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Growing Evidence for Psychodynamic Therapy for Depression

Abstract. Psychodynamic therapy (PT) for depression is the least examined treatment method for depression, compared to cognitive-behavioral therapy (CBT) and interpersonal therapy. This article, consisting of five randomized clinical trials of short psychodynamic supportive psychotherapy (SPSP) conducted over the last 25 years in Amsterdam, will review the trial results to provide answers to the question about which role SPSP can play in the treatment of depression. The researchers conclude that it is justified to qualify SPSP an empirically supported therapy form of PT for depression. In particular, adding SPSP to pharmacotherapy yields better results than pharmacotherapy by itself. Adding medication to SPSP may have a significant added value, but it is not as large as in the first comparison. The results also confirm no difference in efficacy between CBT and SPSP.

Keywords: depression, short psychodynamic supportive psychotherapy, clinical trial, evidence-based practice, psychodynamics, clinical effectiveness

Introduction

Depression is one of the most prevalent mental disorders worldwide. The lifetime prevalence ranges from 15% to 20% (Kessler et al., 1994). Depression is currently treated in different ways. It is well established

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that psychological interventions are effective in the treatment of depression. In recent decades, a large number of trials have been conducted in which the effects of psychological treatments of depression have been examined. These studies clearly show that psychological treatments have large effects in terms of symptom reductions and increased well-being (Cuijpers, van Straten, Warmerdam, & Andersson, 2008). The most examined psychological treatment for depression is probably cognitive-behavioral therapy (CBT), with interpersonal therapy coming next. Short-term psychodynamic therapy (PT) is probably the least examined treatment method of these three therapies.

The efficacy of PT for depression was the focus of three meta-analyses. The first meta-analysis (Leichsenring, 2001) included six studies comparing PT with CBT and found that both psychotherapies were equally effective in the treatment of depression, a result the author suggested should be regarded as preliminary, due to the small number of included studies. The second meta-analysis (Churchill et al., 2001) compared PT to CBT and found that patients receiving CBT were more likely to recover than those receiving PT, but found no differences in posttreatment symptoms, symptom reduction, or drop-out. The third meta-analysis of our own research group (Driessen et al., 2007) was the most extensive study, and included many more trials than the first two meta-analyses. This study included 23 studies encompassing a total of 1,365 subjects (713 in the PT conditions, 551 in the alternative psychotherapy conditions, and 101 in the control conditions). In this last meta-analysis, PT appeared effective in the treatment of depression in adults. The pre- to posttreatment effects were consistently large, indicating a significant reduction of depressive symptoms after PT. These reductions were maintained at three-month, six-month, and one-year follow-ups. In this analysis no significant differences between PT and other psychotherapies were apparent at the three-month follow-up, but a nonsignificant trend did indicate a possible small superiority of the other psychotherapies at the one-year follow-up. The authors of the last meta-analysis concluded that PT resulted in a large and enduring decrease of depression levels, that PT was more effective than control conditions, and that PT may be considered to be an empirically validated treatment method for depression.

In the 1970s and 1980s, different types of short-term PT (all based on psychoanalytic models) were developed by Malan (1963), Mann (1973), Sifneos (1979), Davanloo (1980), Luborsky (1984), Strupp and Binder

(1984), and Pollack and Horner (1985). The most recently developed and extensively studied variant in the family of psychodynamic treatments is the Short Psychodynamic Supportive Psychotherapy (SPSP), developed in the early 1990s as a structured treatment for depressed outpatients by De Jonghe (De Jonghe, Rijnierse, & Janssen, 1994; De Jonghe et al., 2013). SPSP is a face-to-face, individual psychotherapy, consisting of 16 sessions in six months (eight weekly sessions, then eight fortnightly sessions). The emphasis is on supportive techniques that counter regression and foster psychological growth. The primary goal of SPSP is to cure depression. The secondary goal is to reduce patients' vulnerability to depression. For a full description of the theory and methods of SPSP we refer to the most recent article by De Jonghe et al. (2013).

Up to now, the efficacy of SPSP has been examined by a single research group, who conducted five randomized clinical trials in similar but different study populations, and used identical research designs (e.g., the same instruments and assessment periods), with a research period of each trial lasting about four years. In this article, we will review the trial results of the last 25 years.

Methods

Goals of the Five RCTs

At the start of our study project we were interested in the incremental value of SPSP in combination with pharmacotherapy. The second trial investigated the comparative efficacy of two versions of combined therapy, one with eight sessions of SPSP and one with 16 sessions of SPSP. The third trial assessed the relative efficacy of combined therapy and SPSP on its own. The fourth trial concerned SPSP alone and pharmacotherapy alone. And in the last trial SPSP is compared with an already empirically supported therapy, namely CBT. In Table 1 the comparisons of all the trials are listed.

The fourth trial started with a randomized clinical trial of eight weeks, making a direct comparison between antidepressants and SPSP. At eight weeks, all patients with less than a 30% decrease in symptoms were offered combined therapy for an additional period of 16 weeks. Non-responsive patients receiving antidepressants were therefore offered complementary psychodynamic supportive psychotherapy, whereas

Table 1

Comparisons of the Trials

Experimental Arm			Control Arm
First trial	SPSP 16 sessions with pharmacotherapy	versus	Pharmacotherapy
Second trial	SPSP 16 sessions with pharmacotherapy	versus	SPSP 8 sessions with pharmacotherapy
Third trial	SPSP 16 sessions with pharmacotherapy	versus	SPSP 16 sessions
Fourth trial	SPSP 16 sessions	versus	Pharmacotherapy
Fifth trial	SPSP 16 sessions	versus	CBT 16 sessions

SPSP = Short Psychodynamic Supportive Psychotherapy; CBT = Cognitive Behavioral Therapy

nonresponsive patients receiving psychodynamic supportive psychotherapy were offered complementary antidepressants. In the fifth trial, patients received antidepressants in addition to their psychotherapy if they showed severe depressive symptoms (Hamilton Depression Rating Scale score > 24) at the start of treatment.

The first trial started in June 1993 and had an inclusion period until June 1995. The second trial started in August 1995 and had an inclusion period of three years until September 1998. The third trial ran from April 1997 until June 2002. The fourth trial started in July 2002 and ran until November 2005. The fifth trial started in February 2006 and had an inclusion period until November 2009. The trials were all conducted in various outpatient clinics in Amsterdam.

Study Samples

Inclusion. The samples of the five random controlled trials consisted of new, consecutively registered depressed patients at three outpatient clinics of the Mental Health Institution Arkin in Amsterdam. Patients were referred by general practitioners. In addition to written consent, inclusion criteria were: age between 18 and 65 years and a DSM-III-R (American Psychiatric Association [APA], 1980) or DSM-IV (APA, 1994) defined Major

Table 2

Hamilton Depression Rating Scale (HAM-D) Inclusion Criteria and Mean Baseline HAM-D Scores at Baseline of All the Trials

	Severity of Depression	HAM-D Inclusion Criterion at Baseline
First trial	Mild, moderate and severe	> = 14
Second trial	Mild, moderate and severe	> = 14
Third trial	Mild and moderate	> 11 and <25
Fourth trial	Mild and moderate	> 11 and <27
Fifth trial	Mild, moderate and severe	> = 14

Depression with or without dysthymia. The DSM diagnosis was assessed by means of a semi-structured interview (Huyser, De Jonghe, Sno, & Schalken, 1996). A further inclusion criterion was a certain score on the 17-item Hamilton Depression Rating Scale (HAM-D; Hamilton, 1967). In Table 2, the HAM-D inclusion criteria of the trials are depicted as well as the mean HAM-D scores of all the patients at base line.

In the third and fourth trials (De Jonghe et al., 2004; Dekker et al., 2008; Van, Dekker, et al., 2009), patients with severe depression (HAM-D score 26 or more points) were excluded because it was considered unethical to offer severely depressed patients only psychotherapy and to withhold medication.

Exclusion. The exclusion criteria included the presence of any of the following conditions: a psychoorganic disorder, drug abuse, a psychotic disorder and/or a dissociative disorder, not being reliable enough to participate in a clinical trial (e.g., doctor shopping), serious communication problem (e.g., language barrier), physical restrictions (e.g., the patient will soon leave the country), being "too ill" and/or "too suicidal" (e.g., hospitalization is unavoidable), pregnancy, or a wish to become pregnant. Patients with personality pathology or disorders were not excluded.

Exclusion criteria associated with medication included the following: a contraindication for one of the antidepressants prescribed by the pharmacotherapy protocol, a history of adequate treatment with antidepressants

Table 3

Participants' Flow of the Original Five Trials

	Trial 1	Trial 2	Trial 3	Trial 4	Trial 5
Assessed for eligibility	525	824	463	612	570
Excluded	358	616	360	471	229
Not meeting inclusion criteria	113	158	80	132	133
Meeting inclusion criteria	213	433	251	276	437
Refused	32	25	29	63	73
Randomized	167	208	103	141	341

during the present depressive episode, and use of psychotropic medication not prescribed by the pharmacotherapy protocol. The inclusion and exclusion criteria are the usual ones in clinical pharmacotherapy.

Flow of Participants

In the paragraphs, tables, and figures that follow, we will discuss the main results of the trials. In the second part of this article, we will describe the secondary analyses of the trials, and we will also present therapy results of native and nonnative patients in the SPSP arm of the fifth trial. Table 3 shows the participants' flow of the five trials.

Randomization

All patients in the trials were allocated (through a random allocation procedure) to one of the treatment conditions. Participants of the fourth trial of Dekker et al. (2008) who refused to participate in the randomization procedure were offered the possibility of receiving treatment (psychotherapy or pharmacotherapy) by preference. The results of this by preference group (mostly psychotherapy patients) were described by Van, Dekker, et al. (2009).

Short Psychodynamic Supportive Psychotherapy

SPSP (see also Driessen et al., 2007) was developed as a treatment for depressed outpatients in the early 1990s by De Jonghe et al. (2013). SPSP is rooted in six psychoanalytical theories (described elsewhere; see De Jonghe et al., 2013). Together these theories posit six innate, basic, social needs: sexuality, aggression, the need to engage in relationships, and the need to be protected, loved, and esteemed. If these needs are inadequately met in early infancy, they persist in adulthood as ongoing malignant aspects of the internal relationships, acting as moulds on new external and internal relationships. SPSP considers the gratification of these needs particularly relevant in the treatment of depressed patients. The therapeutic action of SPSP consists in experiencing "relational dissonance," or friction between two contradictory relationships, in the therapeutic situation. One is determined by molds resulting from past relationships, the other by the present relationship with the therapist, in which the patient will experience adequate gratification of his unmet early infantile needs. The proper gratification of unmet developmental needs forms the psychoanalytic definition of "support," which is considered an important curative factor in SPSP (De Jonghe et al., 2013).

In general, psychoanalytically oriented psychotherapies can be placed on a supportive-exploratory continuum. SPSP can be regarded as situated within the supportive half of this continuum. PTs located on the exploratory end emphasize the interpretation of transference. SPSP recognizes the existence of transference but does not interpret it. Specific to SPSP is the distinction of different levels of discourse within the discussion of the problem area. Levels 1, 2, and 3 successively focus on the patient's physical and psychological symptoms and complaints, the influence of life circumstances on the depressive symptoms, and the influence of external interpersonal relationships on the depressive symptoms. At the fourth and fifth levels, the focus shifts to one or more relational patterns in the patients' life and the patients' attitude in life, respectively. The sixth level concerns the past relationships that persist in the patients' current life, and the seventh level concerns the intrapersonal relationship the patient maintains with him- or herself, as a consequence of identification with these past relationships. At the eighth and ninth levels the focus shifts to how the problems discussed at levels 4–7 manifest themselves in the relationship with the therapist. The levels of discourse

can vary considerably during the course of treatment (De Jonghe et al., 2013).

As mentioned previously, support is regarded as the most important curative factor in SPSP and considers support that promotes progression and maturing behavior as adequate, while regarding support that promotes regression as inadequate. The therapist explicitly shows a supportive attitude: being empathic, accepting, committed, active, flexible, clear, definite, patient, and persistent. In addition, the therapist systematically employs supportive techniques such as reducing guilt, shame, and isolation, clarifying, confronting, rationalizing, enhancing self-esteem, advising, and modeling. SPSP, as described by De Jonghe et al. (2013), constitutes the treatment protocol in the present study. According to this protocol, SPSP consists of three treatment phases. In the starting phase, the depressive complaints and their interpersonal context are as follows: psychoeducation about depressive disorders is given; treatment aims are established; and a treatment proposal is made. The second phase is devoted to working on the treatment aims, which usually relate to one of four interpersonal problem areas: mourning, strife, role transformation, or isolation. The problem area is discussed according to the different discourse levels. If possible, a connection is made between the problems in this area and the internal relationships (level 3 and thereafter). Patients are encouraged to experience their emotions and to reflect upon them. In addition, patients are encouraged to change their behavior and cognitions, the consequences of which are discussed. The final phase deals with the treatment termination, including any mourning that arises around ending. The treatment aims are evaluated, as well as the patient's perception of the treatment process. In addition, the patient's prognosis is considered and attention is given to affirmation of the patient's independence and handling of possible problems in the future.

In all trials, patients received 16 sessions of manualized SPSP (De Jonghe et al., 2013), a form of time-limited dynamic psychotherapy during a period of six months (De Jonghe et al., 2013). SPSP focuses on the affective, behavioral, and cognitive aspects of relationships that can be discussed from both an interpersonal or intrapersonal perspective. Depending on the focus of therapy and the capacities of the patient, the therapists' interventions are primarily directed at providing support (e.g., encouraging adaptive coping, reducing feelings of guilt, providing explanations) or enhancing insight by confrontation or interpretation. Manifestations of transference are recognized by the therapist and, if it is

likely to be beneficial, discussed to facilitate the therapeutic process. This means that the technique used in SPSP can vary across the supportive–expressive continuum according to individual patient characteristics and psychological capacities (Gabbard, 2005). The therapists were trained psychiatrists or psychotherapists. Based on audiotaped material of sessions, the therapists were supervised on a weekly basis.

Pharmacotherapy

Pharmacotherapy was provided in accordance with an antidepressant medication protocol, which allowed for changes in medication in response to inefficacy or intolerance. In the first two trials, fluoxetine was given as first antidepressant. In the third and fourth trials, patients started with venlafaxine (for medication protocol, see De Jonghe et al., 2001, 2004; Dekker et al., 2005, 2008).

Medication was provided by a psychiatrist or by an advanced, supervised resident in psychiatry who also conducted psychotherapy, but never to the same patient. The 15-minute medication consultations took place once every two weeks during the first two or three months of treatment, and once a month thereafter. In all the trials with a combination arm, different therapists provided the psychotherapy and pharmacotherapy.

Therapists

Approximately half of the SPSP therapists were experienced psychiatrists or psychotherapists, and half of them were residents in psychology and psychiatry. Therapists were trained in a 16-hour course, and in order to qualify for being a treatment provider in the study, they needed: (1) to complete one or more supervised therapies; (2) to be found competent in practicing SPSP by one of the two supervisors; and (3) if still in training, they had to participate in a weekly 90-minute group supervision with tape-recorded sessions ensuring adherence to the psychotherapy manual. The other therapists met twice a week for peer supervision, this meeting was chaired by one of the supervisors who also reviewed audiotaped material to maintain protocol adherence.

Outcome Measures

The principal outcome measure was the difference between the assessments at baseline and those at week 24. The primary instrument was the 17-item Hamilton Depression Rating Scale (HAM-D; Hamilton, 1967).

HAM-D data are provided by independent observers (fellows). They gathered their data using a semi-structured interview (De Jonghe, 1994; Kupka, De Jonghe, Koeter, & Vermeulen, 1996). In the review of Bagby, Ryder, Schuller, and Marshall (2004), the interrater reliability (Pearson's r) ranged between 0.82 and 0.98. During the study, they discussed their audiotaped assessments monthly with an expert from our research group. Obviously, the patients and the treating physicians in the trials were not blind. The research fellows, however, were given as little information as possible about the treatment condition and were instructed to restrict themselves to the discussion of the HAM-D items only. Efficacy is expressed in success rates. Success is defined as HAM-D remission on the HAM-D scale, i.e., score ≤ 7.

A second instrument was the Clinical Global Impression of severity (CGI-severity; Guy, 1976). CGI data were provided by the attending clinicians. A third instrument is a self-rating scale: the depression subscale of the Ninety Symptom Checklist (SCL-depression; Arrindell & Ettema, 1986). CGI of severity success is defined as a final score of 1 (meaning a normal mood) or 2 (meaning a borderline case between normal mood and mildly depressive mood). SCL-depression success is defined at the end of therapy as an improvement of the magnitude of at least 1 standard deviation (in comparison with the baseline score). In short, efficacy assessments are based on data drawn from three sources: independent observers, the treating clinicians, and the patients. The assessments were done at weeks 4, 8, 12, 16, and 24.

Statistics

In the main articles the methods of analysis were conducted on three samples of patients. The first sample was an Intention-To-Treat (ITT) sample and consisted of all the patients who entered the studies for randomization. The second sample was the Per Protocol (PP) sample: patients who started with the treatment to which they were allotted. The third Observed Cases sample consisted of patients who started with therapy and for whom the data were gathered at the relevant assessment points.

Results

Patients. In all the trials, the patient groups were more or less equal to each other; two-thirds were women; about 60% were between 20 and 40 (average age 38); 70–80% had received secondary to higher education;

60% cohabited with at least one other person and 40% lived alone; about 20–30% were married; 35% had a job; 30% had been on sick leave for some time; 40–50% had experienced one of more previous depressive episodes; 20–40% had taken medication in the past months; for 30–50%, the duration of the present episode was longer than one year; and the mean HAM-D score of approximately 19 and the mean SCL-90 score of about 49 were far above the national average (De Jonghe et al., 2001, 2004; Dekker et al. 2005, 2008, 2013).

There is a slight trend of patients having more severe problems; more patients with more depressive episodes; more medication use at intake; a longer duration of the present episode. This trend is related to the fact that the outpatient clinics of later trials were more often located in lower-class and deprived areas.

Main results of the trials. In the first trial, we (De Jonghe et al., 2001, p. 228) concluded that combined treatment (SPSP plus pharmacotherapy) was significantly more beneficial than pharmacotherapy alone. Also, there were significantly fewer dropouts in the combined therapy and, ultimately, there were significantly more patients recovered in the combined therapy (see the percentages of recovered patients in the secondary analyses of this article). So, combined therapy seemed preferable to pharmacotherapy in the treatment of depressed outpatients.

In the second trial we (Dekker et al., 2005, p. 55) found that 8 or 16 psychotherapy sessions in addition to pharmacotherapy over a period of six months appeared to be equally effective in dealing with symptoms. That was true for both moderately and severely depressed patients.

In the third trial, our conclusion (De Jonghe et al., 2004, p. 44) was that psychotherapy alone (SPSP) was more beneficial than combined therapy (SPSP plus pharmacotherapy). The six-month feasibility of psychotherapy 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. Neither the attending clinicians nor the independent observers were able to ascertain this, but patients' experiences were clearly in favor of combined therapy.

In the fourth trial, we (Dekker et al., 2008, p. 4) have determined which sequence is preferable for the acute treatment of depression: starting with SPSP or with pharmacotherapy. This trial started with a randomized clinical trial of eight weeks, making a direct comparison possible

between antidepressants and SPSP. To our knowledge, a psychodynamic psychotherapy was never before compared directly to treatment with antidepressant medication. In the first article of this trial, we reported that the benefit of the psychotherapy SPSP was greater than pharmacotherapy. Of the 204 patients suitable for the study, 141 were randomized for SPSP or antidepressants. The remaining 63 patients refused randomization because they did not want to get antidepressants.

In a by-preference model (Van, Dekker, et al., 2009), these patients were offered a choice between SPSP or antidepressants. Almost all the patients preferred SPSP and not antidepressants. The feasibility for both treatment conditions (SPSP or antidepressants) throughout the first eight weeks in this study was almost similar. The study attrition rates (about 28%), in comparison to other studies, reported dropout rates of 33–48% within the first six to eight weeks (Anderson, Nutt, & Deakin, 2000; Linden, Gothe, Dittmann, & Schaaf, 2000). The efficacy of SPSP and antidepressants in the first eight weeks was not equivalent. We found slightly better results for antidepressants by week four. This benefit had almost disappeared by week eight.

The second article of this trial (Dekker et al., 2013) covered the entire course of treatment of six months and focused on the differential efficacy (at 24 weeks) of the treatment strategies. At eight weeks, all patients with less than a 30% decrease in symptoms were offered combined therapy for an additional period of 16 weeks. Nonresponsive patients receiving antidepressants were therefore offered complementary PT, whereas nonresponsive patients receiving PT were offered complementary antidepressants. Stepped-care strategies, like the one in this study, seemed clinically logical, but in our study about 40% of the patients declined the offer of additional therapy, despite the limited effect of monotreatment. The acceptance rate for SPSP or antidepressants after nonresponse was similar in both conditions. Given the widespread support for and implementation of stepped care and sequential treatment strategies, this was an unexpected finding. Concerning efficacy of the two sequential strategies (antidepressants after unresponsive SPSP or SPSP after unresponsive antidepressants), we found that patients receiving psychotherapy from the outset were better off by week 24 (end of treatment), compared to those receiving pharmacotherapy. Our final conclusion was that SPSP has a somewhat slower start than pharmacotherapy alone in the first eight weeks of treatment, but that SPSP prevailed on most assessments in the end.

In the fifth trial (Driessen et al., 2013), noninferiority was shown of SPSP relative to CBT for posttreatment observer- and patient-rated depression scores. Based on observed data, 24.3% of the patients in the CBT condition and 21.3% in the SPSP condition met the remission criterion at the posttreatment assessment. Our conclusion was that the results contribute to the evidence base of psychodynamic therapy for depression.

Reduction of depressive symptoms during treatment. In the first four trials, the efficacy of pharmacotherapy alone is examined in two trials (trials 1 and 4). The efficacy of SPSP (with 16 sessions) alone was examined in two trials (trials 3 and 4) and the efficacy of SPSP (16 sessions) in combination with antidepressants from the onset was examined in three trials (trial 1, 2, and 3). We will now give an impression of the reduction of symptoms during treatment of pharmacotherapy alone, of SPSP alone, and of SPSP in combination with antidepressants.

The mean HAM-D scores of pharmacotherapy during treatment in two trials diminished during the first 12 weeks, but became higher again towards the end of the therapy. It seems that at that point medication reached the lowest point of symptoms reduction.

In the Per Protocol Sample of trial 1, the success of pharmacotherapy, according to the independent research fellow (HAM-D <8), was about 23%, the success according to the doctor (CGI-Severity below 3) was about 48%, and the success according to the patient was about 55%. In trial 4, these success percentages were 9%, 32%, and 53%. In the SPSP alone condition, we did not see such a bend of scores. At the end of therapy, the reduction of depressive symptoms continued.

In the Per Protocol Sample of trial 3, the success of SPSP alone, according to the independent research fellow, was about 32%, the success according to the therapist was about 67%, and the success according to the patient 60%. In trial 4, these success percentages were 27%, 49%, and 52%.

Looking at the combined treatment, we did not see a bend up towards the end either. The HAM-D scores at the end of therapy were also lower than the ones in pharmacotherapy and SPSP alone.

In the Per Protocol Sample of trial 1, the success of combined therapy, according to the independent research fellow, was about 43%, the success according to the doctor was about 63%, and the success according to the patient was about 75%. In trial 2, these success percentages were 29%, 47%, and 60%, respectively. In trial 3, the success percentages were, 43%, 79%, and 77%, respectively.

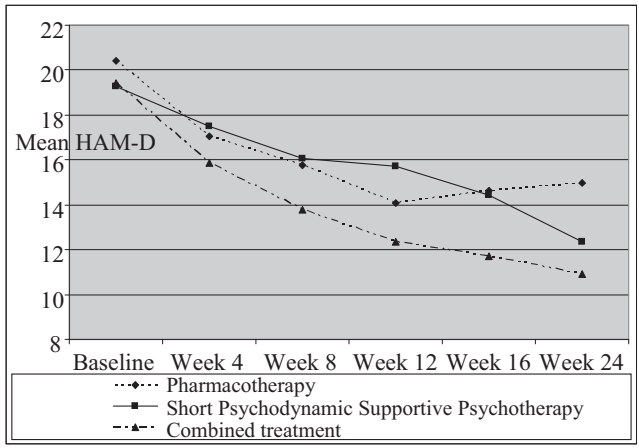

Figure 1. Mean outcome of all four trials.

In Figure 1 the mean HAM-D scores during treatment of pharmacotherapy alone (trials 1 and 4), of SPSP alone (trials 3 and 4) and of the combination of SPSP and pharmacotherapy (trials 1, 2 and 3) are depicted. As you can see, at the end of treatment, SPSP alone is closer to combined therapy than to pharmacotherapy alone.

Figure 2 shows the mean scores on the Hamilton Depression Rating Scale of SPSP and CBT of study 5 (Driessen et al., 2013). The depression scores of both conditions (SPSP; dotted line, and CBT; black line) improve during treatment.

Observed response rates were 38.7% for CBT and 36.9% for SPSP. The percentage of patients who met the remission criterion at posttreatment assessment was 24.3% of the patients in the CBT condition, and 21.3% of the patients in the SPSP condition (OR = .82; 0.45–1.50). No statistically significant treatment differences were found on any of the three outcome measures, both posttreatment and at the follow up. This study was recently published in *American Journal of Psychiatry*. Dr. M. E. Thase (2013) dedicated an editorial to the study and concluded: "On the basis of these findings, there is no reason to believe that psychodynamic psychotherapy is a less effective treatment of major depression than CBT. This large study expands the literature on controlled studies of psychodynamic psychotherapy, which heretofore was relatively meager" (p. 954).

Secondary Analyses

Influence of Presence of Personality Disorders on Outcome

In 2005, Kool wrote a thesis on the influence of personality disorders on treatment outcome (Kool, 2005). The primary research aim of the thesis was to determine and study the characteristics of the subgroup of depressed patients with comorbid personality disorders, compared to the group without personality disorders. The data used were drawn from the same study that De Jonghe et al. (2001) used. The researcher drew the following conclusion: depressed patients with a comorbid personality disorder turned out to have more severe scores of depression. The following conclusion was surprising: For depressed patients without a personality disorder, there was no justification for adding psychotherapy to pharmacotherapy as treatment results did not differ significantly between the conditions. However, for depressed patients with personality disorders, combined therapy was significantly more effective than pharmacotherapy. These superior results are related to the characteristics of SPSP. The short-term, anti-regressive, and structured nature of this therapy and its focus on relationships, impairments in social functioning, and quality of life seem essential ingredients for improvement in the group with comorbidity. Reviewing the follow-up data, the researcher

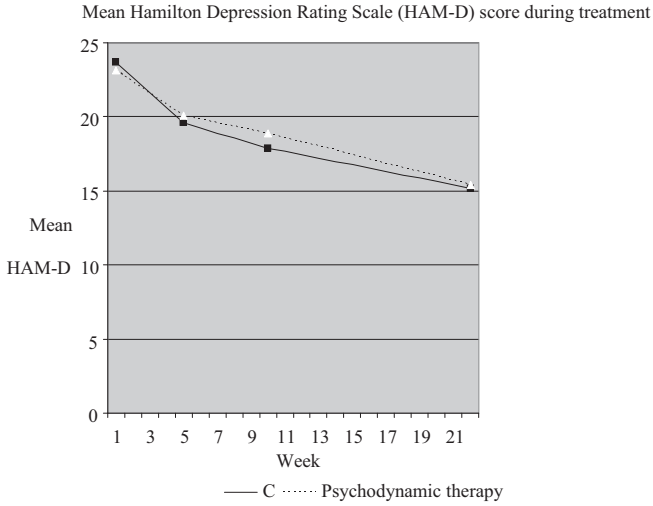

Figure 2. Mean outcome of trial 5.

concluded that there was a significant reduction in personality pathology. In the combined group, this was found not only in patients who had recovered from depression, but also in patients who had not recovered. In the pharmacotherapy condition, the significant decrease in personality pathology was restricted to patients who had recovered from depression. The last conclusion was that no significant differences in remission rates were found between the groups with and without personality disorders.

Predictors of Outcome

In Van's thesis, predictive factors for outcome of SPSP were explored. In a review, Van, Schoevers, and Dekker (2008) concluded that easily identifiable factors such as age, gender, marital status, and duration of depression may be predictive for outcome. They also found that predictors were different across treatment options, which makes them potentially clinical relevant for selecting the optimal approach in an individual patient.

With the data of our trials, Van, Schoevers, Peen, van Aalst, and Dekker (2008) first investigated the role of easily identifiable patient characteristics such as gender, age, severity, and duration of depression. The patient sample consisted of 97 patients treated with SPSP only and 171 patients with the combination of SPSP and antidepressants (the third trial). In SPSP alone, an unfavorable outcome appeared to be related to older age and longer duration of the depression and to severity of comorbid anxiety and somatic symptoms. In contrast, these results were not found in combined therapy, suggesting these patients needed to be treated with antidepressants as well. Comparing SPSP alone with combined therapy revealed that the later was more favorable for patients with anxiety. It was also found that although in general patients with an early nonresponse are at risk for ultimate treatment failure, a considerable number of early nonresponsive patients required more time before favorable effects became noticeable. This suggests that it is worthwhile to continue treatment despite absence of initial improvement (Van, Schoevers, Kool, et al., 2008).

With respect to psychodynamic factors, adaptive level of object relational functioning was only very modestly related to outcome (Van, Hendriksen, et al., 2009). Defense styles appeared to be more relevant (Van, Schoevers, Peen, Abraham, & Dekker, 2009). Especially patients with a so-called "symbiotic defense" style characterized by giving up and apathetic withdrawal were at risk for both drop-out and poor outcomes.

What is remarkable and in line with theoretical considerations is that patients using more neurotic styles such as affect denial and repression showed a more favorable outcome.

Influence of Patients' Ethnic Background on Outcome

In the first two trials, not many patients of different ethnic minorities participated in the trials. In the third trial, 14 patients of ethnic minorities (about 7%) participated in the study. In the fourth trial, 22 patients of ethnic minorities (about 16%) participated. In the fifth trial, the participation of ethnic minorities was much higher. In a total sample of 342 patients, about 44% patients (N = 150) were of ethnic minorities. About 30% of these patients came from Surinam, 30% from Morocco, 15% from Turkey, and 25% from other countries. There were no significant differences between the native and nonnative group of patients concerning gender, working situation, duration of depression, recurrence, or working situation. However, nonnatives were significantly younger, lived together more frequently with at least one other person, and were less highly educated than the native patients. Nonnative patients were slightly more depressed at the beginning of treatment, and they remained so to the end, but their amount of improvement in the SPSP condition was similar and not significantly different than for the native patients.

Discussion

About 25 years ago, we began to look for evidence of effectiveness of the psychodynamic treatment of depression. Evaluating all the research results of the five trials we can safely say that PT (short term and supportive in the form of SPSP) has proven to be effective. The depression slopes in the figures speak for themselves. Adding SPSP to antidepressants yields better results than antidepressants by itself. Adding medication to SPSP may have a significant added value, but it is not as big as in the first comparison. Effectiveness of antidepressants appears to set in quicker than SPSP on its own, but in the end SPSP (with or without the addition of antidepressants after eight weeks) seems better than the evidence-based pharmacotherapy (with or without the addition of SPSP after eight weeks). And last but not least, the results of the trials confirm no difference in efficacy between CBT and SPSP. So, it is justified to qualify SPSP as an empirically supported therapy form of PT for depression. In the earlier mentioned editorial, Dr. Thase (2013) reached the same conclusion: "The study by Driessen et al. is noteworthy because it provides

some of the strongest evidence to date that short-term psychodynamic psychotherapy is an effective treatment for major depression" (p. 953).

Several studies in the last few decades (Leichsenring, 2001; Driessen et al., 2010) have demonstrated evidence for the effectiveness of PT for depression. In the latest Dutch guidelines for the treatment of depression, our studies of SPSP, together with these meta-analyses, contributed significantly to qualify PT as an evidence-based treatment. In the former guideline (Kwaliteitsinstituut voor de Gezondheidszorg, 1994), that was not the case and only CBT and interpersonal therapy were considered the standard treatments. We were very pleased that the tide had turned now. However, in England, in the most recent guideline (NICE, 2009), PT as evidence based treatment for depression was still considered controversial.

In 2010, psychodynamic-oriented researchers and therapists therefore developed a protocolized form of PT named dynamic interpersonal therapy (Lemma, Target, & Fonagy, 2011), which they are now testing in a randomized trial in comparison to CBT.

Retrospect

In the 1990s, the developer of SPSP (De Jonghe in the Netherlands) added two elements to PT that were sometimes considered controversial in the psychoanalytic community, but previously had been determined necessary in treating patients, i.e., the therapeutic strength of adequate support. This is in line with Wallerstein's (1989) study, indicating that psychoanalysis is both more supportively conducted by therapists and supportively experienced by patients than initially thought. In addition, theoretical considerations by Misch (2000) on the aims and application of supportive therapy were used.

The choice for the emphasis on adequate support was closely related to the serious and often chronic depressive conditions of the patients referred to our departments. These patients have to deal with heavy suffering and significant disturbance of psychosocial functions. The depressive symptoms that could be seen in affects, thoughts, and behavior are often based on a relational etiology. Interpretation of this meaning is easily experienced as a confirmation of the already excessive self-criticism and judgment and does not lead to increased insight. Adequate support by enhancing ego functions is more justified at that moment. It was and is

indeed important that the support is adequate; in other words, that it is actually directed at growth and development.

Looking back at our earlier randomized research into SPSP has been an inspiring enterprise for our research group. In the 20 years that we have done the five trials, we have treated a broad group of approximately 900 patients with depression.

In retrospect, we believe it would have been better to compare SPSP with a waiting list condition or a placebo condition in an earlier phase as this would have contributed sooner to an evidence based qualification of SPSP. The reason we did not do this had to do with the spirit of the times 20 years ago. At that time, it was simply not permitted to deny depressive patients immediate treatment. However, other approaches, such as CBT and internet therapy, have done so. This has contributed to quicker acceptance as an empirically supported therapy.

Another reflection is that we did not expand the most important findings of the second trial by pursuing a line of research into the long-term effectiveness of short-term therapies.. The finding of this trial was that eight sessions of SPSP did as well as 16 sessions of SPSP in the combined version.

However, we felt therapists were reluctant to perform the eight sessions as a monotreatment. They felt that eight was too few; therefore we did not continue that line of research. Looking back, we now feel that was a pity. Presently, health insurance companies are applying strong pressure to keep mental-health treatment as short and as cheap as possible. Because of financial pressure, mental health care organizations need to react to that. For instance, it has become a trend to reduce evidence-based treatments from 16 to 12 sessions or duration from 45 to 30 minutes. All this with the aim of offering a cheap package price for treatment of depression. From a clinical and scientific point of view, however, this can be considered as a risk of undertreatment that needs to be opposed until research confirms that these types of reductions are justified.

Today

The last trial in which SPSP and CBT were compared will be in fact the proof of the pudding because it is a direct comparison of SPSP with the most established empirically supported treatment for depression. How did we manage to work together with therapists form two opposite orientations? Each year, all CBT and SPSP therapists were invited to a joint

meeting to discuss the progress of the research. During these meetings, there was a constructive and competitive atmosphere where our treatment successes were described and the laborious struggles to record progress with difficult patients were critically discussed.

The findings of our trials show that after an additional theoretical course in psychodynamics, and under close supervision, SPSP can be applied by psychologists and residents with relatively little other experiences in psychoanalysis or psychodynamic psychotherapy. Related to this, the Dutch Society for Psycho-Analytical Psychotherapy (NVVP) has opened a section where psychologists, psychotherapists, and psychiatrists could be officially registered as SPSP therapists.

This meant that not only therapists but also patients could be offered a choice for their preferred treatment approach—in short, SPSP as "talking about the emotional and relational background of the depression" or CBT as "working on a change in cognition and behavior." Both interventions are probably equally effective to reduce depressive symptoms, but possibly not equally effective in every individual patient.

The Future

One of the objectives for SPSP in the near future is to add more specific mechanisms of change, emphasizing such things as behavioral activation during the first few weeks of treatment. In our fourth trial, it turned out that a reduction of symptoms was achieved less quickly during the first four weeks of treatment in SPSP than pharmacotherapy. Our explanation is that pharmacotherapy probably leads to more rapid symptom reduction, e.g., a better sleeping pattern, resulting in feelings of hope. A further development of the SPSP protocol may be profitable.

Stepped care is essential. Although the effectiveness of PT has been shown, there is still a large number of depressive patients who do not reach complete remission, varying from 25-45%. CBT and interpersonal therapy have very similar remission rates; possibly this suggests that all forms of short-term psychotherapy achieve a ceiling effect at this level. Essentially, it is not known what to do to get higher remission rates because there are no high quality follow-up trials in psychotherapy. In addition, several studies have showed that incomplete remission is the most important risk factor for future relapse. So, there is a strong need to improve treatment results.

In our view, there are various options. Outcomes of depression treatment may be related to therapy doses. It is suggested that remission rates depend on intensity and duration of therapy (Keller, 2001), but we need to study that more rigorously in controlled designs. It is therefore relevant to know whether increasing treatment dose (in frequency and duration) can improve remission rates. A different approach is to offer booster sessions after acute treatment is ended. It is well known that these booster sessions reduce the possibility of relapse, although the effect is small, about 20% lower over a period of two years (e.g., Bockting et al., 2005). So far this has only been studied for booster sessions after CBT or interpersonal therapy and not for PT.

Matched care where necessary. Sufficient studies show the effectiveness of long-term PT. Specifically, we are talking about PT for (almost always) patients with a combination of several disorders, on Axis I as well as on Axis II, which have a chronic course and to whom previously treatments were not successful (Leichsenring & Rabung, 2011). Maybe we should consider more long-term treatment options for these types of patients. The same may be true for patients with high levels of comorbidity such as personality disorders, anxiety disorders, and posttraumatic stress disorders.

International collaboration. More international collaboration between schools of different treatment approaches is needed. Short-term and protocolized supportive psychodynamic therapies such as SPSP, dynamic interpersonal therapy, and supportive expressive therapy (Luborsky, 1984; Barber & Crits-Christoph, 1995) will likely show more similarities than differences. Most ideal for the near future would be for an international study group to transform the best elements of each short-term psychodynamic therapy into an international collective short-term PT (protocolized and documented), not only for depression, but also for anxiety and personality disorders. International collaboration is highly desirable in the case of clinical relevant efficacy and efficiency. Such an initiative has recently been established for long-term treatment of personality disorders.

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