



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. To reduce patient's vulnerability to depression is a secondary goal. The emphasis is on supportive techniques that counter regression and foster psychological growth. The putative process consists in experiencing 'relational dissonance', i.e., feeling two contradictory relationships in the therapeutic situation simultaneously. One is determined by the past, the other by the present. Mostly unconsciously, the patient experiences adequate gratification of his unmet early infantile needs, as they manifest themselves in the archaic aspects of the therapeutic relationship, which is assumed to be an important curative factor. SPSP unfolds as a discourse in which nine levels can be distinguished. Each regards a specific subject, which is the focus of the interaction between patient and therapist at that level. The results of a mega-analysis pooling the original data of three randomised clinical trials suggest that SPSP and pharmacotherapy are equally efficacious, in treating outpatients with mild to moderate major depressive disorder. Combined they are as efficacious as SPSP alone and more efficacious than pharmacotherapy alone. Therefore, we consider Short-term Psychoanalytic Supportive Psychotherapy (SPSP) a valuable extension to the existing options for the treatment of depressed patients.

1. Introduction

Several options, both pharmacological and psychological, are available for the treatment of depressed patients. Their effectiveness is undeniable but unfortunately a considerable amount of patients do not (fully) respond. . In addition, as depressed patients constitute a heterogeneous group, it seems probable that different patients need different treatments. Therefore, the search for new alternatives that could potentially benefit patients with poor outcome of otherwise effective therapies, is useful (Fava, 2006). We think Short-term Psychoanalytic Supportive Psychotherapy (SPSP) could constitute a valuable extension to the existing options. SPSP is a short-term cure tailored to the conditions of depressed patients . It t combines a psychoanalytic with supportive stance. It is. We are not aware of any other psychoanalytic therapy presenting these characteristics. First, we summarize the theoretical roots of SPSP in this article. Secondly, we portray its principal characteristics. Thirdly, we try to elucidate its position among other therapies and finally we report on the efficacy studies providing empirical validation of its efficacy.

2. Theoretical roots of SPSP

SPSP is rooted in Freud's drive theory (Freud, 1957) and Ego-psychology (Freud, 1961). 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 engage in relationships, to be loved, to be protected and to be esteemed, brought to the fore by Klein's object-relations theory (Klein, Balint's primary love theory (Balint, 1952), Bowlby's attachment theory (Bowlby, 1969) and Kohut's self-psychology (Kohut, 1971; Kohut, 1977), respectively. 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. We distinguish between

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3 interactions with others present in the outer world ('external-interpersonal'), with others only
4 present in the inner world ('internal-interpersonal') and between I and Me. The latter we call the
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8 'IntraPersonal Relationship' (IPR). Second and third type relationships are 'internal
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10 relationships'. Internal-interpersonal relationships are seen as internalised external-interpersonal
11 relationships. The IPR results from the subject identifying with (some aspects) of (some) internal-
12 interpersonal relationships. The IPR results from the subject identifying with (some aspects) of (some) internal-
13 interpersonal relationships. Carl's case may help elucidate these concepts. He thinks that the
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15 relation with his mother, deceased years ago has gradually evaporated. She does not play a role in
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17 his life any longer. Much to his surprise, however, he dreamt about her last night. She was being
18 reproachful, about what is unclear. Apparently she is part of his past that lives on in his present as
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20 an internal-interpersonal relationship. In therapy, it gradually occurs to him, that he as an adult is
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22 no less disappointed in himself than she was in him when he was a child. He has come to view
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24 himself, in his perception that is, as he used to be seen by her. It has become a lasting,
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26 unconscious aspect of his IPR. He did not seek therapy for his malignant IPR itself but for its
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28 natural, logical consequences: he desperately craves recognition and consequently "buys"
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30 appreciation with pleasing behaviour; he is exceedingly naïve in contacts with sycophants: he
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32 fears and expects rejection and consequently shuns contacts and withdraws into grandiosity; he is
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34 exceedingly suspicious of his loving partner and behaves in a self-defeating way, making his
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36 darkest prophecies come true. The consequence is that he feels chronically rejected, lonely,
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38 inferior, depressed, and that is what he is asking help for. If inadequately met in early infancy,
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40 developmental needs persist in adults as ongoing, malignant, early infantile aspects of internal
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42 (interpersonal and intrapersonal) relationships. They manifest themselves in the archaic aspects of
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44 relationships, where they act as moulds on potentially new relationships, thus stimulating
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46 repetition instead of growth.
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58 We suggest the therapeutic action of SPSP resides mainly in its power to evoke, in the patient, an
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60 experience of relational dissonance or friction between two contradictory, external-interpersonal

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3 relationships, simultaneously felt in the present. Simplifying matters, we hereafter sketch what
4 may happen in Carl's therapy. On one hand, Carl is driven to externalise his internal, rather
5 malignant relationships, especially his IPR. He projects them on to and into the therapist and
6 experiences him as a rather debasing person. That relationship is dominated by Carl's past. In that
7 sense it is 'old' and 'unrealistic'. On the other hand, due to the interaction between the therapist's
8 genuine behaviour and Carl's capacities to test reality, he experiences the therapist as a rather
9 valuing person. That relationship is dominated by actual reality. In this sense, it is 'new' and
10 'realistic'. Both relationships regard the same developmental need, to be esteemed, manifesting
11 itself in the therapeutic relationship. The new relationship must be new enough but not too new. If
12 it bears too much novelty there is no dissonance. The two feeling states pass each other without
13 any wringing, jarring contact, hence without mutual influence. Dissonance is not a persisting
14 phenomenon. It tends to evolve towards consonance. In the end, either the new or the old
15 relationship will prevail. If the new, benevolent relationship is not new enough, the old
16 relationship will prevail. Carl's malevolent internal relationships are strengthened and his old
17 feelings confirmed. Retraumatization is the result and the process is anti -therapeutic. On the other
18 hand, if the new, benevolent relationship differs neither too little nor too much from the old one, it
19 may prevail. Carl will experience adequate gratification of his unmet early-infantile need. This
20 gratification forms the core of 'psychoanalytic informed support', in our view the most important
21 curative factor in SPSP. In so far Carl internalises the new relationship and identifies with it, the
22 old, malevolent, internal relationships (the old templates) will be corrected by it. Thus personality
23 is structured or restructured. At its deepest level, this process neither is neither reflexive, explicit,
24 verbal, symbolic, declarative nor repressed. It unfolds at the 'procedural knowledge level'. It is
25 unconscious but not dynamically so. It nevertheless may result in emotional insight, as Carl,
26 feeling adequately supported, may abandon his resistances and defences and shift to self-
27 exploration.

3. 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 patient's vulnerability to depression. We conceive the latter as the shaping or altering of the internal relationships, especially the 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. They are 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 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. In that sense, it 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 (Bion, 1962), holding (Winnicott, 1965), mirroring (Kohut, 1977), developmental help (Fonagy and Target, 1996) and

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3 the judicious blending of homeostatic ('maternal') and disruptive ('paternal') attunement.

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5 Supportive interventions can consist of practical action, e.g. making a telephone call on behalf of
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7 the patient. We exercise restraint in these matters though, because this type of support easily
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9 furthers regression. 'Helping the patient to help himself' remains the leading idea. To this purpose
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11 verbal interventions mostly suffice. We mention some examples: showing interest by providing
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13 and asking information, expressing understanding and empathy, expressing acceptance and
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15 esteem, reducing guilt feelings, shame and isolation, reassuring, normalising, instilling hope,
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17 motivating, facilitating verbalisation, exploring by listening actively and by asking open and
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19 closed questions, encouraging to dwell upon feelings, furthering acknowledgment and acceptance
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21 of painful or frightening affects, fostering controlled abreaction (catharsis) while discouraging all
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23 too heavy affects, evoking new and advisable feelings or furthering more adequate coping with
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25 feelings, clarifying, confronting, suggesting new ideas or possibilities, if necessary not shunning
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27 to give advice, if it needs be persuading, countering dysfunctional cognitions and behaviours, and
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29 encouraging autonomy. The aforementioned interventions are not adequate or inadequate in
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31 themselves. It is their (non) integrated and (non) judicious application and the patient's perception
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33 of it that determine whether they are adequate or not.
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43 **4. The typical course**

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45 SPSP presents important nonverbal communicative aspects but is essentially a 'talking cure'. It
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47 unfolds as a discourse in which we distinguish nine levels. We illustrate our views with vignettes
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49 regarding the SPSP treatment of Catherine, a 28-year-old head nurse. She is a psychiatric
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51 outpatient suffering from DSM-IV defined, moderate major depressive disorder. The case has
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53 been modified for discretion's sake; still we trust the vignettes convey the essence of the message.
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57 4.1. At the first level the focus is on the patient's physical and psychological complaints and
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59 symptoms. For at least ten months, Catherine's life has been miserable. Most importantly, she is
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3 tired all the time for no good reason. She awakes exhausted and drags herself through the day (she
4 still works at the hospital). Besides that, her mood is low, her interest has vanished and nothing in
5 life is pleasurable anymore. She cries a lot without even knowing why: 'Isn't that silly?' Catherine
6 understands there is something wrong with her. In this sense she gives evidence of some insight.
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8 The therapist asks her how she explains her depressed state herself. There is no explanation. 'I
9 may have a creeping physical illness the doctors can't find.' She is here on the advice of her friend
10 but she doesn't believe in it. The therapist registers her demand to be rescued. He knows he is
11 unable to do it. He feels powerless, which he conceives as a token of her own powerlessness. He
12 listens with an attentive ear and shows empathy, not pity. He is careful, not worried. He considers
13 the situation serious, not hopeless. He provides some psycho-education on depression, discusses
14 how to cope with her symptoms but refrains from giving advice beyond very simple, day-to-day
15 issues. Meanwhile, he cautiously inquires after suicidality, which in Catherine's case is not a
16 matter for concern. Apart from that, he simply bides his time.

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34 4.2. At the second level the focus shifts from symptoms and complaints to life circumstances,
35 which somehow might influence or have influenced the depression. It is a first step in looking for
36 an explanation. The therapist enquires about Catherine's actual life situation and maps out its
37 taxing and supporting aspects. He asks whether Catherine's mood reacts to circumstances. Indeed,
38 it does. Reluctantly, she tells that she went on a holiday with her boyfriend the other day and had
39 indeed felt better then, only to sink back as soon as she resumed work. She had also felt very
40 depressed when recently visiting a rather busy restaurant, but walking her dog had lightened her
41 up. The therapist comments that it is a positive fact that her depression still is sensitive to
42 circumstances. What happened in her life about a year ago? The hospital ward had to move
43 temporarily. The patients were upset, there was a lot to do and she worked even harder than she
44 used to. 'But somehow I was not "there" at work, it was as if I was constantly somewhere else in
45 my thoughts. I was criticised for that and it upset me a great deal'. She was not angry with the
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3 manager, on the contrary, she sympathized with him. After all, he was right, she was absent-
4 minded. Catherine is able to relate her symptoms to circumstances. She realizes that they are at
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6 least contributory to the development and continuation of her symptoms. Catherine shows
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8 growing insight. The therapist says it is important that she realizes her depression did not come
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10 out of the blue. In some sense it is understandable. She objects that did not depress her colleagues.
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12 He proposes to jointly explore the impact of life circumstances on her mood. Everybody's life, he
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14 says, is highly determined by what happens and even more by the way events are perceived. He
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16 does not miss how remarkably understanding Catherine is towards her critical boss but he does
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18 not bring the issue to the fore.
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25 4.3. At the third level the focus shifts from life circumstances to one or more external,
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27 interpersonal relationships. This level specifies the former one by translating 'circumstances' into
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29 'relationships'. The therapist wonders how 'being overloaded with work' relates to 'people in the
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31 work situation' and where Catherine was 'in her thoughts' a year ago, while working at the
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33 hospital. Was there something the matter with important people in her life? Yes, there was her
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35 grandfather on mother's side. He died around that time. 'I loved my grandfather very much; in fact
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37 he was more like a father to me than my father was. But I think I am over it now, it happened such
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39 a long time ago.' The therapist asks how grandfather died. The story brings tears to Catherine's
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41 eyes. In those days she was a great comfort to her grandmother and her mother. She arranged the
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43 funeral almost all by herself. The therapist says: "You were there for your grandmother and for
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45 your mother but who was there for you?" Now she is silent and cries. The therapist wonders
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47 where her father was. He didn't come to the funeral. Her parents separated when Catherine was
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49 eleven, after long years of unhappy marriage. The relationship between them never normalized.
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51 'Nobody asked me how I felt and how I was coping with grandfather's death.' 'Afterwards, my
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53 mother had no time to ask about or listen to my feelings. Every time I tried to tell her, she said:
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55 'Stop crying, I'm getting too sad'. Catherine was not angry with her mother, on the contrary, she
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3 empathized with her. Her mother was the one having a hard time. After all, it was about her father
4 and not, as in Catherine's case, about her grandfather. The therapist keeps exploring facts and
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7 experiences. Meanwhile, he is moved by Catherine's account. He sees a brave, forlorn child and
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10 wonders how he could reach it while Catherine herself is out of touch with it. He also feels
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13 outraged about what was done to her but just in time realizes that Catherine, who is totally
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16 unaware of it in herself, has aroused this feeling in him. Catherine's insight increases. She realizes
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19 the importance of strained relationships in what happened with her. Still, she conceives her
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22 problem as 'external' and muses upon external solutions, e.g. looking for another job.

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25 4.4. At the fourth level the focus shifts from one or more relational problems to one or more
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28 relational patterns in patient's life. The therapist wonders about the situations at the hospital and
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31 the funeral. Different as they may be, do they present a common feature? 'Yes, I felt overlooked'.
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34 Her colleagues, and particularly the head of the ward, never asked her how she herself was doing
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37 during the hectic period at the hospital. At the funeral the family was glad she managed the
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40 situation quite efficiently ('I'm good at that'), for sure, but everybody seemed too much absorbed
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43 in their own grief to show any interest in hers. Catherine gradually recognizes the pattern, even in
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46 the relationship with her boyfriend. 'Work has to be done, problems have to be tackled and it all
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49 falls on my shoulders. I'm the worker ant of the ward and the help and stay of the family. Besides
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52 that, nobody seems interested in me. Sometimes I even doubt whether my boyfriend knows me.'
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55 She is amazed, even frightened, by the realization how deeply these feelings are entrenched in her
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58 life. The therapist feels less powerless. Clearly, mutual acceptance and cooperation begin to
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61 prevail in the therapeutic relationship. Catherine feels better and has started self-exploration. The
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64 therapist values her growing awareness of an interfering pattern or theme in her life ('being
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67 overlooked'). Wonder is the beginning of wisdom, he says. Catherine shows growing insight but
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70 she conceives her problems and their potential solutions still external.

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3 4.5. At the fifth level the focus shift from external problems and patterns to an internal issue: the
4 patient's attitude in life. The therapist does not challenge Catherine's views on the selfishness and
5 ingratitude of people. After a while Catherine increasingly puts her ideas into perspective. 'Of
6 course, I don't make things easy for others. I get myself lumbered with responsibilities, I volunteer
7 for work I am not supposed to do, and I resent asking for help. I'm good at putting on a happy
8 face. Small wonder they see me as the uncomplicated, funny one who needs no help at turning
9 problems into challenges and opportunities.' Catherine is quite knowledgeable on dog issues but at
10 the dog-club she seldom speaks her mind from fear she might 'give the wrong answer'. 'I am
11 always afraid they'll think I am a stupid, fat girl'. Catherine is quite upset by the discovery that the
12 problem is not 'out there' but inside her. 'Doesn't that make the problem irremediable?' The
13 therapist feels rewarded. Catherine is able to discuss her own contribution in maintaining the
14 interpersonal pattern she has become aware of at level four. She now exhibits psychoanalytically
15 defined self-insight. Apparently she trusts him and feels sufficiently safe to explore uncharted
16 waters. He is well aware she has taken quite a step and no interpretations were required to get her
17 to do so. He realizes she is doing what he wants her to do: question herself instead of others. He
18 admits to her that this seems to him the right path to follow. He understands her new insight
19 frightens her and comments that the chances on changing herself are considerably higher than
20 those on changing the world.
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45 4.6. At the sixth level the focus shifts to an epigenetic explanation of level five. It is about how
46 past relationships persist in the patient's actual life. The therapist says he doubts Catherine's
47 attitudes are just inborn and suggests looking for their sources. The aim, he explains, is not
48 'digging up the past' but 'understanding the present better'. This is not a difficult task for
49 Catherine. 'I can still hear my father say to me: 'You are a stupid, fat girl. I'd rather had the girl
50 next door for a daughter.' It hurts, she cries. When Catherine cried at father's comments, he would
51 reply she was 'a moron to cry for this'. She fears the therapist would think the same without
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3 saying. He says he doesn't, on the contrary, he understands she couldn't possibly feel safe with her
4 father. Father was not always that derogative though. Each time she came home with good school
5 marks, merited by hard work, he would praise her. Her mother was a master in covering up. She
6 frequently told Catherine not to cry or to stop crying, and cleared the sky by making funny
7 remarks. 'Together we laughed a lot'. Meanwhile mother suffered from various ailments. She
8 didn't speak about it, but Catherine knew. It still happens that her mother's suffering face haunts
9 her. Catherine was often to be found at her grandparents' home. The therapist feels Catherine
10 progresses in understanding instead of condemning herself. The relationship is really
11 collaborative now. Self-insight expands to the aftermath of early experiences. The discourse is
12 about former external relationships living on in the present as a result of internalisation. It is about
13 internal interpersonal relationships, 'the other in me', not of course the historical but the narrative
14 other. Catherine makes contact with the forlorn child she once was and deep down still is. It didn't
15 take genetic interpretations for her to do so. The therapist says Catherine is on track of an
16 important echo of her past into the present. It may be a painful trail but in the end it will be
17 rewarding.

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20 4.7. At the seventh level the focus shifts to the relationship the patient maintains with herself as
21 the consequence of identification with internal-interpersonal relationships. 'It may be true',
22 Catherine says, 'that my parents from the past still live on in me but how is it possible that they
23 still have so much power over me? I'm not a little girl anymore!' She has not had contact with her
24 father in years. She considers her mother a bore, still she phones her daily. She has a boyfriend
25 who repeatedly and unambiguously demonstrates he finds her attractive, smart and loving.
26 Annoyingly enough, she doesn't seem to believe him and secretly fantasizes about flirting with
27 other men, if not about more than that. She feels guilty and shameful about her thoughts. The
28 therapist says she has yet another secret: 'I am a stupid, fat girl who is not allowed to cry or to be
29 unhappy and who has to do nothing but work and care for others.' This, the therapist explains, is
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3 not establishing a fact. It is the passing of a judgement by a judge ('You are a stupid, fat girl etc.')

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5 on a convict who resigns herself to the verdict. Does it get through to her that once the judges

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7 were her father and mother, but now she is the judge herself? That she has become the judge her

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9 parents once were? It dawns on Catherine that she is treating herself as she was treated as a child

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11 in her remembered, subjective past. 'Yes, I am the one who thinks I am unattractive and dumb,

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13 yes, I condemn myself to work and care for others, yes, I forbid myself to cry or to be unhappy.'

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15 In other words, she realizes that she has identified with internal interpersonal relationships. At

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17 present, it is not her father who belittles her, nor is it her mother who dismisses her sorrow. She is

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19 treating herself the way her parents treated her, or at least the way she feels they treated her. The

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21 therapist muses: the more Catherine realizes what she is doing to herself, how she does it, why she

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23 does it and what the normal consequences of it are, the better/higher the chances are she will be

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25 able to alter it.

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32 4.8-9. At the eight and ninth level the focus shifts to how the problems discussed at the levels four

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34 to seven manifest themselves in the relationship with the therapist. It regards working in the

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36 transference (level 8) and transference neurosis (level 9). It is not the SPSP therapist's intention to

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38 elaborately or deeply discuss the transference. With some patients, however, some discussion of

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40 transference is possible and indicated or even unavoidable, e.g., when the patient's transference

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42 interferes with the working alliance.

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45 SPSP starts at level one and in many cases rises to level five. The levels six and seven are reached

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47 considerably less often. Level eight may be reached for some time with some patients but can

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49 hardly be worked through fully. Level nine is unattainable. The therapeutic course is normally

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51 characterized by considerable fluctuations in the level of discourse. The therapist is expected to

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53 adapt to this variability.

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5. Position of SPSP among other psychodynamic orientated therapies

SPSP obviously differs from long-term therapies, but it also varies from the existing short-term psychoanalytic therapies. Markowitz (Markowitz et al., 1998) 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 from 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.' These characteristics refer to an interpretative and not a supportive technique. 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 (Klerman et al., 1984) reports: '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 (Elkin et al., 1985) 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 (Elkin et al., 1985) state: 'this approach uses techniques derived from psychodynamically oriented therapies, but treatment is focused on the patient's current life and interpersonal relationships'. Klerman (Klerman, 1984) write: 'IPT is concerned with interpersonal, not intrapsychic phenomena'. The IPT focus focuses on the current, depression-related relational context. . . Using the aforementioned nine levels of discourse one might say that IPT is characterized on level

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3 (the interpersonal level). The aim of SPSP is to achieve the discourse that is necessary and
4 possible. Obviously in some cases it is not possible to go beyond level 3 (or even to exceed level
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8 1). In these instances there may be not much difference between SPSP and IPT. Clearly at this
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10 moment we do not know which approach is preferable for an individual patient. A direct head to
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12 head comparison is required to shed more light on this .
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17 **6. Empirical validation of SPSP**

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20 Until now, the efficacy of SPSP in ambulatory patients presenting a DSM-IV defined, mild to
21 moderate major depressive disorder has been tested in three Randomised Clinical Trials by De
22 Jonghe (Jonghe et al., 2001; Jonghe et al, 2004) and Dekker (Dekker et al., 2007). A single
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24 research group conducted the three trials in different but similar study populations, using an
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26 identical research design, with each trial lasting six months. Patients were treated with SPSP,
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28 pharmacotherapy or combined therapy, i.e., the combination of SPSP and pharmacotherapy. De
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30 Maat (Maat et al., in press) performed a mega-analysis pooling the original data of the three
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32 RCTs. The mega-analysis compared SPSP (n=97), pharmacotherapy (n=45) and combined
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34 therapy (n=171). Independent observers (17-item Hamilton Depression Rating Scale, HDRS),
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36 therapists (Clinical Global Impression of Severity and of Improvement, CGI-S and CGI-I) and
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38 patients (depression sub-scale of the Symptom Checklist, SCL, and the Quality of Life
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40 Depression Scale, QLDS) assessed efficacy. Pearson chi-square calculations (level of significance
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42 .05) were used to compare base, dropout, response and remission rates. ANCOVA analysed
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44 (including baseline scores for outcome measures as covariates) were used to test inter-group
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46 differences. The results showed no significant differences in dropout rates, although dropout from
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48 both pharmacotherapy and SPSP was lower in combined therapy than in the corresponding single
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50 treatments. Table 1 summarizes the efficacy results, expressed in success percentages at treatment
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52 week 24 (per protocol design).
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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, independent observers ($p=0.214$) did not find differences between SPSP and pharmacotherapy. Patients ($p=0.036$) and therapists ($p=0.026$) did, in favour of SPSP. All three 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. There is some indication that patients and therapists favour SPSP over pharmacotherapy for symptom reduction, but not for quality of life improvement. No efficacy difference was found between SPSP and combined therapy, except that patients thought that combined therapy was more efficacious in terms of symptom reduction. Kool (Kool et al.,

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3 2003) demonstrated that the superior efficacy of combined therapy over pharmacotherapy shows
4 particularly in cases presenting depression combined with personality pathology.
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10 **7. Conclusion**
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12 SPSP is a valuable extension of the existing options for the treatment of depressed patients. It
13 emphasizes the therapeutic potentials of psychoanalytically defined support. Further research
14 regarding its efficacy in depression and other disorders is warranted, including its relative efficacy
15 compared to that of other approaches.
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For Peer Review

Literature

Balint, M. 1952. Primary love and psychoanalytic technique. London: Hogarth Press.

Bion, WR. 1962. Learning from experience. London: Heinemann Medical Books.

Bowlby, J. 1969. Attachment and Loss. New York: Basic Books.

Dekker J, Molenaar P, Kool S, et al. 2005. Dose-effect relations in time-limited combined psycho-pharmacological treatment for depression. *Psychological Medicine* 35:47-58.

Elkin I, Parloff MB, Hadley SW, et al. 1985. NIMH Treatment of depression collaborative research program: Background and research program. *Arch Gen Psychiat* 42:305-316.

Fava, G. 2006. The intellectual crisis of psychiatric research. *Psychotherapy and Psychosomatics* 75:202-208.

Fonagy P, Target M. 1996. Playing with reality I: Theory of mind and the normal development of psychic reality. *Int J Psychoan* 77:217-234.

Freud, S. 1957. Instincts and their vicissitudes, 1915. Standard Edition, 14: 117-140. London: The Hogarth Press.

Freud, S. 1961. The Ego and the Id, 1923. Standard Edition, 19: 12-66 London: The Hogarth Press.

Jonghe F de, Kool S, Aalst G van, Dekker J, Peen J. 2001. Combining psychotherapy and antidepressants in the treatment of depression. *J Affective Disorders* 64:217-229.

Jonghe F de, Hendriksen M, Aalst G van, et al. 2004. Psychotherapy alone and combined with pharmacotherapy in the treatment of depression. *Brit J Psychiat* 185: 37-45.

Klein, M. 1975. The Writings of Melanie Klein, volume 1-4. London: The Hogarth Press.

Klerman GL, Weissman MM, Rounsaville BJ, Chevron ES. 1984. Interpersonal therapy of depression. New York: Basic Books.

1
2
3 Kohut, H. 1971. The analysis of the self. New York: International Universities Press.
4

5 Kohut, H. 1977. The restoration of the self. New York: International Universities Press.
6

7
8 Kool S, Dekker J, Duijsens IJ, de Jonghe F, Puite B. 2003. Efficacy of combined therapy and
9
10 pharmacotherapy with depressed patients with or without personality disorders. Harvard
11
12 Review of Psychiatry 3: 133-141.
13
14

15 Maat S de, Dekker J, Schoevers R, van Aalst G, Gijsbers-van Wijk C, Hendriksen M, Kool S,
16
17 Peen J, Van R, de Jonghe F.[in press] Short Psychodynamic Supportive Psychotherapy,
18
19 Antidepressants and their Combination in the Treatment of Major Depression: A mega-
20
21 analysis based on three randomised clinical trials. Accepted for publication by the
22
23 journal Depression and Anxiety.
24
25

26
27 Markowitz JC, Svartberg M, Swartz HA. 1998. Is IPT time-limited psychodynamic
28
29 psychotherapy? J Psychotherapy Practice Research 7: 185-195.
30

31 Winnicott DW. 1965. The maturational processes and the facilitating environment. London:
32
33 The Hogarth Press.
34
35
36
37
38
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