative research questions. Therefore the analyses were in part explorative, demonstrating trends that need verification in experimental designs. This is relevant particularly for the findings regarding therapeutic technique (chapters 4 and 5) as this was rated afterwards and not experimental manipulated. Another consequence of this design is that ratings by therapists were retrospective and despite the fact that the therapists were blinded to outcome, they could have been biased by the presumed improvement.

2) The therapeutic alliance was measured twice during treatment: at week 5 or 12 and at the end of treatment. More alliance data at short time intervals would have enabled us to look at individual patient alliance levels related to change (Barber et al., 2010) and we may have found a stronger predictive value of the alliance on change. Crits-Christoph et al. (2011) found evidence that the alliance – outcome correlation is probably larger than the 7.5% outcome variance that is found in meta-analyses, when at least 4 treatment sessions are used. As the studies of Crits-Christoph et al. (2011) and Falkenström et al. (2013) demonstrate, we might have to shift from prediction of alliance over the full course of treatment towards session-to-session prediction in order to capture the impact of alliance on outcome more reliably.

3) At the start of this project, we did not have a SPSP adherence scale to measure the application of APS. However, therapists were well trained and closely supervised by experienced supervisors on the bases of audio taped material, thus a sufficient level of APS adherence and competence could be guaranteed. We are currently working on an adherence scale to optimize the monitoring of the supportive technique in SPSP.

4) Due to a relatively large therapist group and few patients per therapist in our subsamples, we were not able to analyze the between and within therapist variability (Baldwin et al., 2007). Therefore specific individual differences in the efficacy of therapists as well as differences among outcomes in one therapist may have been present that were not detected.

5) The second factor of the HAQ I (internal change) is weaker than the factor relationship: its intercorrelation is weaker with one item loading inconsistently on this factor across studies. Furthermore, Barber & Crits-Christoph (1996) and Barber, Crits-Christoph, &
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Luborsky (1996) have stated that this factor reflects early symptom improvement or outcome and, therefore, recommended the use of the short version of the HAQ I, which comprises six relationship items derived by interjudge correlations. Next, the HAQ II was developed, which comprises relationship items only (Luborsky et al., 1996). We fully agree with the development of these two improved instruments and recommend the HAQ II for further research.

6) As is common in psychotherapy process studies, alliance scores are generally rated high (Barber, 2009). This limits its predictability on change on the one hand. On the other hand, it limits to find other patient, therapist, socio-demographic and process variables to be predictive of the level of alliance during the course of treatment. Furthermore, patients who were unsatisfied with the therapeutic relationship might be missing in data sets therefore blurring the results.

7) The therapist group in all the RCT’s was a mix of experienced and less experienced psychotherapists as well as trainees in psychotherapy. While this closely resembled clinical and daily practice, it may have influenced the evaluation of technique and defense in chapters 4 and 5 and the adherence to the SPSP model in general. However, therapists were well trained and closely supervised by experienced supervisors on the bases of audio taped material, thus a sufficient level of adherence and competence could be guaranteed. Also, we found no differences in predictive value between well and less experienced therapists (both psychologists and psychiatrists) on the alliance or symptom change.

8) Psychodynamic psychotherapy was the only psychotherapy modality we studied. It would be interesting to compare the results of this study in Cognitive Behavioral Therapy, as this form of therapy is frequently conducted in depression throughout the world. To date there is no reason to believe that the prediction of alliance on outcome differs across treatment modalities. 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).

Findings in a broader perspective

Which treatment?
In 2000, the empirical evidence was conflicting regarding the preferable treatment modality in the treatment of depression. The aim was to investigate the acceptability, feasibility and effectiveness of combined treatment versus psychotherapy alone. We hypothesized that combined treatment was superior to psychotherapy alone on all three domains. The main results were that psychotherapy was more acceptable to patients than combined treatment, that there was no difference regarding feasibility and that both modalities were equally effective with the exception of the patients subjective experience that combining antidepressants and psychotherapy in the treatment of depression had clear advantages. Two meta-analyses (de Maat et al., 2007; Pampallona et al., 2004) confirmed our finding indicating the advantage of combining pharmacotherapy and various forms of time-limited psychotherapies. Therefore it is recommended to offer combined treatment to patients suffering from depression but also to give them the alternative of psychotherapy alone.
Pharmacotherapy can be added as stepped care modality when psychotherapy does not bring about the expected change.

**Which patients and which therapists?**

**Which demographics influence outcome?**
Regarding patient characteristics predicting outcome or alliance, overall we did not find evidence for predicting variables that select patients for having better alliances or outcome. Patients with a recurrent depression showed less mature levels of Object Relational Functioning (ORF) and chronicity of depression predicted change in symptoms over time. This is in contrast to other studies in which it was not detected as variable with an independent influence on subsequent symptom change (Barber, 2009). Recently, Bohart & Wade (2013) concluded that there is little evidence that socio-demographic variables significantly moderate psychotherapy outcome and that research has to develop more hypotheses in which the richness of the complex interaction between patient, therapist and therapeutic techniques becomes comprehensible.

**Which object relations influence outcome?**
Every clinician knows that the nature and severity of personality pathology has impact on the therapeutic bond. In addition, patients with personality pathology can elicit intense counter transference reactions dependent on the temperament and personality of the therapist, his unresolved issues or traumata stemming from childhood or later on in life, his actual life circumstances, making the establishment of a good therapeutic relationship a challenge for the therapist. Notwithstanding the importance of extending psychotherapeutic treatment in the post doc psychotherapy programs, challenges in the therapeutic relationship are part and parcel of being a psychotherapist. Evidence points at an association between the quality of patient’s Object Relational Functioning (ORF) and the quality of the therapeutic relationship (Piper et al., 2004). 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). We found that the overall maturity of ORF measured was higher in patients who showed a better treatment response. Unlike our hypothesis, no association was found between ORF and the therapeutic alliance. This can be interpreted in line with psychoanalytic theory that ORF is a separate concept, distinctive from the therapeutic alliance. ORF is unconscious or non-conscious and is not necessarily related to the appraisal of the therapeutic relationship while the alliance is a conscious affect or cognition of the appraisal of the therapeutic bond (Van et al., 2009).

**Which personality disorders influence outcome?**
Little is known about DSM IV defined personality disorders and its relevance for the psychotherapeutic treatment of depression. Due to this scarcity on studies, for the clinician who deals mainly with the DSM classifications as a starting point for treatment, nothing but his own clinical judgment determines what technique is required to foster the alliance (Barber, 2009). Therefore, we investigated the impact of personality pathology on the quality of the therapeutic relationship. Much to our surprise and unlike clinical lore as well as the mounting evidence from developmental studies on the complexity of structural personality organization (Levy & Scala, 2012; PDM Task Force, 2006) and its impact on
interpersonal functioning (Tufekcioglu et al., 2013), we did not find an association between PD and early alliance in SPSP.

How can we explain these results? Of interest is that Tufekcioglu et al. (2013), also found no association between DSM IV axis II personality disorders and the quality of the alliance. The patient population in this study consisted mostly of cluster C and PD NOS personality pathology. The authors hypothesized that in line with Bender (2005) and Muran et al. (1994), these patients are easier to build an alliance with because of their compliant behavior and avoidance of problems that may threaten the therapeutic relationship. In contrast, our patient population consisted of all PD clusters. The majority of the patients (63%) were classified with one or more personality disorder. Cluster C pathology (54%) was most common but cluster A (43%) en B (33%) PD disorders were also included. We hypothesized that it may be useful to interpret these findings in the context of Adequate Psychoanalytic Support (APS) as the supposed mechanism of change in SPSP. APS requires monitoring of the alliance and interventions are tailored to the specific personality pathology of the patient. APS in a patient with cluster A pathology aims at external control of the ego in overwhelming interpersonal situations, while in cluster B patients the aim is self control of the ego. In contrast, in patients with cluster C pathology, the ego is stimulated to let go of the massive control. The SPSP therapist monitors constantly where it is that the ego needs support in order to foster progression. At the same time a new external affective relationship is established within in the therapeutic dyad, creating a dissonance of an old (malevolent) and at the same time a new (benevolent) relationship. Thus support in SPSP is not an isolated technique. Instead, APS is an alliance fostering technique suitable particularly for patients with ORF and axis II pathology. Further psychotherapy process research, particularly focused on the quality of the alliance related to personality pathology is needed to test this hypothesis.

**Which therapist’s variables influence outcome?**

We also wanted to know more about the influence of the therapist as their individual differences and their impact on alliance and outcome, gain increasing attention (Barber et al., 2013). According to review studies, differences between therapists explain 5 to 10% of the variability in outcomes across treatments and settings (Baldwin & Imel, 2013). However, Beutler et al. (2004) could not find evidence that variables such as age, gender, years of experience, professional discipline, degree, and training, specific or general competence of the therapists, were directly related to treatment outcome. General variables such as therapists’ age, gender, experience or profession did not predict symptom change or the alliance course in our study. This finding is in line with the research literature to date. It is probably not a specific characteristic that makes one therapist better over another (Beutler et al., 2004). But the within therapist variability is very high (Baldwin & Imel, 2013) indicating that some therapists do better with some patients but not with others. Differences in interpersonal behavior or skills to form or engage in better alliances in specific treatments with specific patients may be the key to better understand what makes a therapist successful with a given patient (e.g. Hubble et al., 2010). This is clinically an interesting finding, since it may create an evidence base for therapist matching. Thus process-outcome research may lead to better scrutinize the complex contributions of patients and therapists in their therapeutic dyad in order to optimize psychotherapy outcomes.
Which psychodynamic technique?

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; Summers & Barber, 2010; Stern et al., 1998).

Frans de Jonghe developed short-term Psychoanalytic Supportive Psychotherapy (SPSP) 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 comorbid personality pathology. In the beginning, SPSP was defined as a psychodynamic psychotherapy on the supportive half of the supportive expressive continuum (De Jonghe et al., 1994). More expressive technique such as confrontations or upward interpretations was considered suitable depending on the psychological capacities and ego strength of the patient. As SPSP was further developed, its core technique was defined as 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).

This theoretical refinement in the development of SPSP, enabled us to compare the relative association between supportive and more insight facilitating technique on outcome. We know from the literature that 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 clinical and classical psychoanalytic assumption is that expressive technique when utilized in patients with stronger ego capacities, lead to better outcome (Greenson, 1967; Kernberg, 1984). We therefore 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. We found indeed that insight facilitating supportive technique was related to better outcome but defense style, as evaluated by the therapist, appeared to be the strongest independent predictor of outcome. Unlike the classical psychoanalytical assumption, we did not find an association between expressive technique with patients who utilize mature defense styles and treatment success. This can be seen in line with some
recent findings in the literature suggesting that patients with a primitive defense style may profit from insight promoting supportive interventions (Leichsenring, 2005; Owen & Hilsenroth, 2011). However, from our data it could not be concluded that outcome indeed would have been better if more expressive technique had been applied in the primitive defense group, as other recent findings indicate (Diener et al., 2007; Högland et al., 2008).

Which alliance?

When this project was started, there was a paradigm shift going on in thinking about the mechanisms of change in psychotherapy. During my training as a psychotherapist, and later as a psychoanalytic psychotherapist, the emphasis was on psychoanalytic theory of pathology and structural change, structural diagnosis and therapeutic technique. But more and more, the emphasis altered towards the idea that common factors unrelated to the theoretical assumptions that guide the technique, were predictive of psychotherapy success. The evidence of psychotherapy outcome studies in the 1970’s – 1990’s yielded equivalence between psychotherapy modalities and a famous response to this was the declaration of the “Dodo bird’s” verdict: Everyone has one and all must have prizes (Luborsky et al., 1975).

When psychotherapy treatment manuals and randomized clinical trials entered the arena of psychotherapy research, different psychotherapy modalities battled to win a prize and to conquer a place in the national treatment guidelines. Thus at that time there was a debate between proponents of the non-specifics argument with its emphasis on the therapeutic relationship as the supposed mechanism of change, and the proponents of the particular theory driven techniques of specific psychotherapy schools as curative factors for long lasting change.

Already Freud (1913) emphasized the importance of and attitude of collaboration and cooperation between patient and therapist for successful psychoanalytic treatment. He used the term “rapport” to refer to the patient-therapist relationship. He called it the “vehicle for success” that probably should not be analyzed. The one-person psychology that psychoanalysis was, with the therapist as an observer and the one who interprets unconscious material that is yet hidden from the patient but known by the therapist, progressed toward a two-person view on the psychotherapeutic process in where the therapist is a participant as much as the patient is (Messer & Wolitzky, 2010). The concept of a working alliance was first formulated by Greenson (1967), and was defined as “the relatively nonneurotic, rational rapport, which the patient has with his analyst”. It is this reasonable and purposeful part of the feelings the patient has for the analyst which makes for the working alliance. He saw the alliance as one between the “reasonable ego” of the patient and the “analyst’s analyzing ego”. The patient’s ability to maintain a working alliance depends on his or her ability to effect a split between the “experiencing ego” and the “observing ego”. From then on there has been a tension in psychoanalysis between the concept of non-gratification and the concept of the working alliance. Among traditional analysts, the issue of the relative importance of insight versus the therapeutic value of the relationship in itself has been an ongoing dialectic (Richards & Lynch, 2008). Classical psychoanalysts are concerned that the patient can experience some degree of transference gratification as a result of a good working alliance, while relational psychoanalysts are not concerned about this. In fact, they view frustration and deprivation as a greater danger than the adequate gratification of unmet needs (Messer & Wolitzky, 2010).
Which instrument for assessing alliance?
The Helping Alliance Questionnaire I (HAQ I; Alexander & Luborsky, 1986) stems from the
definition of the therapeutic relationship or alliance concept that follows from the work of
Bordin (1979) and involves interaction and working on the tasks and targets of therapy in the
context of an affective bond. This alliance measure was implemented in our RCT’s. 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
therapeutic alliance on outcome and change in our trials, we first aimed at the psychometric
properties of one of our main process measures. 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. 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 (Hatcher, 2010). Our study extended and
differentiated the theoretically assumed distinction by Bordin (1979) and Alexander &
Luborsky (1986) between a factor that comprised supportiveness and helpfulness and a goal-
oriented, or collaboration factor. Our study suggests that patients view supportiveness and
helpfulness as separate elements of the alliance. We recommended 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. A
bridge towards improvement of alliances in clinical practice can then be made.

What comes first: alliance or 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). It is by far the only process factor in
psychotherapy that explains something of why psychotherapy works. However, this relation
between alliance and treatment success does not imply causation (e.g., Barber et al., 2000).
It has been questioned whether a good early 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). In order to do so, the alliance as a mediator of change has to be demonstrated.
Alliance research has not been able to repeatedly demonstrate the alliance – outcome
timeline: alliance predicts change and change predicts alliance (Kazdin, 2007). With regard to
the timing of assessment, the studies that found a predictive role of the alliance on symptom
decline beyond prior change, all measured the alliance in the first treatment month (Crits-
Christoph et al., 2013). We wondered whether the impact of the therapeutic relationship on
symptom change would be different when it was measured early in the therapeutic process
or later on when the affective bond between patient and therapist had its chance to
develop. Therefore 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.

Alliance in the first phase of treatment did predict symptom change from week 5 onward. Alliance was not predicted by prior symptom change. However, alliance at week 12 did not predict subsequent symptom change beyond prior symptom change and again the alliance course was not predicted by early symptom change. These results provide additional support for the role of early alliance as a mediator of change in short-term psychodynamic psychotherapy for depression. It stresses the importance of optimizing the quality of the alliance and thus the lowering of drop-out rates (Barber et al., 1999) in the first phase of short-term dynamic therapy. These results do not doubt the important role of the alliance in the middle of psychotherapy but question its direct role on outcome when measured halfway through therapy. Barber et al. (2000) and Crits-Christoph et al. (2011) hypothesised that the alliance later in treatment is more confounded by prior change than the alliance early in treatment. Few studies found significant predictions of late alliance (DeRubeis & Feeley, 1990) and findings are mixed for mid-treatment alliance related to outcome (Castonguay et al., 2006).

From a psychotherapeutic point of view, one may speculate that the initial stage of the therapeutic encounter is based on expectations and hope for adequate symptom relief by the therapist, relatively free from archaic attachment patterns. The perceived quality of the alliance in this stage could be more related to treatment success. Over time when (counter) transference phenomena emerge (Meissner, 2001), alliance and transference become intertwined, resulting in a more differentiated and complex effect on treatment outcome (Høgland et al., 2011). Our meager effect of alliance in the middle of treatment on change could be seen as a result of this blur of variables that are intertwined during the therapeutic process with the alliance not detectable anymore as a separate variable influencing outcome due to unconscious intra and interpersonal processes as they emerge and unfold in the psychotherapeutic process.

Early depression symptom change did not have a significant influence on the course of the alliance. In other words, the alliance was not predicted by early symptom change. Here, the alliance literature shows mixed results with only three studies that did find evidence for the prediction of the alliance level (Falkenström et al., 2013; Puschner et al., 2008; Webb et al., 2011). Only Falkenström et al. (2013) predicted both directions of the alliance – outcome relationship session by session in primary care. In doing so, the within patient alliance was predicted and all variables that could account for change on their own, were controlled for. This study demonstrates that improving the alliance with a given patient directly leads to better outcome results at least in very brief treatments. As hypothesized before, due the influences of (counter) transference phenomena that are dealt with differently in various therapy schools, results can be different in mid-long and longer-term treatments such as SPSP. Because the alliance, as an isolated property of the therapeutic relationship, might be interwoven in all components of the psychotherapeutic process, especially as the therapeutic process unfolds and develops, prediction models therefore may miss it over the full course of treatment. Thus 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. However, the fact that early alliance predicts subsequent change and does not influence the alliance level can also be seen as indicative of the state independency of alliance and supports the possible role of the alliance as a mediator of change.

**What comes first: technique or alliance?**
Although no direct inferences can be made from the studies in this thesis regarding the association between therapeutic techniques on the one hand and the therapeutic relationship on the other on outcome or change, the content of this thesis justifies and obligates us to make interpretations and starting points for clinical guidelines. The effect of supportive versus expressive techniques on outcome, are mixed (Diener et al., 2007; Høglend et al. 2008) and the role of the alliance in this complex interplay is not yet well understood but might appear crucial. We found that insight facilitating supportive interventions in SPSP lead to better outcome compared to solely supportive interventions. We further found that defense style was the strongest independent predictor of outcome. But unlike clinical psychoanalytic lore, 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 interventions (Leischenring, 2005; Owen & Hilsenroth, 2011).

**Transference and alliance: intertwined but distinct concepts?**
A form of psychodynamic psychotherapy that lies at the other side of the supportive-expressive continuum is Transference Focused Psychotherapy (TFP), a highly structured, twice-weekly psychodynamic treatment based on Kernberg’s (1984) object relations model of BPD. Fairly recent studies have demonstrated TFP’s effectiveness (Levy et al., 2006) and the theory and technique of TFP have learned us about the effect of insight facilitating interventions in a structured context, thus providing the ego with sufficient holding to prevent it from lasting regression and fostering progression. There are moments in TFP though that the projections or projective identifications, distort reality and temporal regression of the ego does occur. Through interpretations of the horizontal and vertical split dyads, reality is installed and the ego can lean on its adequate reality testing. These are exciting moments in the therapeutic encounter, on a road that never shows its outcome at the onset. The patient must trust the therapist fully and the therapist in turn must trust the patient and his own capacity to contain and understand what’s going on in both of them. I cannot think otherwise than that there is a technique by patient characteristic interaction in the context of the magnitude of the alliance (Levy & Scala, 2012). My patient and I are nowhere without a solid alliance on this rough road to structural change. And notwithstanding the fact that the effect of alliance on outcome is only modest, 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. In contrast to TFP, in SPSP, the pressure on the ego is minimal. The vignette of Peter in chapter 10, illustrates the supportive attitude of the therapist despite Peter’s devaluations and attacks on the therapist’ self-esteem. The technique of APS is and alliance fostering technique: by aiming at the simultaneously felt (malevolent) old and a new (benevolent) relationship, affective laden relational dissonance is the result. The therapist offers himself
as a new self-object (Kohut & Wolf, 1978), without confronting or interpreting the function she serves. She understands Peter’s need for sameness in this struggle to find cohesiveness and reflects his genuine feeling of working together towards a sensible goal. This way, the therapeutic alliance is firmly co-created by both therapist and patient (Lachmann, 2008). By engaging and co-creating in a new accepting relationship in which Peter was allowed to feel, think and say anything that came to his mind, where there was genuine interest in his inner world, two external-interpersonal relationships simultaneously could emerge in the intersubjective therapeutic environment: an old harsh aggressive object relation that infiltrated in his id, ego, super ego and ego ideal, and a new benevolent one. He now for the first time in his life had a sense of what it is like to be real in a relationship and still be cared for without having to clown around. In this sense, APS is an alliance fostering technique and alliance building in SPSP is APS.

Our finding that alliance was predictive of change only early in SPSP, supports this view. At the start of the psychotherapeutic process in SPSP, the supportiveness and helpfulness of the therapist is distinct from change and this supportiveness predicts change towards the end. As the therapy progresses, the affective bond between patient and therapist are no longer detectable as a distinct factor from the change process that occurs. This by no means implies that the bond is not important during the course of SPSP but it could be that we were actually measuring a complex concept, intertwined with the therapeutic technique of APS, thus not so easily detectable and isolated in RCT’s that were designed for efficacy research.

The empirical evidence from the studies in this thesis and of recent empirical findings including TFP, as well as our experience with SPSP 25 (see new perspectives), lead to the assumptions that 1) in SPSP, with APS as its core technique, alliance is technique and technique is alliance. They are inextricably tied together. 2) The more expressive techniques are used in a treatment modality, such as TFP, the more alliance and technique might become distinct concepts with alliance probably as a prerequisite and context for the acceptability of insight promoting interventions such as confrontations and interpretations. These assumptions need more empirical work to determine whether or which holds true.

New perspectives

Broadening the indication for SPSP?
Within the Dutch Psychoanalytic Institute (NPI), SPSP is now applied in patients with chronic or recurrent depression and comorbid personality pathology. The treatment comprises 25 sessions within nine months with a frequency of the first eight sessions two-weekly, followed by nine weekly sessions and the final eight sessions fortnightly. The aim of SPSP 25 is similar to SPSP 16: the remission of depressive symptoms and small but clinically relevant structural personality change. The effectiveness needs to be investigated but our clinical impression shows good results (de Jonghe et al., 2013).

In this more intensive form, in technical terms, the emotional meaning of the depression is more explicitly discussed from the beginning, thus as a defense of affect (e.g. depressed rather than sad, angry, powerless, guilty, ashamed, let down). In SPSP, this is done in an adequate supportive way but it is our experience in this patient group with often long lasting
depressive symptoms that the application of supportive interventions only, may lead to discouragement rather than motivation to change. We need to formulate an answer to this and insight facilitating supportive technique might be an answer. From the very start of SPSP, on the first discourse level (the level of symptoms and complaints), the depression can be reframed as a defense against other affects. On the second discourse level (the level of life circumstances), the depression can be reframed as frustration or aggression towards external circumstances. From the third discourse level (the level of interpersonal conflicts or deficits) and up, the function of the depression in light of feelings and affects towards others in the present, in the past and towards the self can be explored and upward interpretations can be useful. Because the treatment starts intensively (twice a week the first month), transference and counter transference feelings come to the fore more at the start and at termination. Interpersonal conflicts and patterns enter the therapeutic relationship easily. Explorations and when needed confrontations in the transference, related to the depression, can be necessary. Empirical evidence supports this effort since to date, gains in self understanding seems to be the only detectable technique variable that leads to change in psychodynamic psychotherapy (Crits-Christoph et al., 2013).

Differences between clinicians in alliance building
The findings of his thesis underline the importance of a firm therapeutic relationship, especially in the first phase of SPSP. It is predictive of symptom decline at the end of treatment and so far, the alliance is the only process factor that psychotherapy process research has detected to have a moderately low but consistent impact on treatment success. Thus far, the impact of the alliance is greater than the influence of techniques across therapy schools (Crits-Christoph et al., 2013). Although in studies as these, especially in RCT’s, alliance scores are rated high in general, with low deviations from the mean (Barber, 2009), there are individual differences between therapists. Baldwin & Imel (2007) found that therapists who were rated by their patients with high mean alliance scores, showed significantly better outcomes than therapists who formed weaker alliances according to their patients. In our study, on individual data level, we found that patients with good alliance scores often had low HAM-D end scores. But we also found therapists with bad alliance scores but good results and vice versa. Because the remission rate of depressive disorder hovers somewhere between 35% and 70% (Lambert, 2013), a substantial amount of our patients do not respond to treatment. Furthermore, we are learning that when therapists apply manualized treatments to selected symptom clusters without addressing the complex person who experiences the symptoms and without attending to the therapeutic relationship that supports the treatment, therapeutic results are short-lived and rates of remission are high (PDM Task Force, 2006). We are therefore obligated to make our treatments work for more patients and optimizing the alliance is one way to do this. The field however is lagging behind in the development of practice and training guidelines (Sharpless et al., 2010). This is partly due to its complexity. A good psychotherapeutic process consists of the interaction of two people intimately working together with their own life history, unresolved pain, attachments pattern, temperament, interpersonal style and expectations. This makes psychotherapy such a rich experience but at the same time, the patient-therapist couple is vulnerable to the same patterns of conflict and misunderstandings as normal couples are for all the same reasons.
Can alliance-fostering technique be learned and trained?

Competence and judgment that underlie the choice and manner of interventions may be as important as the specific technique that is used. Clinicians should be aware of the importance of a firm therapeutic bond especially in the first phase of short-term treatment. In current practice, dominated by extensive waiting lists and pressure on the costs of mental health care in the Netherlands, it is all too tempting to just treat the depression by means of a simple PDT or CBT protocol conducted by a post graduated psychology student and thus creating a large patient turn over. However, it takes practice, experience, tact, interpersonal skill and a good deal of self-reflection to engage in a psychotherapeutic process, independent of its duration. Both over structuring and under structuring predicts a negative alliance as does the excessive use of either therapist silence or self-disclosure (Sharpless & Barber, 2009). These skills are part of the post-doc training programs of psychologists and psychiatrists but the ability to form alliances may be a trait rather than a trainable skill (Crits-Christoph et al., 2006). Because the feeling of being understood in an affectively laden relationship is highly dependent on internal object representations of both patient and therapists, it is yet unknown whether therapists can be trained or improved in this skill (Høgland et al., 2011; Crits-Christoph et al., 2006). What can be trained is the ability to emphatically co-create treatment goals in case of below average alliance scores and there is evidence that this might enhance the alliance and reduce dropout (Roos & Werbart, 2013).

We have to train our students in alliance fostering technique in the post doc programs. But in order to optimize treatment results, we should train ourselves constantly in optimizing alliances with our patients. DeFife & Hilsenroth (2011) describe how to engage the patient as an active ‘copilot’ in the treatment situation. Alliance building is not about being nice or friendly. In SPSP it is about:

a. feeling empathy for the (un- or non conscious) affect the patient is communicating whether verbally, physically or by acting-out;
b. explicitly communicating the treatment course and its rationale for the alleviation of symptoms;
c. engender confidence in the treatment;
d. setting goals for treatment thus stimulating progression from the first encounter. It is about the non-verbal communication of working together in the same direction that gives the patient the feeling of being understood and helped at the same time. It gives direction to the unknown and uncertain road that psychotherapy is for most people. At least one person in the room takes the lead in the sense that he or she initiates the journey, defines it whether ambiguous, unclear, and uncertain;
e. the implicit or explicit development of a dynamic hypothesis about the symptoms in their context of current life circumstances, inter- and intra personal current and past relationships;
f. being alert, flexible and adjusting the supportive technique to the individual patient ego capacities;
g. fostering affective expression.

It is our task to teach our students the capacity to build firm alliances with different patients. That gives them the inner compass to choose their interventions in the context of the alliance. Crits-Christoph et al. (2010, 2006), developed alliance-fostering psychotherapy and incorporated in their Supportive Expressive psychotherapy for depression, practical
guidelines for the clinician. Based on the definition of alliance by Bordin (1979), they aimed at three components: agreement on tasks, agreement on goals and therapeutic bond. The primary techniques designed at agreement on goals were 1) establishing explicit goals and 2) regularly evaluating goals. In regard to agreement on tasks they developed an initial socialization process, conducted during the first one or two sessions, to orient the patient to the general tasks of treatment. This was an intervention that should be presented at the appropriate time and worded so as to enhance the initial alliance. Therapists were instructed to review tasks regularly and assess whether there is still agreement with the patient about the tasks. The techniques for the bond element of the alliance were personal role involvement, interactive coordination, communicative contact and mutual affirmation. Therapists were trained in a one-day workshop and additional supervision by a highly experienced clinician. An adherence checklist was used in the supervision, which proved to be helpful. The authors formulated two overarching themes in their lessons learned from the implementation of these initial guidelines. The importance of 1) a positive alliance between the supervisor and the trainee and 2) the clinical flexibility to tailor any technique to the individual patient. They report importance of fostering the alliance throughout therapy, of doing far more than learning specific tricks for building the alliance. The therapist is encouraged to self-reflect and incorporates the skills into his own interpersonal issues. These enhanced skills enable therapists to tailor the alliance-building techniques to the unique expectations, needs and personalities of diverse patients. We are planning on incorporating the training of this skill into the SPSP manual.

**Direct implications and recommendations for clinical practice**

Although restricted due to the mainly explorative design of the studies we conducted, the findings presented in this thesis have implications for clinical practice and can be regarded as considerations and recommendations that may be taken into account by the clinician when treating depressed patients.

**Treatment choice**

1) There were no differences regarding feasibility and effectiveness in psychotherapy alone or combined therapy but patients’ subjective experience was that combining antidepressants and psychotherapy in the treatment of depression had clear advantages. Later restudies have confirmed the advantage of combining pharmacotherapy and various forms of time-limited psychotherapies (de Maat et al., 2007; Pampallona et al. 2004). Therefore it is recommended to offer combined treatment to patients suffering from depression but also to give them the alternative of psychotherapy alone. Pharmacotherapy can be then be added as stepped care modality when psychotherapy does not bring about the expected change.

**Use of clinical judgment**

2) Maturity of defense style, as evaluated by the therapist, appeared to be the strongest independent predictor of outcome. Clinical judgment on the level of defense style was sufficiently reliable. We therefore recommend training on therapist level to further improve the clinical judgment of defense style and to address this to every intake or initial session of treatment. Furthermore, clinicians were able to evaluate their own therapeutic technique. In case of SPSP, APS technique has to be tailored to the level
of defense and the clinician should bear this in mind from the outset of treatment. By means of a rather simple form like the TEF, we could implement this. This does not have to imply extra diagnostic tools. Instead, adding a list of defense mechanisms according to Vaillant (1971) and the awareness of its importance can enhance APS technique and gives the SPSP therapist the choice to flexibly vary of the supportive-insight facilitating continuum.

3) The finding that there was no association between expressive technique with patients who utilize mature defense styles and treatment success, can lead to several clinical implications. First, it implies modesty in the psychodynamic assumptions made by ego psychologists (Greenson, 1967). Second and in line with recent developments (Leichsenring, 2005; Owen & Hilsenroth, 2011), it frees the psychodynamic psychotherapist from an inflexible attitude but instead gives way to offer insight promoting supportive interventions in a less healthy patient group. Third, as the SPSP therapist tailors his interventions to the ego strength, defense style and psychological capacities of his patient, treatment can be started right away after intake. The findings in chapters 6 and 7 that the level of ORF and personality pathology did not predict the quality of the alliance, is fully in line with this. No expensive and time-consuming diagnostic assessments are needed to start SPSP. Despite its value and the fact that the accuracy and reliability of clinical judgment has to be improved (Garb, 1998), in order to start SPSP, it is not recommended.

4) Insight facilitating technique was related to better outcome. SPSP needs a further operationalization of these interventions that extend the technique of APS. The SPSP therapist needs guidelines and tools on how to use confrontations and upward interpretations in such a manner that there is sufficient structure and containment for the ego to maintain its reality testing and progressive stance. Especially with the patient group that we see more often in the mental health institutions that suffer from recurrent of chronic depression and severe personality pathology, the importance of compelling the ego at an optimal balance in order to create object relational dissonance and therefore structural change, seems worthwhile to investigate in clinical practice. The theory and technique of TFP (Levy et al., 2006) can be a valuable example.

Role of the alliance

5) The HAQ I or HAQ II should be added to every Routine Outcome Monitoring battery that every mental health institution in the Netherlands is obligated to use. When the HAQ I is added, it is recommended that the scores on the factors relationship and internal change are separated. This offers to both the patient and the clinician 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.

6) The SPSP therapist can rely on the method of APS in the sense that no matter what type of personality pathology enters his consultant room for treatment, the technique of APS is suitable for every patient type. Although APS is different in nature in a cluster A, B or cluster C patient, it can be tailored to the optimal balance for ego progression and relational dissonance in the therapeutic relationship. While we gain more knowledge
Alliance training

7) Clinicians should be aware of the importance of a firm therapeutic bond especially in the first phase of short-term treatment. We have to train our students in alliance fostering technique in the post doc programs. But in order to optimize treatment results, we should train ourselves constantly in optimizing alliances with our patients. We need to train clinicians in the ability to emphatically co-create treatment goals (Roos & Werbart, 2013).

8) It is our task to teach our students the capacity to build firm alliances with different patients. That gives them the inner compass to choose their interventions in the context of the alliance. Crits-Christoph et al. (2010, 2006), developed alliance-fostering psychotherapy and incorporated in their Supportive Expressive psychotherapy for depression, practical guidelines for the clinician. We are planning on incorporating the training of this skill into the SPSP manual.

9) General variables such as therapists’ age, gender, experience or profession did not predict symptom change or the alliance course in our study. This finding is in line with the research literature to date. It is probably not a specific characteristic that makes one therapist better over another (Beutler et al., 2004). But the within therapist variability is very high (Baldwin & Imel, 2007) indicating that some therapists do better with some patients but not with others. In practice, this means that matching based on these general characteristics, at this moment is not based on empirical evidence and is recommended to be avoided.

Implications for further research

1) This thesis attempted to search for the relative effect of supportive versus more expressive technique, as this is a key theme in psychodynamic theory and thinking of structural change. To date, results imply that the use of dynamic interpretations in general is related to positive therapeutic effects but that use of transference interpretations at high levels might be anti therapeutic for some patients. However, the clinical implications are small due to the small number of studies that have been conducted. Also there is some evidence that competence to dynamic interventions is predictive of the outcome of dynamic psychotherapy at least in depressive and anxiety disorders (Crits-Christoph et al., 2013). Therefore the use of dynamic techniques in psychodynamic psychotherapy needs further empirical underpinning. Furthermore, therapists’ adherence and competence should be addressed standardized as part of treatment and (group) supervision. That will enable us to do process-outcome research in large groups.

2) In this thesis, depression chronicity predicted change in symptoms over time and this is in contrast to other studies in which it was not detected as variable with an independent influence on subsequent symptom change (Barber, 2009). Note however that among these studies, three of them included exclusively chronically depressive disorders thus
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Chronicity in these studies was not an independent variable which influence on change could be analyzed (Barber et al., 2000; Klein et al., 2003; Strauss et al., 2006). To clarify matters for research purposes as well as for clinical guidance, the influence of chronicity on the alliance – outcome relationship should be addressed in a more uniform way in different patient groups in alliance research.

3) Without a doubt alliance is predictive of outcome and this thesis supports evidence for its mediating role on change when measured early in treatment. However, the eleven studies worldwide that found a predictive role of the alliance on symptom decline beyond prior change, all measured the alliance in the first treatment month. Much less is known about its predictive role on outcome and change towards the middle and end of a treatment process. Furthermore, most studies are conducted in short-term treatment or during a one-year therapy course. To date, we have no knowledge of the development of the alliance and its impact on treatment success in longer term psychotherapy. As dynamic psychotherapies often have a longer duration, clinically this is of major importance.

4) The definition and operationalization of the alliance concept differs between studies. The Bordin (1979) definition of alliance as a degree of affectively engaging in collaborative goal oriented work is widely used. Alliance assessments are numerous, all measuring the elements of interaction, collaboration and affective bond proportionally different (Elvins & Green, 2008), leading to confusion about its definition and its meaning (Barber et al., 2013). Furthermore, the subscales of these instruments are factor analytically derived and capture elements of therapist, patient and relationship features that are not separated from relationship factors, therapeutic technique and (un) conscious enactments in the patient-therapist dyad (Hatcher & Barends, 2006). Some authors state that we need to review the alliance concept: not as a component in itself but as a property of all components of the psychotherapeutic process (Hatcher & Barends, 2006). Alliance, real and primitive relationship aspects, transference and countertransference phenomena as well as the use of technique are intertwined (Greenson, 1976; Messer & Wolitzky, 2010) and proportionally differ during a psychotherapeutic process (Meissner, 2001). Clinically however, our results underline the importance of a firm early alliance. The Relationship factor of the HAQ I comprise the feeling of being understood by the therapist and of working together in the same direction. Among the four alliance instruments recommended by Martin et al. (2000), are three measures focusing on the affective bond between patient and therapist: the Working Alliance Inventory (WAI), the HAQ and the California Psychotherapy Alliance Scale (CALPAS). The latter focuses mainly on the affective bond whereas the HAQ and the WAI also focus on the agreement on goals en working in the same, direction (Elvins & Green, 2008). Webb et al. (2011) found, surprisingly, that it was not the Bond factor of the WAI that predicted change but the Agreement factor. Thus, research is needed to compare the relative predictive value of the bond aspect and the goal oriented aspect of the alliance and the hypothesis should be tested that they predict treatments proportionally different during a therapy course. The HAQ II could be used for this purpose, since it comprises both elements.
5) In this thesis, the alliance was measured twice during treatment. Crits-Christoph et al. (2011) found evidence that the alliance – outcome correlation is probably larger than the 7.5% outcome variance that is found in meta-analyses, when at least 4 treatment sessions are used. We strongly recommend for future alliance research to focus more on session-by-session alliance prediction within patients in different therapies and populations. Unconscious intra and interpersonal processes as they emerge and unfold in the psychotherapeutic process could be addressed more adequately this way and we could gain more knowledge about the complexity of moments of meeting in which the relationship as it is implicitly known by two people, constantly alters and changes mental states and behavior. (Stern et al., 1998).

6) Future research has to the obligation to focus on how training in alliance fostering skills can enhance alliance and treatment success. We need to develop an instrument that can be used across modalities that therapists can use to improve themselves and their treatments. We owe this to our patients.
Discussion

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