

**Summary ‘On the effectiveness of psychoanalytic therapy,
Short if possible, long if necessary?’**

Psychoanalytic therapies have been, from the very beginning, contentious: applauded by some and reviled by others. The situation today is not essentially different. The popularity among clinicians and patients alike is underscored by studies of Wiener (1994) and Luborsky et al. (1993). Yet, criticism too persists. Since we live in the era of evidence based medicine, its main argument is that psychoanalytic therapies are not ‘scientifically proven’.

Contrary to what many people think, psychoanalytic therapies have been investigated intensively. Short forms of psychoanalytic therapies have been investigated by means of Randomised Controlled Trials (RCTs). A large number of reviews and meta-analyses provide the integrated results (Crits-Christoph, 1992, Leichsenring, 2005, Leichsenring, 2001, Anderson and Lambert, 1995, Leichsenring, 2003, Doidge, 1997), pointing to positive evidence for the efficacy of these therapies. Because of serious practical and ethical problems, long-term psychoanalytic therapy has been investigated mainly in cohort studies. Several reviews have been carried out to summarize the evidence for long-term psychoanalytic therapy (Bachrach et al., 1991; Doidge, 1997; Fonagy, 1999; Leichsenring, 2005), showing that there is evidence for the effectiveness of long-term psychoanalytic therapy.

However, despite the evidence, a striking discrepancy between the enduring ‘belief’ in the effectiveness of psychoanalytic therapies within the psychoanalytic community and the tenacious ‘disbelief’ outside remains. This discrepancy is what motivated the studies in this thesis, researching available existing evidence as well as participating in a project digging for more evidence in this controversial field of psychoanalytical therapy.

The aim of this thesis is:

1. To investigate the efficacy of short-term psychotherapy in the treatment of depression, relative to that of pharmacotherapy and combined therapy.
2. To present the characteristics of Short-term Psychoanalytic Supportive Psychotherapy (SPSP) and one of its main therapeutic agents: support.
3. To investigate the efficacy of SPSP in the treatment of depression, relative to that of pharmacotherapy and combined therapy.
4. To investigate the effectiveness of Long-term PsychoAnalytic Therapy (LPAT).
- 5.

The aim of this thesis translates into eleven specific research questions, that can be formulated and (tentatively) answered as follows.

1. What is the efficacy of short-term psychotherapy compared to that of pharmacotherapy in ambulatory psychiatric outpatients presenting a major depressive disorder ?

Chapter 2 presents a meta-analysis, based on RCTs published between 1980 and 2005, comparing the relative efficacy of time-limited (max. 6 months) psychotherapy and pharmacotherapy in the treatment of ambulatory, psychiatric outpatients diagnosed with unipolar, non-psychotic major depressive disorder. To enhance the clinical homogeneity among the studies in this meta-analysis, strict inclusion criteria regarding patient samples, diagnoses and treatment settings were applied. Ten studies were included, considering 1.233 patients (640 treated with pharmacotherapy and 593 treated with psychotherapy), suffering, on average, from moderate depression. One study considered IPT; the remaining studies applied Cognitive-Behavioural Therapy (CBT). The dropout rate in pharmacotherapy (28.4%)

was significantly higher than in psychotherapy (23.6%). The remission rates (HDRS measured) of psychotherapy (38%) and pharmacotherapy (35%) at treatment termination did not differ. This latter conclusion held for both chronic and non-chronic, mild or moderate depression. Both treatments performed better in mild (HDRS<20) than in moderate (HDRS>20) depression. At follow-up, relapse in pharmacotherapy (56.6%) was larger than in psychotherapy (26.5%).

2. What is the efficacy of short-term psychotherapy compared to that of short-term psychotherapy plus pharmacotherapy in ambulatory, psychiatric outpatients presenting a major depressive disorder?

Chapter 3 presents a meta-analysis, based on RCTs published between 1980 and 2005, comparing the relative efficacy of time-limited (max. 6 months) psychotherapy and combined therapy (psychotherapy and antidepressants) in the treatment of ambulatory, psychiatric outpatients diagnosed with unipolar, non-psychotic major depressive disorder. Again, it aimed at high clinical homogeneity. Seven studies were included, considering 903 patients (459 treated with psychotherapy and 444 treated with combined therapy), suffering, on average, from moderate depression. One study considered psychoanalytic therapy; the remaining studies applied CBT. Dropout rates for combined therapy (25%) and for psychotherapy (24%) did not differ statistically. The remission rates (HDRS measured) showed that combined therapy (46%) did better than psychotherapy (34%). However, remission rates depended on severity and chronicity. In mild, non-chronic depression combined therapy (42%) and psychotherapy (37%) performed statistically equal. No data on mild, chronic depression were found. In moderate, non-chronic depression remission rates did not differ either (combined therapy 44% and psychotherapy 39%). Only in moderate, chronic depression combined therapy (48%) was superior to psychotherapy (32%).

3. What is Short-term Psychoanalytic Supportive Psychotherapy (SPSP)?

Chapter 4 describes the theoretical and practical characteristics of SPSP. SPSP is a face-to-face, six-month, individual psychotherapy consisting of sixteen sessions (starting with eight weekly sessions, followed by eight fortnightly sessions). SPSP's primary goal is to cure depression. The secondary goal is to reduce patient's vulnerability to depression. The latter is conceived as the shaping or altering of internal relationships, especially the relationship the patient has with himself (IntraPersonal Relationship, IPR). Taking into account SPSP's restricted number of sessions, it is all too obvious that personality change will be limited. Setting, frame and contract are ingredients of the supportive approach.

SPSP unfolds as a discourse in which we distinguish nine levels:

1. physical and psychological complaints and symptoms,
2. life circumstances, which somehow influence or have influenced the depression,
3. problems with external, interpersonal relationships,
4. relational patterns in the patient's life,
5. the patient's attitude in life,
6. the persistence of past relationships in the patient's actual life,
7. the relationship the patient maintains with herself as the consequence of identification with internal-interpersonal relationships,
8. the manifestation of problems discussed at previous levels in the relationship with the therapist,
9. transference neurosis. This last level is not attainable in the short-course of SPSP.

4. How may adequate, psychoanalytically defined support contribute to personality change?

Chapter 5 aims to propose a psychoanalytic definition of support and to elaborate on its role as an agent of change in psychoanalytic therapies (be they short or long). In the classic, psychoanalytical view, interpretation leads to insight, which in turn can result in personality change. This view is not challenged but it is contended that a second, largely neglected process also plays an important part: support may lead to personality change, which in turn may result in insight.

Essential to this proposition is the notion that internal relationships represent vital personality aspects. Their alteration is crucial to personality change. The longstanding interpretation versus relationship controversy is reformulated as an interpretation versus support debate. The proposed psychoanalytic definition of support is: the proper gratification of unmet developmental needs, as they appear in the archaic aspects of the therapeutic relationship. Then, the controversy comes down to divergent views on the relative roles of interpretation and gratification.

The importance of differentiating between adequate and inadequate support is stressed. Some ideas about the putative mode of action of support are presented, suggesting that it may reside in its power to evoke, in the patient, the experience of a 'dissonance' between two incongruous aspects of the therapeutic relationship: a 'malignant' and a 'benign' one. Both are simultaneously felt in the present, the benign one being determined by the present, the malignant one by the past. If the benign aspect of the relationship prevails over the malignant one and if it becomes internalised, internal relationships, especially 'how I relate to Myself' (the IntraPersonal Relationship, IPR), may change for the better.

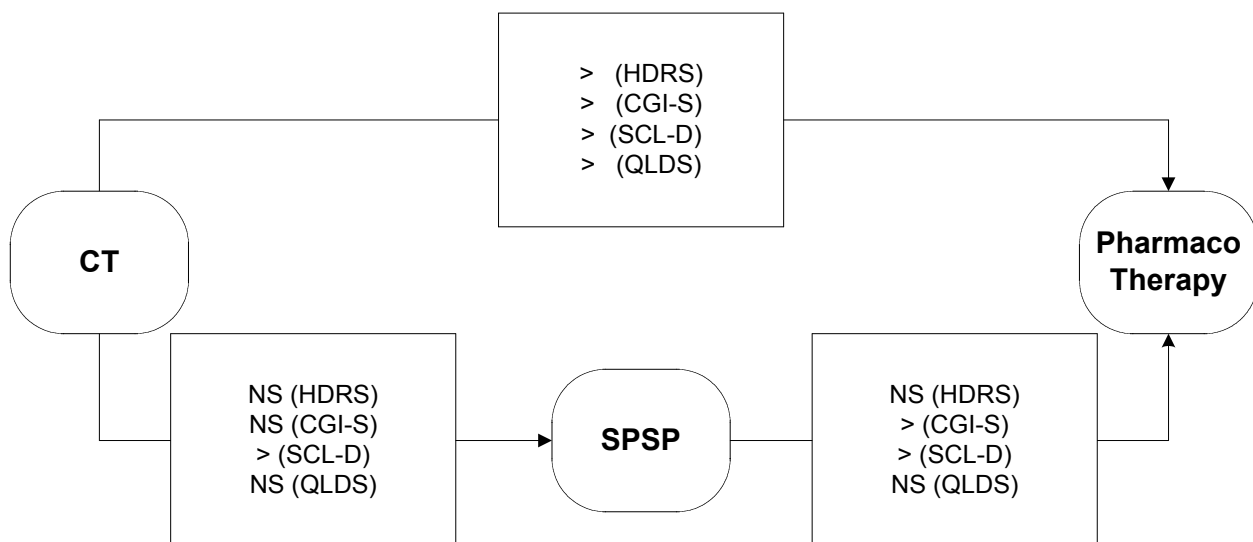
5-7. In ambulatory psychiatric patients presenting a major depressive disorder, what is the efficacy of SPSP compared to that of pharmacotherapy (Q.05), the efficacy of SPSP compared to that of SPSP plus pharmacotherapy (Q.06), and the efficacy of SPSP plus pharmacotherapy compared to that of Pharmacotherapy (Q.07)?

Chapter 6 assesses, by means of a mega-analysis, the relative efficacy of SPSP, pharmacotherapy and their combination in the treatment of ambulatory, psychiatric outpatients diagnosed with mild to moderate depression. The study was based on the data of three consecutive RCTs, carried out and published by the Depression Research Team of Menthum Mental Health in Amsterdam. Based on the results of the original trials, three hypotheses were formulated: Combined therapy is more efficacious than pharmacotherapy and SPSP respectively, and SPSP is more efficacious than pharmacotherapy.

The first hypothesis was confirmed, the other two were rejected. According to the independent observers (HDRS), the main criterion in this study, there was no statistically significant difference in remission rates between SPSP (31%) and pharmacotherapy (24%) (Q.05), nor between combined therapy (40%) and SPSP (31%) (Q.06). However, combined therapy (40%) outperformed pharmacotherapy (24%) (Q.07).

Secondary criteria showed that, according to the therapists (CGI-S), there was no significant difference between SPSP and combined therapy, and both were superior to pharmacotherapy. According to patients' opinions on symptom improvement (SCL-D), combined therapy was superior to SPSP, which in turn outperformed pharmacotherapy. According to patients' evaluations of quality of life (QLDS), there was no significant difference between SPSP and combined therapy, nor between SPSP and pharmacotherapy, but combined therapy was better than pharmacotherapy. Figure 1. presents the results graphically. The symbol > indicates a statistically significant difference at the $p < .05$ level. NS means no statistically significant difference.

Figure 1. Comparative efficacies of combined therapy (CT), Short Psychoanalytic Supportive Psychotherapy (SPSP) and Pharmacotherapy



8. What are the answers to the questions Q.05-07 at the level of two HDRS factors and three SCL-90 subscales of: Depression, Anxiety and Somatic complaints?

Chapter 7 presents a second mega-analysis, using a similar design as the one in Chapter 6. However, the relative efficacy of SPSP, pharmacotherapy and their combination was now assessed examining HDRS factor levels and three SCL subscale levels. In this study, a factor analysis of the mega-analysis sample yielded two main factors, which were labelled 'Mental' and 'Somatic'. A mega-analysis was performed at these HDRS levels and at those of three SCL subscales: Depression (SCL-D), Anxiety (SCL-A) and Somatic complaints (SCL-S). Three hypotheses were formulated:

1. SPSP outperforms pharmacotherapy on the 'Mental' factor of the HDRS (1.a), the SCL-Depression (1.b) and the SCL-Anxiety (1.c);
2. Pharmacotherapy is better than SPSP on the HDRS 'Somatic' factor (2.a) and the SCL-Somatic complaints (2.b);
3. Combined therapy outperforms both monotherapies on all sub-dimensions (3.a-j).

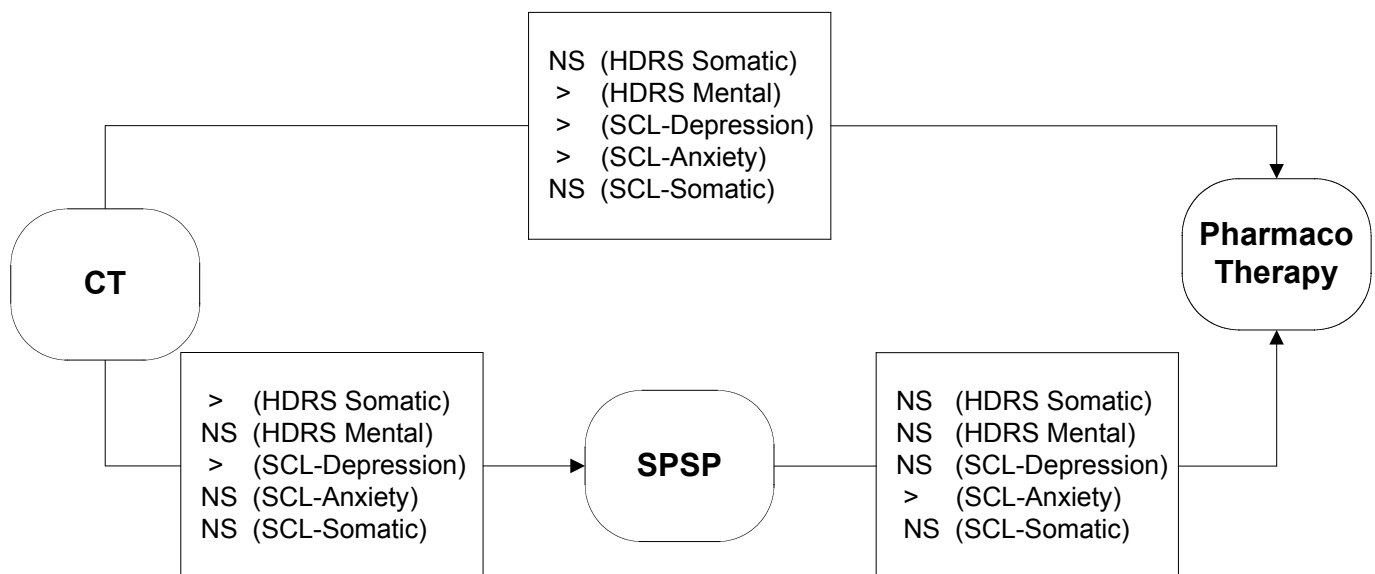
At the level of the HDRS 'Mental' factor, we found there were no differences between SPSP and pharmacotherapy (1.a rejected), nor between SPSP and combined therapy (3.a rejected), but the latter did outperform pharmacotherapy (3.b confirmed). At the level of the HDRS 'Somatic' factor, no differences were found between SPSP and pharmacotherapy (2.a rejected), nor between pharmacotherapy and combined therapy (3.c rejected), but the latter did outperform SPSP (3.d confirmed). At the level of the SCL-D, no differences were found between SPSP and pharmacotherapy (1.b rejected), and combined therapy outperformed both (3.e-f confirmed). At the level of the SCL-A, SPSP equalled combined therapy (3.g rejected)

and both were superior to pharmacotherapy (1.c and 3.h confirmed). At the level of the SCL-S, no differences were found between the two treatments (2.b and 3.i-j rejected).

Summarizing, it could be stated that the first hypothesis is rejected (two out of three comparisons rejected), as well as the second (two out of two comparisons rejected); the third hypothesis seems undecided so far (five of ten comparisons rejected).

Figure 2. presents the results graphically. The symbol > indicates a statistically significant difference at the $p < .05$ level. NS means no statistically significant difference.

Figure 2. Comparative efficacies of Combined Therapy (CT), Short Psychoanalytic Supportive Psychotherapy (SPSP) and Pharmacotherapy at HDRS factor level and SCL subscale level



9. What study type provides the best available evidence in regarding the effectiveness of long-term psychotherapy?

Chapter 8 compares the characteristics of Randomized Clinical Trials (RCTs) and cohort studies. Evidence-based medicine ranks RCTs higher than cohort studies, and does so for good (methodological) reasons. However, the acceptability, feasibility and decisive power of RCTs in Long-Term Psychotherapy (LPT) may be questioned. Randomisation nearly always presents practical and ethical problems for LPT research. It could be postulated that the RCT design in itself can also be divided into a kind of 'hierarchy'. The most informative RCTs (i.e. with highly conclusive power regarding the effectiveness of a treatment) compare a given treatment with no treatment, assignment to a waiting list or a placebo treatment. However, the control conditions that are most informative are so unacceptable to patients that decisive RCTs are, in most cases, unfeasible. At a lesser informative level, comparisons can be made with Treatment As Usual (TAU), treatment in a low dose, another treatment with strong efficacy evidence and another treatment that is assumed (but without strong evidence) to be effective. The 'lower' RCT levels are more feasible but less informative. The advantage of cohort studies is their greater capability to reflect day-to-day clinical practice, their limitation concerns the internal validity. Their decisive power is determined by their methodological

quality and knowledge of the natural course of the investigated disorders. Such knowledge of disorders suitable for LPT treatment is limited but existent.

10. What is the effectiveness of Long-term Psychoanalytic Therapy (LPaT) in clinical terms?

Chapter 9 presents a systematic review of studies, published between 1970 and 2005, assessing the effects of LPaT on clinical variables. In order to enhance clinical homogeneity, it was restricted to individual, ambulatory treatment in adult patients with mostly 'regular' indications for long-term psychoanalytic therapy. In addition it distinguished between two LPT types: long-term psychotherapy and psychoanalysis. Before inclusion in the review, the quality of potential studies was systematically assessed, using an explicit quality criterion. Nineteen out of the 27 studies found, met the quality criterion, all but one cohort studies. Patients suffered from a wide range of disorders, with high rates of co-morbidity of personality and mood disorders. Effectiveness data were pooled, both for symptom reduction and personality change. Psychotherapy yielded large mean ESs (0.78 at termination, 0.94 at follow-up) and high mean overall success rates (67% at termination, 55% at follow-up) in patients presenting moderate pathology. The mean ES was larger for symptom reduction (1.05) than for personality change (0.57). In severe pathology, the results were similar, but it was only possible to calculate the mean ES for personality change (1.09). Psychoanalysis too achieved large mean ESs (0.96 at termination, 1.18 at follow-up) and high mean overall success rates (70% at termination, 54% at follow-up) in patients presenting moderate pathology. Again, the mean ES for symptom reduction was larger (1.23) than for personality change (0.83). Insufficient data regarding severe pathology was available. Success assessments by therapists and patients were in broad agreement. They thought there was more symptom reduction than personality change. There were no differences found between the results of studies meeting the quality criterion and of those of lower quality studies.

11. What is the effectiveness of long-term psychoanalytic therapy (LPaT) in cost and benefit terms?

Chapter 10 presents a systematic review of studies, published between 1970 and 2005, assessing the effects of LPaT on health care use and work impairment. In addition, it presented a financial evaluation of the costs of LPT in these two areas, compared to its benefits. Changes in health care use and work impairment were translated into data regarding numbers of hospital days, medical visits, percentages of patients taking medication and numbers of sick leave days. They were compared with the costs of treatment. Before inclusion in the review, the quality of potential studies was systematically assessed, using an explicit quality criterion. Seven studies (N= 861) met the inclusion criteria. The results show that the mean cost of LPaT per patient is € 20.900. Average yearly cost reduction for days in hospital is 85% at treatment termination and 59% at follow-up (mean 2.9 years). For medical consultations costs it is 54% at termination and 56% at follow-up, for medication costs 70% and 19% respectively and for sick leave costs 61% and 67% respectively. Average yearly health care use and sick leave costs fall by € 5.584 at treatment termination (a 66% reduction). At follow-up (mean 2.9 years) these reductions still amount to € 5.371 (64%). The break-even point for benefits and treatment costs is approximately three years after treatment termination. The reduction in work impairment appears to be the main factor (65%-75%) in these positive results.

Chapter 11 discusses the main findings, the methodological strengths and weaknesses and merits and limitations of the studies. This thesis investigated the efficacy of short-term psychotherapy (among which Short-term Psychoanalytic Supportive Psychotherapy),

pharmacotherapy and their combination in the treatment of psychiatric outpatients suffering from mild to moderate depression. The results show that these treatments do not differ much from each other, yield modest results and probably have short-lived effects. A stepped care approach therefore seems mandatory. Existing guidelines propose various short-term options in case of disappointing first choice treatments. Long-term psychotherapy could be a serious alternative in a stepped care approach. Long-term psychotherapy aims at personality change: reducing vulnerability and increasing strength. This thesis presents data regarding the effectiveness of long-term psychoanalytic therapy (LPaT). It appears that it yields long-standing results in a variety of disorders, among them depression. It also shows that many patients have sought treatment before, apparently to no avail. It seems that the added value of LPaT lies in the changes it may bring about in personality aspects. As mentioned before, LPaT is not a panacea. It can alleviate but not eradicate the damaging influence of an unresolved past on the present, not even in patients most suitable for this type of treatment. A sensible stepped care approach in the psychological treatment of depression seems to start with short-term treatments (psychotherapy, pharmacotherapy or their combination) primarily targeting symptoms and complaints and to leave it at that if patient and clinician consider it will do. If the first steps appear insufficient, long-term psychotherapy aiming at personality characteristics is recommendable. This adage 'short-term if it will do, long-term if apparently necessary' may be applicable in a large range of so-called stress related disorders.