Short-term Psychoanalytic Supportive Psychotherapy for depressed patients

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Abstract

Short-term Psychoanalytic Supportive Psychotherapy (SPSP) is a face-to-face, individual psychotherapy, consisting of sixteen sessions in six months (first eight weekly, then eight fortnightly sessions). It is rooted in psychoanalytic theory. Its primary aim is to cure depression. A secondary goal is to reduce patient's vulnerability to depression. The emphasis is on supportive techniques that counter regression and foster psychological growth. The putative process consists in experiencing a 'relational dissonance', i.e., feeling two contradictory relationships in the therapeutic situation simultaneously, one determined by the past, the other by the present. We assume an important curative factor is to experience, mostly unconsciously, an adequate gratification of 'developmental needs' inadequately met in early infancy and therefore manifesting themselves in the archaic aspects of the therapeutic relationship. SPSP unfolds as a discourse in which we distinguish nine levels. Each regards a specific subject, that at that level is the focus of the interaction between patient and therapist. The efficacy of SPSP in ambulatory patients presenting a DSM-IV defined, mild to moderate major depressive disorder has been tested in five Randomised Clinical Trials. The results have been aggregated in a mega-analysis. They suggest that, in the treatment of outpatients with mild to moderate major depressive disorder, SPSP and pharmacotherapy are equally efficacious and that the combination of SPSP and pharmacotherapy is more efficacious than pharmacotherapy alone but not than SPSP alone. We therefore consider SPSP a valuable extension to the existing options for the treatment of depressed patients.

Introduction

Several options, both pharmacological and psychological, are available for the treatment of depressed patients (1). Their effectiveness is undeniable but limited. In addition, as depressed patients constitute a heterogeneous group, it seems probable that different patients need dissimilar treatments. Therefore, the search for new alternatives continues. We think Short-term Psychoanalytic Supportive Psychotherapy (SPSP) could constitute a valuable extension of the existing options. SPSP is a short-term treatment that combines being psychoanalytic with being

supportive. It is tailored to the conditions of depressed patients. We are not aware of any other psychoanalytic therapy presenting all these characteristics simultaneously, although evidently SPSP is one of the variants of Short-Term Psychodynamic Psychotherapy (STPP), which is an evidence-based therapy for depression (2).
In this article, first, we summarize the theoretical roots of SPSP. Secondly, we portray its principle characteristics. Thirdly, outline its typical course with a case vignette. Then, we try to elucidate its position among other therapies and finally we report on the published studies providing empirical validation of its efficacy.

Theoretical roots of SPSP

SPSP is rooted in Freud's drive theory (3) and Ego-psychology (4). In addition, we value theories that focus on 'developmental needs', i.e., innate, basic, social needs, which must be met adequately in early infancy in order to allow the first stages of growth to unfold. Prominent among them are the need to feel connected (Ferenczi, Klein) (5,6), loved (Balint) (7), protected (Bowlby) (8) and valued (Kohut) (9,10). We consider the vicissitudes of these developmental needs particularly relevant for the treatment of depressed people. In short, we conceptualise patients' problems as consisting of both conflict and developmental pathology. We look at both types of pathology from a relational perspective that integrates the role of drives (which we prefer to call needs). We distinguish between interactions with others present in the outer world ('external-interpersonal'), with others only present in the inner world ('internal-interpersonal') and between I and Me ('IntraPersonal Relationship' or IPR). The second and third types of relationships are 'internal relationships'. Internal-interpersonal relationships are seen as internalised external-interpersonal relationships. The IPR results from the subject identifying with (some aspects) of (some) internal-interpersonal relationships.

Carl's case may help elucidate these concepts. He thinks that the relationship with his mother, deceased years ago, has gradually evaporated. She does not play a role in his internal life any longer. Much to his surprise, however, he dreamt about her last night. She was being reproachful; about what is unclear. Apparently she is part of his past that lives on in his present. Gradually it occurs to him, that he as an adult is no less disappointed in himself than she was in him when he was a child. He has come to view himself, in his perception that is, as he used to be seen by her. He still continues to do so.

If inadequately met in early infancy, developmental needs persist in adults as ongoing, malignant, early infantile aspects of internal (interpersonal and intrapersonal) relationships. They manifest themselves in the archaic, primordial aspects of relationships in general and of the therapeutic relationship in particular, where they act as molds on potentially new relationships, thus stimulating repetition instead of growth.

We suggest the therapeutic action of SPSP resides mainly in its power to evoke, in the patient, an experience of relational dissonance or friction between two contradictory, external-interpersonal relationships, simultaneously felt in the present. Simplifying matters, we hereafter sketch what may happen in Carl's therapy.

On one hand, Carl is driven to externalise his internal, rather malignant relationships, especially his IPR. He projects them on to and into the therapist and experiences him as a rather debasing person. That relationship is dominated by Carl's past. In that sense it is 'old' and 'unrealistic'. On the other hand, due to the interaction between the therapist's genuine behaviour and Carl's capacities to test reality, he experiences the therapist as a rather reliably available, caring, protecting and valuing

person. That relationship is dominated by actual reality. In this sense, it is ‘new’ and ‘realistic’. Both relationships regard the same developmental needs. The new relationship must be new enough but not too new. If it bears too much novelty there is no dissonance. The two feeling states do not have any wringing, jarring contact, and are hence without mutual influence.

Dissonance is not a persisting phenomenon. It tends to evolve towards consonance. In the end, either the new or the old relationship will prevail. If the new, benevolent relationship is not new enough, the old relationship will prevail. Carl’s malevolent internal relationships are strengthened and his old feelings confirmed. Retraumatization is the result and the process is anti -therapeutic. On the other hand, if the new, benevolent relationship differs neither too little nor too much from the old one, it may prevail. Carl will experience adequate gratification of his unmet early-infantile need. This gratification forms the core of ‘adequate psychoanalytic support’ (APS), in our view the most important curative factor in SPSP. In so far as Carl internalises the new relationship and identifies with it, the old, malevolent, internal relationships (the old templates) will be corrected by it, or they will at least be challenged by new templates, thus structuring or restructuring personality. These views are not new. As Greenberg (11) put it in 1986: “If the analyst cannot be experienced as a new object, analysis never gets under way; if he cannot be experienced as an old one, it never ends.” What is relatively new is the recognition that at its deepest level, this process is not reflexive, explicit, verbal, symbolic, declarative or repressed. It unfolds at the ‘procedural knowledge level’. It is unconscious but not dynamically so. It nevertheless may result in emotional insight, as Carl, feeling adequately supported, may become aware of experiences he never has had before.

Principal characteristics of SPSP

SPSP is a face-to-face, six-month, individual psychotherapy consisting of sixteen sessions (first eight weekly, then eight fortnightly sessions). Prior to the start of treatment, the therapeutic frame is discussed and settled by agreement. The therapist will stick to the arrangements firmly but not rigidly. He bears in mind and regularly discusses with the patient that the therapeutic encounter will last only a limited period of time. SPSP’s primary goal is to cure depression. The secondary goal is to reduce the patient's vulnerability to depression. We conceive the latter as the shaping or altering of the internal relationships, especially the IPR. To achieve this goal, two paths can be followed: the adequate interpretation of needs (the structural approach) and the adequate gratification of needs (the developmental approach). The two approaches are not mutually exclusive; on the contrary, we see them as complementary. However, in depressed patients we deem the developmental approach more appropriate. In our experience a basically supportive or gratifying attitude is more applicable to the broad spectrum of patients that are currently seeking treatment for depression, because their underlying vulnerability does not allow for a more interpretive approach. In addition, in their depressed state, patients easily misunderstand or misinterpret more challenging interventions. However, as we did not compare our approach to an interpretive approach, the issue is open to debate.

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, which we define as adequately gratifying developmental needs inadequately met in early childhood. This approach is supposed to evoke peace and quiet, reliability, predictability, carefulness, professionalism, clarity, transparency, unhurried activity and realistic optimism. The therapist's attitude is expected to be basically interested, accepting, affirmative, empathic, concerned, helpful, patient, actively expectant, perseverant, honest, transparent and flexible. The therapist has to adapt to the personality and actual state of mind of the patient. He certainly has to reckon with the role enactment he is invited to participate in by the patient's projective

identification. The therapist is supposed to promote, maintain and, if necessary, restore a supportive therapeutic relationship, to the best of his abilities. We understand the therapeutic relationship to be an interaction, a bilateral phenomenon constituted by the active roles of both contributors. However, this 'two-person approach' does not downplay the processes taking place within patient and therapist, for obviously both have their own personality, history and actual life circumstances. In that sense, it also includes a 'one-person approach' to both participants. The therapist will have to be flexible, adapting his technique to the temporary and structural level of his patient's functioning.

Admittedly, up to now the supportive technique has been less well articulated than the interpretive one. Important aspects of it are containing (12), holding (13), mirroring and the judicious blending of homeostatic (‘maternal’) and disruptive (‘paternal’) attunement, all of them being aspects of developmental help (14). Supportive interventions can be non-verbal. We exercise restraint in these matters though, because this type of support easily furthers regression. 'Helping the patient to help himself' remains the leading idea. To this purpose verbal interventions mostly suffice. We mention some examples: showing interest by providing and asking information, expressing understanding and empathy, expressing acceptance and esteem, reducing guilt feelings, shame and isolation, reassuring, normalising, instilling hope, motivating, facilitating verbalisation, exploring by listening actively and by asking open and closed questions, encouraging a focus on feelings, furthering acknowledgment and acceptance of painful or frightening affects, fostering controlled abreaction (catharsis) while discouraging intense negative affects, evoking new positive feelings or furthering more adequate coping with feelings, clarifying, confronting, suggesting new ideas or possibilities, if necessary not shunning to give advice, or even persuade, countering dysfunctional cognitions and behaviours, and encouraging autonomy. The aforementioned interventions are not adequate or inadequate in themselves. It is their integrated and judicious application and the patient’s perception of it that determine whether they are adequate or not.

The typical course

SPSP contains important nonverbal communicative aspects but is essentially a 'talking cure'. It unfolds as a discourse in which we distinguish nine levels. We illustrate our ideas with vignettes regarding the SPSP treatment of Catherine, a 28-year-old head nurse. Catherine is a psychiatric outpatient suffering from DSM-IV defined, moderate major depressive disorder. The case has been modified for discretion's sake; still we trust the vignettes convey the essence of the message.

The first level the focus is on the patient's physical and psychological complaints and symptoms. For at least ten months, Catherine’s life has been miserable. Most importantly, she is tired all the time for no good reason. She awakes exhausted and drags herself through the day (she still works at the hospital). Besides that, her mood is low, her interest has vanished and nothing in life is pleasurable anymore. She cries a lot without even knowing why: 'Isn't that silly?' Catherine understands there is something wrong with her. In this sense she gives evidence of some insight. The therapist asks her how she understands her depressed state. There is no explanation. 'I may have a creeping physical illness the doctors can't find.' She is here on the advice of her friend but she does not believe in therapy. The therapist registers her demand to be rescued. He knows he is unable to do it. He feels powerless, which he conceives as an indicator of her powerlessness. He listens with an attentive ear and shows empathy, not pity. He is careful, not worried. He considers the situation serious, not hopeless. He provides some psycho-education about depression and discusses how to cope with her symptoms but refrains from giving advice beyond very simple, day-to-day issues. Meanwhile, he cautiously inquires after suicidality, which in Catherine's case is not a matter for concern. Apart from that, he simply bides his time.

The second level is a first step in looking for an explanation. The therapist enquires about Catherine's actual life situation and maps out its taxing and supporting aspects. He asks whether Catherine's mood reacts to circumstances. Indeed, it does. Reluctantly, she states that she went on a holiday with her boyfriend the other day and had indeed felt better then, only to sink back as soon as she resumed work. She had also felt very depressed when recently visiting a rather busy restaurant, but walking her dog had lightened her up. The therapist comments that it is a positive fact that her depression still is sensitive to circumstances. What happened in her life about a year ago? The hospital ward had to move temporarily. The patients were upset, there was a lot to do and she worked even harder than she used to. 'But somehow I was not "there" at work, it was as if I was constantly somewhere else in my thoughts. I was criticised for that and it upset me a great deal'. She was not angry with the manager; on the contrary, she sympathized with him. After all, he was right, she was absent-minded ... Catherine is able to relate her symptoms to circumstances. She realizes that they are at least contributory to the development and continuation of her symptoms. Catherine shows growing insight. The therapist says it is important that she realizes her depression did not come out of the blue. In some sense it is understandable. She objects that the same circumstances did not depress her colleagues. He proposes to jointly explore the impact of life circumstances on her mood. Everybody's life, he says, is highly determined by what happens and even more by the way events are perceived. He does not miss how remarkably understanding Catherine is towards her critical boss but he does not bring the issue to the fore because he believes raising this question at that time would be too confrontational for the patient (which of course may be an unacknowledged countertransferential phenomenon)

The third level further clarifies level two by translating seemingly impersonal life circumstances into relationships. The therapist wonders how 'being overloaded with work' relates to 'people in the work situation' and where Catherine was 'in her thoughts' a year ago, while working at the hospital. Was there something the matter with important people in her life? Yes, there was her grandfather on mother's side. He died around that time. 'I loved my grandfather very much; in fact he was more like a father to me than my father was. But I think I am over it now, it happened such a long time ago.' The therapist asks how grandfather died. The story brings tears to Catherine's eyes. In those days she was a great comfort to her grandmother and her mother. She arranged the funeral almost all by herself. The therapist says: "You were there for your grandmother and for your mother but who was there for you?" Now she is silent and cries. The therapist wonders where her father was. He did not come to the funeral. Her parents separated when Catherine was eleven, after long years of unhappy marriage. The relationship between them never normalized. 'Nobody asked me how I felt and how I was coping with grandfather's death.' 'Afterwards, my mother had no time to ask about or listen to my feelings. Every time I tried to tell her, she said: 'Stop crying, I'm getting too sad'. Catherine was not angry with her mother, on the contrary, she empathized with her. Her mother was the one having a hard time (again a topic not addressed by the therapist, rightly or not, but typical for his more supportive than interpretive approach). After all, it was about her father and not, as in Catherine's case, about her grandfather. The therapist keeps exploring facts and experiences. Meanwhile, he is moved by Catherine's account. He sees a brave, forlorn child and wonders how he could reach it while Catherine is out of touch with these aspects of herself. He also feels outraged about what was done to her but just in time realizes that Catherine, who is totally unaware of it in herself, has aroused this feeling in him. But Catherine's insight increases. She realizes the importance of strained relationships in what happened with her. Still, she conceives her problem as 'external' and muses upon external solutions, e.g. looking for another job.

At the fourth level incidents are understood as part of a pattern. The focus shifts to the presence of one or more relational patterns in patient's life. The therapist wonders about the situations at the hospital and the funeral. Different as they may be, do they present a common feature? 'Yes, I felt

overlooked'. Her colleagues, and particularly the head of the ward, never asked her how she herself was doing during the hectic period at the hospital. At the funeral the family was glad she managed the situation quite efficiently ('I'm good at that'), for sure, but everybody seemed too much absorbed in their own grief to show any interest in hers. Catherine gradually recognizes the pattern, even in the relationship with her boyfriend. 'Work has to be done, problems have to be tackled and it all falls on my shoulders. I'm the worker ant of the ward and the help and stay of the family. Besides that, nobody seems interested in me. Sometimes I even doubt whether my boyfriend knows me.' She is amazed, even frightened, by the realization how deeply these feelings are entrenched in her life. The therapist feels less powerless. Mutual acceptance and cooperation begin to prevail in the therapeutic relationship. Catherine feels better and has started self-exploration. The therapist values her growing awareness of an interfering pattern or theme in her life ('being overlooked'). Wonder is the beginning of wisdom, he says. Catherine shows growing insight but she conceives her problems and their potential solutions as still being external.

At the fifth level there is a shift to viewing external problems as internal. The focus changes from the patient's life circumstances to her attitude in life. The therapist does not challenge Catherine's views on the selfishness and ingratitude of people. After a while Catherine increasingly puts her ideas into perspective. 'Of course, I don't make things easy for others. I get myself lumbered with responsibilities, I volunteer for work I am not supposed to do, and I resent asking for help. I'm good at putting on a happy face. Small wonder they see me as the uncomplicated, funny one who needs no help at turning problems into challenges and opportunities.' Catherine is quite knowledgeable on dog issues but at the dog-club she seldom speaks her mind from fear she might 'give the wrong answer'. 'I am always afraid they'll think I am a stupid, fat girl'. She is quite upset by the discovery that the problem is not 'out there' but inside her. 'Doesn't that make the problem irremediable?' The therapist feels rewarded. Catherine is able to discuss her own contribution in maintaining the interpersonal pattern she has become aware of at level four. She now exhibits psychoanalytically defined, "lived" (not just intellectual) self-insight. Apparently she trusts him and feels sufficiently safe to explore uncharted waters. He is well aware she has taken quite a step and no interpretations were required to get her to do so. He realizes she is doing what he wants her to do: question herself instead of others. He tells her that this seems to him the right path to follow. He understands her new insight frightens her and comments that the chances on changing herself are considerably higher than those of changing the world.

The sixth level adds an epigenetic explanation to level five. The focus shifts to past relationships persisting in the patient's actual life. The therapist says he doubts Catherine's attitudes are just inborn and suggests looking for their sources. The aim, he explains, is not 'digging up the past' but 'understanding the present better'. This is not a difficult task for Catherine. 'I can still hear my father say to me: 'You are a stupid, fat girl. I'd rather had the girl next door for a daughter.' It hurts, she cries. When Catherine cried at father's comments, he would reply she was 'a moron to cry for this'. She fears the therapist would think the same without saying it. He says he doesn't. On the contrary, he understands she couldn't possibly feel safe with her father. Father was not always that derogatory toward her, though. Each time she came home with good school marks, merited by hard work, he would praise her. Her mother was a master in covering up feelings. She frequently told Catherine not to cry or to stop crying, and cleared the air by making funny remarks. 'Together we laughed a lot'. Meanwhile mother suffered from various ailments. She did not speak about it, but Catherine knew. It still happens that her mother's suffering face haunts her. Catherine was often to be found at her grandparents' home. The therapist feels Catherine is progressing in understanding instead of condemning herself. The relationship is truly collaborative now. Self-insight expands to the aftermath of early experiences. The discourse is about former external relationships living on in the present as a result of internalisation. It is about internal interpersonal relationships, 'the other in

me', not of course the historical but the narrative other. Catherine makes contact with the forlorn child she once was and deep down still is. It did not take genetic interpretations for her to do so. The therapist says Catherine is on track in understanding an important echo of her past in the present. It may be a painful trail but in the end it will be rewarding.

The seventh level elucidates the mechanism by which the past persists in the present. The focus shifts to the relationship the patient maintains with herself. 'It may be true', Catherine says, 'that my parents from the past still live on in me but how is it possible that they still have so much power over me? I'm not a little girl anymore!' She has not had contact with her father in years. Although she considers her mother a bore, still she phones her daily. She has a boyfriend who repeatedly and unambiguously demonstrates he finds her attractive, smart and lovable. Annoyingly enough, she does not seem to believe him and secretly fantasizes about flirting with other men, if not about more than that. She feels guilty and shameful about her thoughts. The therapist says she has yet another secret: 'I am a stupid, fat girl who is not allowed to cry or to be unhappy and who has to do nothing but work and care for others.' This, the therapist explains, is not establishing a fact. It is the passing of a judgement by a judge ('You are a stupid, fat girl etc.') on a convict who resigns herself to the verdict. Does it get through to her that once the judges were her father and mother, but now she is the judge herself? That she has become the judge her parents once were? It dawns on Catherine that she is treating herself as she was treated as a child in her remembered, subjective past. 'Yes, I am the one who thinks I am unattractive and dumb, yes, I condemn myself to work and care for others, yes, I forbid myself to cry or to be unhappy.' In other words, she realizes that she has identified with internal interpersonal relationships. At present, it is not her father who belittles her, nor is it her mother who dismisses her sorrow. She is treating herself the way her parents treated her, or at least the way she feels they treated her. The therapist muses: the more Catherine realizes what she is doing to herself, how she does it, why she does it and what the normal consequences of it are, the better the chances are she will be able to alter it.

At the eighth level the problems discussed at levels four to seven become a subject of discussion in the transference. Lived self-insight broadens to what happens in the here and now of the interaction between therapist and patient. It is not the SPSP therapist’s intention to elaborately or deeply discuss the transference. With some patients, however, some discussion of transference is possible and indicated or even unavoidable, e.g., when the patient’s transference interferes with the working alliance. Catherine fares well. No, she has nothing to say, or, yes she has, but the therapist should not take it personally. With a shy giggle she tells him that she had a dream last night, “something stupid”. It was an abnormal therapeutic session that took place in the kitchen at the therapist’s home, with his wife rummaging in the next room. “Isn’t it preposterous?” The therapist is not thrown off balance. He says Catherine can dispose of her dream with a shrug or take it seriously and question it, conceiving her dream as a mute film for which she wrote the script. She is interested. Her late grandfather considered dreams important. The therapist says the dream is obviously about her and himself, and points out it occurred during the night preceding their parting. It is the sixteenth and last session, after which both of them will go their way. “Of course, I understand I have intermingled professional and private relationships” she says. The therapist says that, as they have talked for six months and as she has taken him deeper into confidence than anyone else, it is rather normal that he has become more to her than just a neutral, professional figure. “Indeed, it’s not too queer an idea. To be honest, I would like to know what you think of me, not as a patient, but as a person.” The therapist shuffles in his chair a bit and clears his throat before replying: “I take it you are rather apprehensive about my opinion on who you are and you would like me to take away that worry?” Yes, he might. “Well, I can understand that. You told me your father appreciated you as a hard worker, and your mother as a dedicated care giver, but you always knew inside you were more than just what they wanted you to be. Here I wanted you to be a

patient as you wanted me to be a therapist. As we worked together I realized quite well you are more than just a patient, but that was not the subject of our conversations." It is not much the therapist gives but Catherine is content with it and they part.

The discourse reaches level nine when all or most of the important aspects of patient's problems manifest themselves in the transference and can be worked through in depth. In our experience, it rarely happens in short-term therapies.

SPSP starts at level one and in many cases rises to level five. The levels six and seven are reached considerably less often. Level eight may be reached for some time with some patients but can hardly be worked through fully. Level nine is unattainable. The therapeutic course is normally characterized by considerable fluctuations in the level of discourse. The therapist is expected to adapt to this variability.

Position of SPSP among other therapies

SPSP obviously differs from long-term therapies, but it also varies from the existing short-term psychoanalytic therapies. Markowitz et al. (15) characterize Short-Term Psychodynamic Psychotherapy (STPP) as 'a treatment of less than 40 sessions that focuses on the patient's re-enactment in current life and the transference of largely unconscious conflicts deriving form early childhood'; 'key techniques are psychoanalytic, such as confrontation, interpretation, and work in the transference.'; 'STPP, even when emphasizing events, focuses on transference in the office and the linking of extra-session interpersonal events to the transference.' While sharing certain components of STPP as described here, SPSP differs in employing more supportive than interpretive techniques.

There are many non-psychoanalytic short-term therapies. We will not attend to this subject in this article. However, the relationship between SPSP and InterPersonal Therapy (IPT) deserves some discussion. Both modalities share common features. Klerman et al. (16) report: 'In training IPT psychotherapists and in discussions with clinical and research colleagues, we find a close relationship between IPT and dynamic psychotherapies. Many experienced, dynamically trained and psychoanalytically oriented psychotherapists report that the concepts and techniques of IPT are already part of their standard approach'. Elkin et al. (17) characterize cognitive behaviour therapy and IPT, as '... to some extent, representatives of two different and important basic orientations to psychotherapy, the behavioural and the psychodynamic.' In their research project, only therapists who had been trained in psychoanalytic psychotherapy were eligible as IPT therapists. On the other hand, there are significant differences between IPT and SPSP. Elkin et al. (17) state: 'this approach uses techniques derived from psychodynamically oriented therapies, but treatment is focused on the patient's current life and interpersonal relationships'. Klerman et al. (16) write: 'IPT is concerned with interpersonal, not intrapsychic phenomena'. The IPT therapist focuses on the current, depression-related interpersonal context. The therapy does not shift from external to internal (interpersonal and intrapersonal) relationships, as it does in SPSP. Using the aforementioned nine levels of discourse we would say: the main IPT focus is at what we call level 3 (the relational problem behind the complaints and symptoms), while the shifting SPSP levels reach as far as necessary and possible. Obviously in some cases it is not possible to go beyond level 3 (or even to exceed level 1). Still, even on these "low" levels, the SPSP therapist keeps in mind the importance of adequately gratifying, by his attitude and technique, verbally and nonverbally, the developmental needs of his patient. In this sense, from the start of therapy on, the intentions of the SPSP therapist differ from those of the IPT therapist.

Empirical validation of SPSP

Until now, the effectiveness of SPSP in ambulatory patients presenting a DSM-IV defined, mild to moderate major depressive disorder has been tested in five Randomised Clinical Trials by De Jonghe et al. (18, 19), Dekker et al. (20, 21) and Driessen et al. (1). A single research group conducted these five trials in similar but different study populations, using an identical research design, with each trial lasting six months. In the first three trials, patients were treated with SPSP, pharmacotherapy or combined therapy, i.e., the combination of SPSP and pharmacotherapy. De Maat et al. (22) performed a mega-analysis pooling the original data of three of these RCTs. The mega-analysis compared SPSP (n=97), pharmacotherapy (n=45) and combined therapy (n=171). Effectiveness was assessed by independent observers (17-item Hamilton Depression Rating Scale, main criterion), therapists (Clinical Global Impression of Severity and of Improvement) and patients (depression sub-scale of the Symptom Checklist, SCL, and the Quality of Life Depression Scale). Drop-out rates were calculated. Pearson chi-square calculations (level of significance .05) were used to compare base, dropout, response and remission rates. ANCOVA analysed (including baseline scores for outcome measures as covariates) were used to test inter-group differences. The results showed no significant differences in dropout rates, although dropout from both pharmacotherapy and SPSP was lower in combined therapy than in the corresponding single treatments. Table 1 summarizes the efficacy results, expressed in success percentages (success being defined as remission, not as response) at treatment week 24 (per protocol design).

Table 1

Scale	Rater	Success percentage		
		Pharmacotherapy	SPSP	Combined therapy
HDRS	Independent	24%	31%	40%
CGI-I	Therapist	49%	66%	65%
SCL	Patient	44%	64%	73%
QLDS	Patient	40%	53%	58%

As far as symptom reduction was concerned, the ratings of independent observers (p=0.214) did not show differences between SPSP and pharmacotherapy. However, patient (p=0.036) and therapist (p=0.026) ratings did find differences in favour of SPSP. All three ratings consistently found differences favouring combined therapy over pharmacotherapy (patients, p=0.000; therapists, p=0.024; independent observers, p=0.024). Independent observers (p=0.062) and therapists (p=0.430) found no differences between combined therapy and SPSP, but patients (p=0.016) found combined therapy superior. As far as improvements in quality of life were concerned, patients found no differences between SPSP and pharmacotherapy (p= 0.073) or between SPSP and combined therapy (p=0.217). However, they did find combined therapy superior to pharmacotherapy (p=0.015). The results of this mega-analysis suggest that, in the treatment of outpatients with mild to moderate major depressive disorder, independent observers, patients and therapists alike found SPSP plus pharmacotherapy to be more efficacious than pharmacotherapy alone, for both symptom reduction and quality of life improvement. They also suggest that independent observers found SPSP and pharmacotherapy equally efficacious. Patients and therapists ratings favour SPSP over pharmacotherapy for symptom reduction, but not for quality of life improvement. No difference in effectiveness was found between SPSP and combined therapy, except that patients thought that combined therapy was more effective in terms of symptom reduction. Kool et al. (23) demonstrated that the superior effectiveness of combined therapy over pharmacotherapy was found particularly in cases in which depression was combined with personality pathology. Dekker et al. (20) found in the fourth trial that SPSP has a somewhat slower start than pharmacotherapy alone in the first 8 weeks of treatment, but that SPSP prevails on most assessments in the end.

Conclusion

SPSP is a valuable extension of the existing options for the treatment of depressed patients We interpret its effectiveness as deriving from the therapeutic potential of psychoanalytically defined support, i.e., adequate gratification of developmental needs inadequately met in early infancy. Its effectiveness in depression has been demonstrated in several trials. Further research is warranted, especially in regard to its efficacy in other disorders than depression, and in regard to its relative efficacy compared to that of other approaches.

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