

Depression Studies Pertinent to NICE Guidelines: Short-term Psychodynamic Psychotherapies (STPP)

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Overview

STPP methods have been developed and researched over the past 40 years to shorten emotionally focused treatment of a broad range of conditions including depression, anxiety, somatic problems and personality disorders. These treatments are under 40 sessions of average and have now been studied with over 60 randomized controlled trials of variable quality and 5 meta-analyses that support the method as being effective compared to minimal treatment and wait list controls for a broad range of conditions as noted above. (Abbass AA, Hancock JT, Henderson J, et al. Short-term psychodynamic psychotherapies for common mental disorders. Cochrane Database of Systematic Reviews. 2006(4).

Herein, I will provide references (and abstracts of more recent studies) to RCT and Non-RCT studies of STPP with depression. Because depression, and especially treatment resistant depression, is often mixed with personality disorder (PD), I will highlight the body of data showing the efficacy of this method in PD and some studies that examined the 2 conditions. This is critical to examine because we know that the majority of patients treated with front line treatment do not remit, thus treatment resistance of some degree is the norm. For any brief treatment to be effective and have a significant impact on the overall system, personality problems must thus be addressed.

In summary, STPP is effective with lasting effects, likely cost effective, and preferred by patients over medication treatments. STPP is also effective with personality disorders even combined with depression suggesting they be considered a first line option in those cases to reduce the rate of non-response and perhaps prevent chronicity.

Randomized Controlled Trials of STPP for Depression

Research report Combining psychotherapy and antidepressants in the treatment of Depression F. de Jonghe*, S. Kool, G. van Aalst, J. Dekker, J. Peen. Journal of Affective Disorders 64 (2001) 217–229

Objective: To compare the efficacy of antidepressants with that of antidepressants plus psychotherapy (“combined therapy”) in the treatment of depression. *Method:* 6 month randomised clinical trial of antidepressants ($N=84$) and combined therapy ($N=83$) in ambulatory patients with Major Depression and a 17-item HDRS baseline score of at least 14 points. The antidepressant protocol provides for three successive steps in case of intolerance or inefficacy: fluoxetine, amitriptyline and moclobemide. The combined therapy condition consists, in addition to pharmacotherapy, of 16 sessions of Short Psychodynamic Supportive Psychotherapy. Efficacy is assessed using the 17-item HDRS, the CGI of Severity and of Improvement, the depression subscale of the SCL-90, and the Quality of Life Depression Scale. The data analysis is conducted on three samples: the

intention-to-treat sample, the per protocol sample and the observed cases sample. *Results:* After randomisation, 32% of the patients refused the proposed pharmacotherapy while 13% refused the proposed combined therapy. In 24 weeks, 40% of the patients who started with the pharmacotherapy stopped medication; 22% of those receiving the combined therapy did so. The difference in success rates is statistically significant, favouring combined therapy, in 23%, 31% and 62% of the patients after 8, 16 and 24 weeks of treatment, respectively. At week 24, the mean success rate is 40.7% in the pharmacotherapy group and 59.2% in the combined therapy group. *Conclusion:* Patients found combined treatment significantly more acceptable, they were significantly less likely to drop out of combined therapy and, ultimately, significantly more likely to recover. Combined therapy is preferable to pharmacotherapy in the treatment of ambulatory patients with major depression.

Psychotherapy alone and combined with pharmacotherapy in the treatment of depression. de Jonghe F, Hendricksen M, van Aalst G, Kool S, Peen V, Van R, van den Eijnden E, Dekker J. Br J Psychiatry. 2004 Jul;185:37-45

BACKGROUND: The relative efficacy of psychotherapy and combined therapy in the treatment of depression is still a matter of debate. **AIMS:** To investigate whether combined therapy has advantages over psychotherapy alone. **METHOD:** A 6-month randomised clinical trial compared Short Psychodynamic Supportive Psychotherapy (n=106) with combined therapy (n=85) in ambulatory patients with mild or moderate major depressive disorder diagnosed using DSM-IV criteria. Antidepressants were prescribed according to a protocol providing four successive steps in case of intolerance or inefficacy: venlafaxine, selective serotonin reuptake inhibitor, nortriptyline and nortriptyline plus lithium. Efficacy was assessed using the 17-item Hamilton Rating Scale for Depression, the Clinical Global Impression of Severity and of Improvement, and the depression sub-scale of the Symptom Checklist. **RESULTS:** The advantages of combining antidepressants with psychotherapy were equivocal. Neither the treating clinicians nor the independent observers were able to ascertain them, but the patients experienced them clearly. **CONCLUSIONS:** The advantages of combining antidepressants with psychotherapy are equivocal.

Combined Brief Dynamic Therapy and Pharmacotherapy in the Treatment of Major Depressive Disorder: A Pilot Study

Giuseppe Maina Gianluca Rosso Chiara Crespi Filippo Bogetto Psychother Psychosom 2007;76:298–305

Background: The relative efficacy of supplemental psychotherapy in the treatment of depression is still a matter of debate. Moreover, the superiority of brief dynamic therapy (BDT) over supportive psychotherapies is not well established. The aim of this study is to compare the efficacy of BDT added to medication with that of brief supportive psychotherapy (BSP) added to medication in the treatment of major depressive disorder. **Method:** A 12-month randomized clinical trial compared BDT (n = 18) with BSP (n = 17) combined with antidepressants in outpatients with major depressive disorder. Both psychotherapies were added during the first 6 months of the trial; all patients continued to

be treated with only pharmacotherapy (paroxetine or citalopram) in the following 6-month continuation phase. Efficacy was assessed using the 17-item Hamilton Rating Scale for Depression (HAM-D), the Hamilton Rating Scale for Anxiety and the Clinical Global Impression (CGI). The data analysis was conducted on two samples: the per-protocol (PP) sample and the observed-cases (OC) sample. **Results:** Thirty-two patients completed the study. Although at the end of the combined therapies (T2) no differences emerged between the two treatment approaches, the group of patients treated with BDT showed a further clinical improvement at the end of the study (T3): a significant reduction in symptomatology emerged on the HAM-D (PP sample: $F = 75.154$, $p = 0.03$; OC sample: $F = 67.149$, $p = 0.022$) and on the CGI total scores (PP sample: $F = 78.527$, $p = 0.016$; OC sample: $F = 74.104$, $p = 0.007$). The difference in remission rates on the HAM-D (75 vs. 12.5% at T3) is statistically significant favoring BDT. **Conclusions:** BDT combined with antidepressants is preferable to supportive psychotherapy combined with medication in the treatment of outpatients with major depression.

Randomized controlled trial comparing brief dynamic and supportive therapy with waiting list condition in minor depressive disorders. Maina G, Forner F, Bogetto F. Psychother Psychosom. 2005;74(1):43-50.

BACKGROUND: Although many evidences suggest the presence of specific therapeutic factors in brief dynamic therapy (BDT), few studies have investigated its efficacy in the treatment of depressive disorders in comparison to other psychotherapies. The aim of this study was to determine whether BDT is more effective than brief supportive psychotherapy (BSP) and waiting list condition in the treatment of minor depressive disorders. **METHOD:** Thirty patients with primary DSM-IV dysthymic disorder, depressive disorder not otherwise specified or adjustment disorder with depressed mood completed a randomized controlled trial with three treatment groups (BDT, BSP, waiting list condition). A 6-month follow-up was performed for patients treated with both psychotherapeutic approaches. Other psychiatric treatments were not permitted throughout the treatment period and the 6-month follow-up. Symptoms were assessed at baseline, at the end of treatment, and after 6 months of follow-up. **RESULTS:** Patients treated with both psychotherapeutic approaches showed a significant improvement after treatment in comparison to non-treated controls, but BDT was more effective at follow-up evaluation. **CONCLUSIONS:** BDT is a promising treatment for minor depressive disorders. This study also suggests that BDT is more effective than supportive psychotherapy in improving the long-term outcome of depressive disorders.

Psychodynamic Psychotherapy and Clomipramine in the Treatment of Major Depression Yvonne Burnand, Ph.D. Antonio Andreoli, M.D. Evelyne Kolatte, M.D. Aurora Venturini, M.D. Nicole Rosset, Ph.D. (*Psychiatric Services* 53: 585–590, 2002)

Objective: The authors compared a combination of clomipramine and psychodynamic psychotherapy with clomipramine alone in a randomized controlled trial among patients with major depression. *Methods:* Seventy-four patients between the ages of 20 and 65 years who were assigned to ten weeks of acute outpatient treatment for major depression were studied. Bipolar disorder, psychotic symptoms, severe substance dependence,

organic disorder, past intolerance to clomipramine, and mental retardation were exclusion criteria. *Results*: Marked improvement was noted in both treatment groups. Combined treatment was associated with less treatment failure and better work adjustment at ten weeks and with better global functioning and lower hospitalization rates at discharge. A cost savings of \$2,311 per patient in the combined treatment group, associated with lower rates of hospitalization and fewer lost work days, exceeded the expenditures related to providing psychotherapy. *Conclusions*: Provision of supplemental psychodynamic psychotherapy to patients with major depression who are receiving antidepressant medication is cost-effective.

Comparative Effects of cognitive-behavioral and brief psychodynamic psychotherapies for depressed family caregivers. Gallagher-Thompson, D., & Steffen, A.M. (1994). Journal of Consulting and Clinical Psychology, 62(3), 543-549.

Clinically depressed family caregivers (N = 66) of frail, elderly relatives were randomly assigned to 20 sessions of either cognitive-behavioral (CB) or brief psychodynamic (PD) individual psychotherapy. At posttreatment, 71% of the caregivers were no longer clinically depressed according to research diagnostic criteria (RDC), with no differences found between the 2 outpatient treatments. The results suggested therapy specificity; there was an interaction between treatment modality and length of caregiving on symptom-oriented measures. Clients who had been caregivers for a shorter period showed improvement in the PD condition, whereas those who had been caregivers for at least 44 months improved with CB therapy. These findings suggest that patient-specific variables should be considered when choosing treatment for clinically depressed family caregivers.

Effects of treatment duration and severity of depression on the effectiveness of cognitive-behavioral and psychodynamic-interpersonal psychotherapy. Shapiro, D.A., Barkham, M., Rees, A., Hardy, G.E., Reynolds, S., & Startup, M. (1994) Journal of Consulting and Clinical Psychology, 62(2), 522-534.

A total of 117 depressed clients, stratified for severity, completed 8 or 16 sessions of manualized treatment, either cognitive-behavioral psychotherapy (CB) or psychodynamic-interpersonal psychotherapy (PI). Each of 5 clinician-investigators treated clients in all 4 treatment conditions. On most measures, CB and PI were equally effective, irrespective of the severity of depression or the duration of treatment. However, there was evidence of some advantage to CB on the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). There was no evidence that CB's effects were more rapid than those of PI, nor did the effects of each treatment method vary according to the severity of depression. There was no overall advantage to 16-session treatment over 8-session treatment. However, those presenting with relatively severe depression improved substantially more after 16 than after 8 sessions.

RCT's of STPP for both Personality Disorder and Depression

Efficacy of combined therapy and pharmacotherapy for depressed patients with or without personality disorders. Kool S, Dekker J, Duijsens IJ, de Jonghe F, Puite B. *Harv Rev Psychiatry*. 2003 May-Jun;11(3):133-41.

In general, depressed patients with personality pathology--Axis II disorders--respond less well or less quickly to the various kinds of individual treatment that are available, whether pharmacotherapy, psychotherapy, or both combined. This article sets forth the results of a six-month, randomized clinical trial of antidepressants and combined therapy in ambulatory patients with major depression and a baseline score of at least 14 on the 17-item Hamilton Rating Scale for Depression (HAM-D-17). The presence or absence of Axis II pathology was determined on the basis of a self-report version of the International Personality Disorder Examination. The study's antidepressant protocol provided for three successive steps in case of intolerance or inefficacy: fluoxetine, amitriptyline, and moclobemide. In addition to pharmacotherapy, the combined-therapy condition included 16 sessions of Short Psychodynamic Supportive Psychotherapy. Efficacy of the therapy provided was assessed using the HAM-D-17 and also other instruments. According to the results in secondary analyses, it emerged that combined therapy was more effective than pharmacotherapy for depressed patients with personality disorders. Combined therapy was not more effective than pharmacotherapy alone for depressed patients without personality disorders. It is recommended that depressed patients with comorbid personality pathology should be treated with combined therapy, with the focus of psychotherapy being not on the patient's symptoms and complaints, but on all aspects of the patient's actual relationships.

Impact of Cluster C Personality Disorders on Outcomes of Contrasting Brief Psychotherapies for Depression Hardy, G.E., Barkham, M., Shapiro, D.A., Stiles, W.B., Rees, A., & Reynolds, S. *Journal of Consulting and Clinical Psychology*, 1995; 63 (6) 997-1004.

Twenty-seven of 114 depressed clients, stratified for severity of depression, obtained a Diagnostic and Statistical Manual of Mental Disorders (3rd ed.; DSM-III; American Psychiatric Association, 1980) diagnosis of Cluster C personality disorder--that is, avoidant, obsessive-compulsive or dependent personality disorder (PD clients)--whereas the remaining 87 did not (non-personality-disorder [NPD] clients). All clients completed either 8 or 16 sessions of cognitive-behavioral (CB) or psychodynamic-interpersonal (PI) psychotherapy. On most measures, PD clients began with more severe symptomatology than NPD clients. Among those who received PI therapy, PD clients maintained this difference posttreatment and at 1-year follow-up. Among those who received CB therapy, posttreatment differences between PD and NPD groups were not significant. Treatment length did not influence outcome for PD clients. PD clients whose depression was also relatively severe showed significantly less improvement after treatment than either PD clients with less severe depression or NPD clients.

Non RCT studies of STPP for Depression

Short-term psychodynamic psychotherapy for depression: an examination of statistical, clinically significant, and technique-specific change. *J Nerv Ment Dis.* 2003 Jun;191(6):349-57. Hilsenroth MJ, Ackerman SJ, Blagys MD, Baity MR, Mooney MA.

This study investigates the effectiveness of short-term psychodynamic psychotherapy (STPP) for depression in a naturalistic setting utilizing a hybrid effectiveness/efficacy treatment research model. Twenty-one patients were assessed pre- and post-treatment through clinician ratings and patient self-report on scales representing specific DSM-IV depressive, global symptomatology, relational, social, and occupational functioning. Treatment credibility, fidelity, and satisfaction were examined, all of which were found to be high. All areas of functioning assessed exhibited significant and positive changes. These adaptive changes in functioning demonstrated large statistical effects. Likewise, changes in depressive symptoms evaluated at the patient level utilizing clinical significance methodology were found to be high. A significant direct process/outcome link between STPP therapist techniques and changes in depressive symptoms was observed. Alternative treatment interventions within STPP were evaluated in relation to subsequent improvements in depression and were found to be nonsignificant. The present results demonstrate that robust statistical and clinically significant improvement can occur in a naturalistic/hybrid model of outpatient STPP for depression.

INTENSIVE SHORT-TERM DYNAMIC PSYCHOTHERAPY OF TREATMENT-RESISTANT DEPRESSION: A PILOT STUDY Allan Abbass, M.D., F.R.C.P.C. *Depression and Anxiety* 23:449–452, 2006.

This pilot study examined the effectiveness of Intensive Short-term Dynamic Psychotherapy (ISTDP) in treatment-resistant depression (TRD). Ten patients with TRD were provided a course of ISTDP. Clinician and patient symptom and interpersonal measures were completed every 4 weeks, at termination, and in follow-up. Medication, disability, and hospital costs were compared before and after treatment. After an average of 13.6 sessions of therapy, all mean measures reached the normal range, with effect sizes ranging from 0.87 to 3.3. Gains were maintained in follow-up assessments. Treatment costs were offset by cost reductions elsewhere in the system. This open study suggests that ISTDP may be effective with this challenging patient group. A randomized, controlled trial and qualitative research are warranted to evaluate this treatment further and to examine its possible therapeutic elements.

RCT's of STPP for Personality Disorders

TABLE From Evidence-based Psychodynamic Therapy with Personality Disorders
Stanley B. Messer and Allan A. Abbass In Press. J. Magnavita (Ed.). *Evidence-based Treatment of Personality Dysfunction: Principles, Methods and Processes*. Washington, DC: American Psychological Association Press.

Study	PD Diagnosis	SCL-90, BSI, or GSI ES	IIP ES	GAF ES
Winston et al, 1991, 1994	Cluster A, B and C	0.70		
Hardy et al, 1995	Cluster C, Depression	0.58	1.13	
Hellerstein et al, 1998	Cluster B and C	0.31	0.27	
Munroe-Blum et, 1999	Borderline	1.00		
Svarberg et al, 2004	Cluster C	0.94	1.05	
Vinnars et al, 2005	Cluster A, B and C	0.72		0.64
Muran et al, 2005	Cluster C, NOS	-0.17	0.30	0.67
Abbass et al, in press	Cluster A, B and C	1.62	1.27	2.68
Mean ES (SD)		0.80 (0.44)	0.89 (0.57)	1.63 (1.12)

Note many of these patients had PD with comorbid depression, dysthymic disorder or both. Our article (Abbass, in press 2008) is an example and over ½ of patients had depression and nearly ½ had dysthymic disorder (appended).

Abbass A., Sheldon A., Gyra J., Kalpin A. (in press). Intensive Short-term Dynamic Psychotherapy for DSM IV personality disorders: A randomized controlled trial. *Journal of Nervous and Mental Disease*.

Hardy, G. E., Barkham, M., Shapiro, D. A., Stiles, W. B., Rees, A., Reynolds, S. (1995). Impact of Cluster C personality disorders on outcomes of contrasting brief psychotherapies for depression. *Journal of Consulting & Clinical Psychology*, 63, 997-1004.

Hellerstein, D. J., Rosenthal, R. N., Pinsky, H., Samstag, L. W., Muran, J. C. & Winston, A. (1998). A randomized prospective study comparing supportive and dynamic therapies. *Journal of Psychotherapy Practice and Research*, 7, 261-271.

Munroe-Blum, H. & Marziali, E. (1995). A controlled trial of short-term group treatment for borderline personality disorder. *Journal of Personality Disorders*, 9, 190-198.

Muran, J. C., Safran, J. D., Samstag, L. W. & Winston, A. (2005). Evaluating an alliance-focused treatment for personality disorders. *Psychotherapy: Theory, Research, Practice, Training*, 42, 532-545.

Svartberg, M., Stiles, T. C. & Seltzer, M. H. (2004). Randomized, controlled trial of the effectiveness of short-term dynamic psychotherapy and cognitive therapy for Cluster C personality disorders. *American Journal of Psychology*, 161, 810-817.

Vinnars, B., Barber, J. P., Noren, K., Gallop, R. & Weinryb, R. M. (2005). Manualized supportive-expressive psychotherapy versus nonmanualized community-delivered psychodynamic therapy for patients with personality disorders: Bridging efficacy and effectiveness. *American Journal of Psychiatry*, 162, 1933-1940.

Winston, A., Pollack, J., McCullough, L., Flegenheimer, W., Kestenbaum, R., & Trujillo, M. (1991). Brief psychotherapy of personality disorders. *Journal of Nervous and Mental Disease*, 179(4), 188-193.

Winston, A., Laikin, M., Pollack, J., Samstag, L. W., McCullough, L. & Muran, J. C. (February 1994). Short-term psychotherapy of personality disorders. *American Journal of Psychiatry*, 151, 190-194.

Other STPP Studies: Note some are old and did not have well defined or current STPP methods.

1. **Barkham M., Shapiro DA, Hardy GE, Rees A. Psychotherapy in two-plus-one sessions: Outcomes of a randomized controlled trial of cognitive-behavioral and psychodynamic-interpersonal therapy for subsyndromal depression. J Consult Clin Psychol 1999. 67(2): 201-211.**
2. **Gallagher DE, Thompson LW. Treatment of major depressive disorder in older adult outpatients with brief psychotherapies. Psychotherapy: Theory, Research and Practice 1982;19(4): 482-490.**
3. **Thompson LW, Gallagher D, Steinmentz Breckenridge J. Comparative effectiveness of psychotherapies for depressed elders. J Consult Clin Psychol, 1983; 55:385-390.**
4. **Hersen M, Bellack AS, Himmelhoch, JM, Thase, ME. Effects of social skill training, amitriptyline, and psychotherapy in unipolar depressed women. Behavior Therapy, 1984;15: 21-40.**
5. **Reynolds S, Stiles, WB, Barkham, M, Shapiro, DA, Hardy, G, Rees, A. Acceleration of changes in session impact during contrasting time-limited psychotherapies. Journal of Consulting and Clinical Psychology, 1996;64: 577-586.**
6. **Shapiro DA, Rees A, Barkham M, Hardy G, Reynolds S, Startup M. Effects of treatment duration and severity of depression on the maintenance of gains after cognitive-behavioral and psychodynamic-interpersonal psychotherapy. J Consult Clin Psychol 1995; 63(3): 378-387.**
7. **Shapiro DA, Firth J. Prescriptive v. explorative psychotherapy: Outcomes of the Sheffield Psychotherapy Project. Brit J Psychiatry 1987;151: 790-799.**