UCL

The Tavistock and Portman NHS
NHS Foundation Trust

Long-Term Psychoanalytic Psychotherapy for Treatment-Resistant Depression

Primary and Secondary findings from the Tavistock Adult Depression Study

Felicitas Rost, PhD

Helen (45) - TADS patient

“Well, depression…which is the feeling of worthlessness, helplessness, inability to make decisions to get on with your life, a desire not to get on with your life, in fact a desire to end one’s life… a feeling that there is no point in anything, and that you have no value in society or any place in it, and the world would be a lot better off without you.”

Treatment Resistant/Refractory Depression

- 12% of depressed patients experience long-term, relapsing and complex forms (Andrade, 2003).
- Significant impact on work functioning, interpersonal relationships and quality of life (Greden, 2001)
- Comorbidity is the rule (Kessler, 2005)
- The “heart-sink” patients can have a particular negative effect on service providers and individual caregivers (Thase, 1992; McPherson & Armstrong, 2009)
- These patients are at a severe disadvantage in terms of research guiding their clinical management.

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The Tavistock Adult Depression Study (TADS)

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*The Study started in 2001 with Phil Richardson as PI. Peter Fonagy took over after his death in 2007. **Many honorary researchers and assistant psychologist have worked on TADS over the years to which we are extremely grateful.**

TADS Trial

Design	**Pragmatic RCT**
Index Problem	**Clinical Representative Sample in Primary Care** **Treatment refractory Depression - TRD**
Treatment	**18 months of once-weekly psychoanalytic psychotherapy for depression**
Therapists	**Senior Clinicians from the Tavistock Clinic Adult Department**
Control	**Treatment as Usual (UK GP care)**
Sample	**129**
Follow-up	**2 years**

Outcome Measures

- **Depression symptomatology and severity:**
- Hamilton Rating Scale for Depression (HRSD)
- Becks Depression Inventory (BDI-II)

- **Psychiatric Diagnosis:**
- Structured Clinical Interview for DSM-IV (SCID-I)

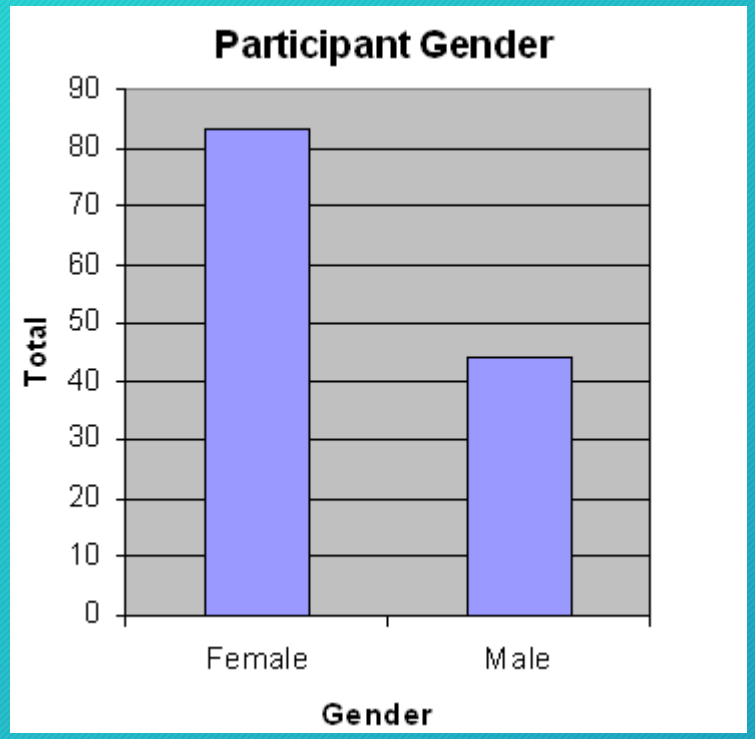
- **Personality Disorder assessment:**
- Shedler-Westen Assessment Procedure Q-sort (SWAP)

- **Quality of life and functioning:**
  - Clinical Outcomes in Routine Evaluation (CORE)
  - Quality of Life Enjoyment and Satisfaction Questionnaire (Q-les-Q)
  - Global Assessment of Functioning (GAF)
- **Object Relations:**
  - Persons Relating to Others Questionnaire (PROQ-2a)
  - Object Relations Interview (ORI)

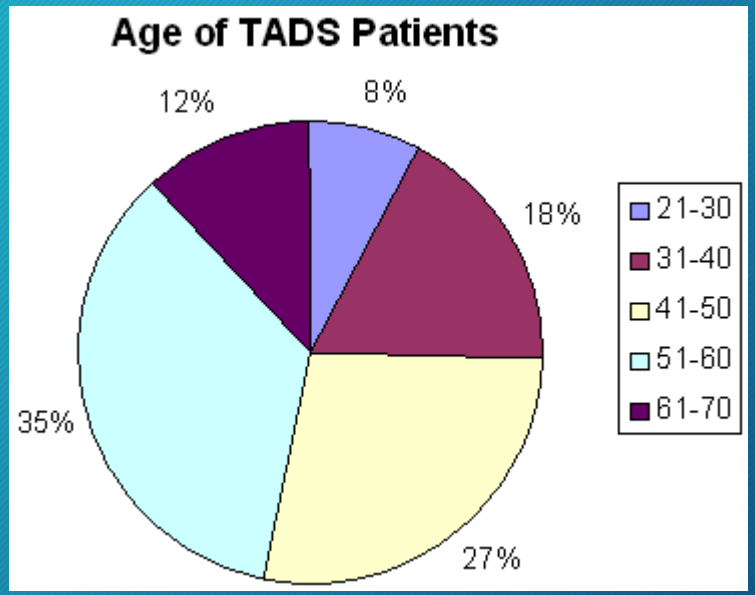
- **Health Economic Evaluation:**
  - Client Service Receipt Inventory (CSRI)
  - GP medical records (1 year pre and 2 years post treatment)

Patient Group at Baseline

Demographics: Gender & Age

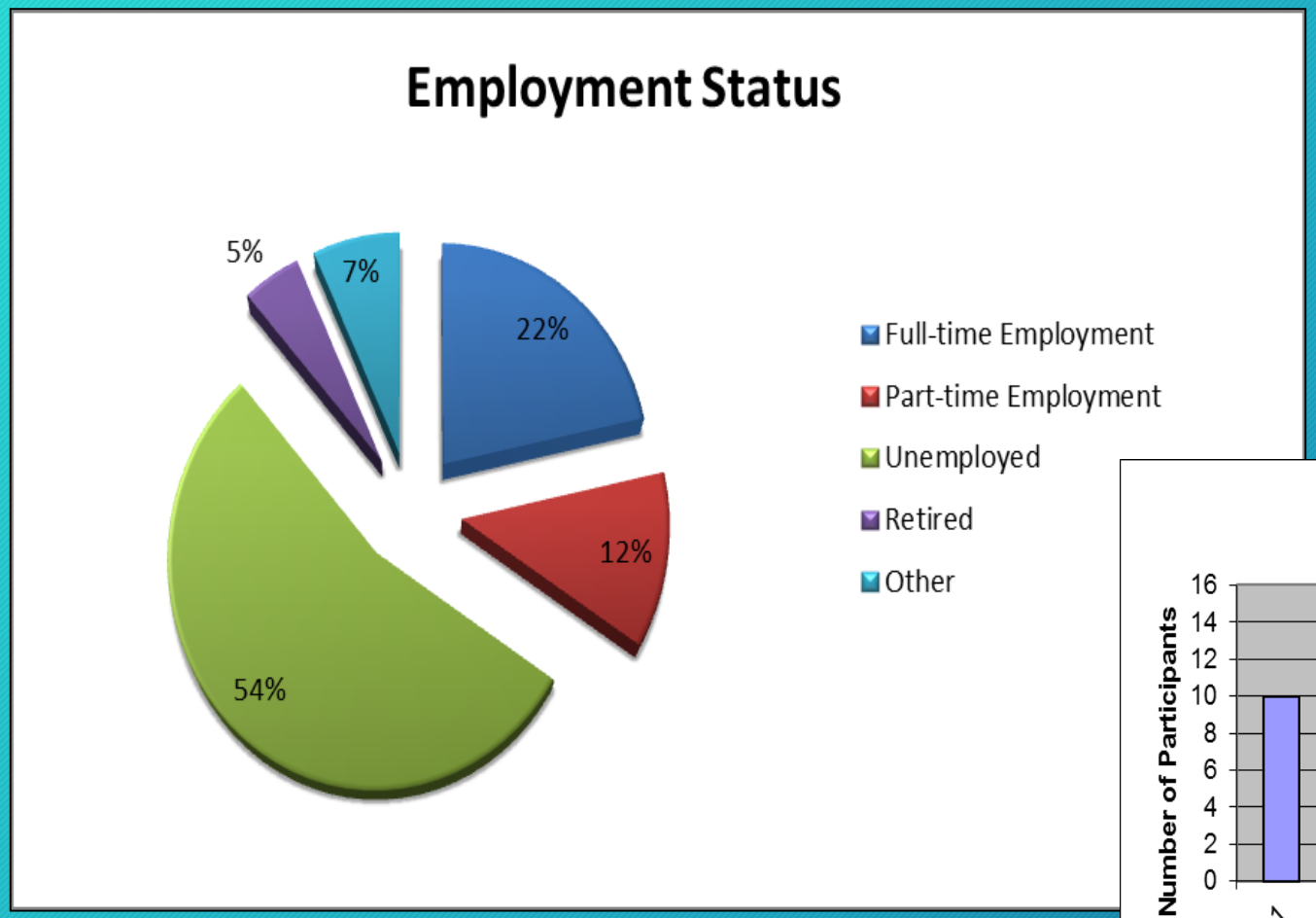


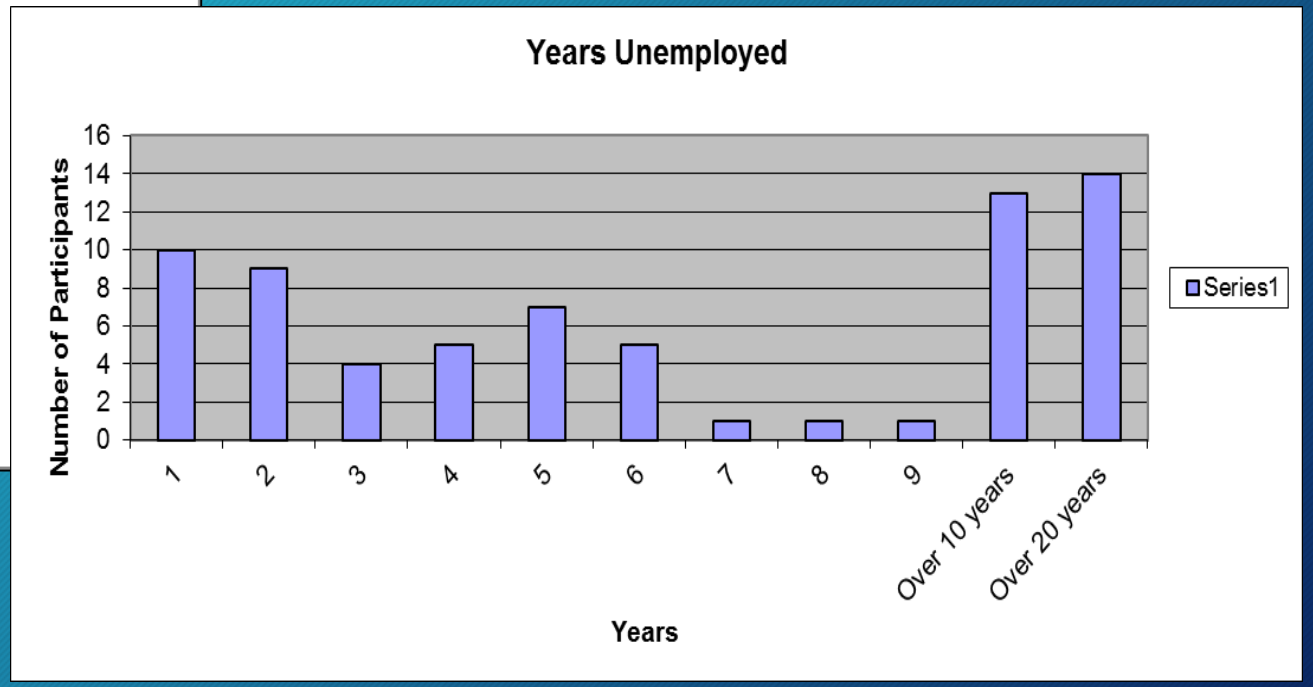
- 65% 35%



- Range 23-69 years
- Average age = 48

Employment Status





Relationships

55% Single

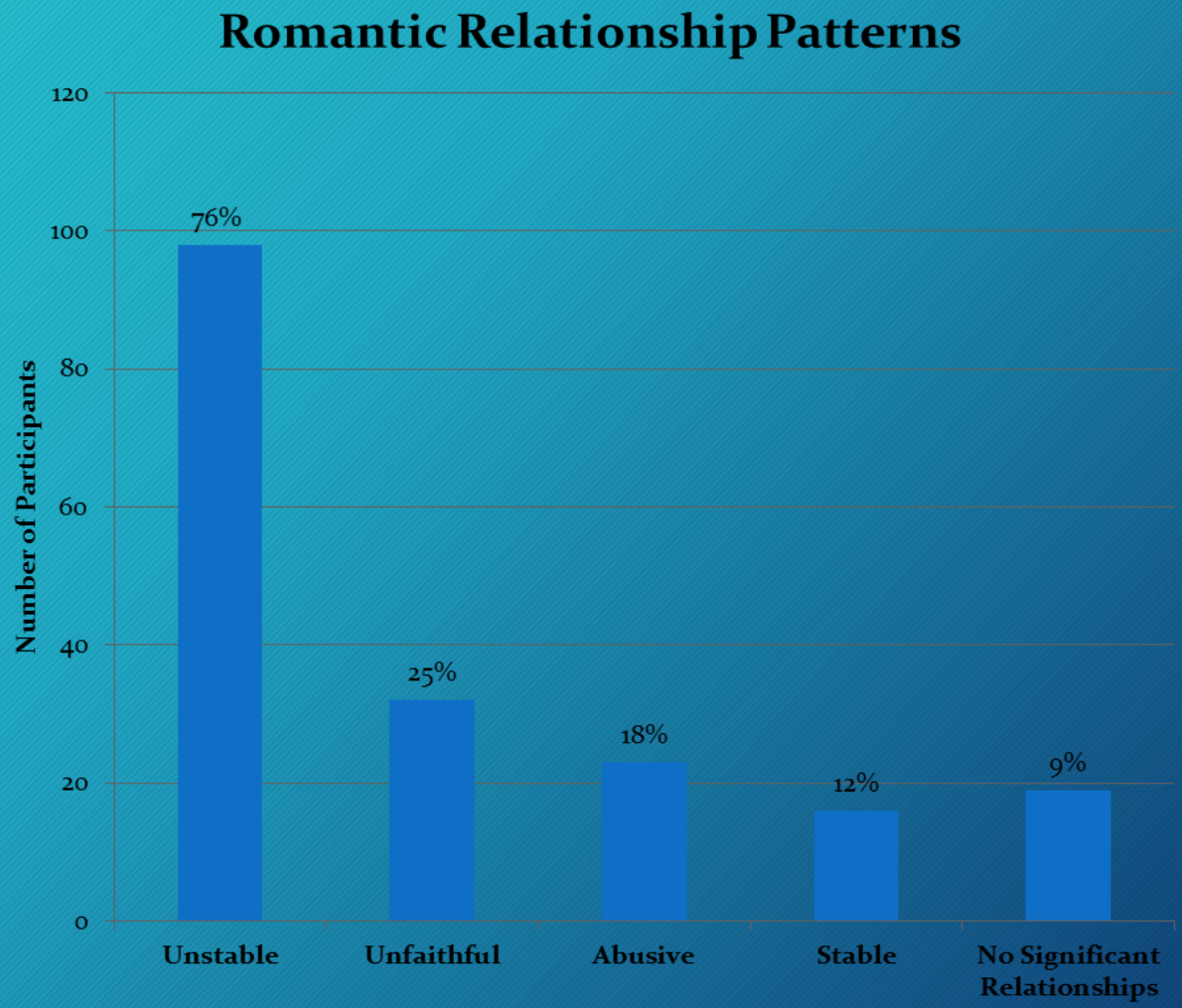
24% Divorced/Separated

12% Married

47% live alone

19% live with their partner

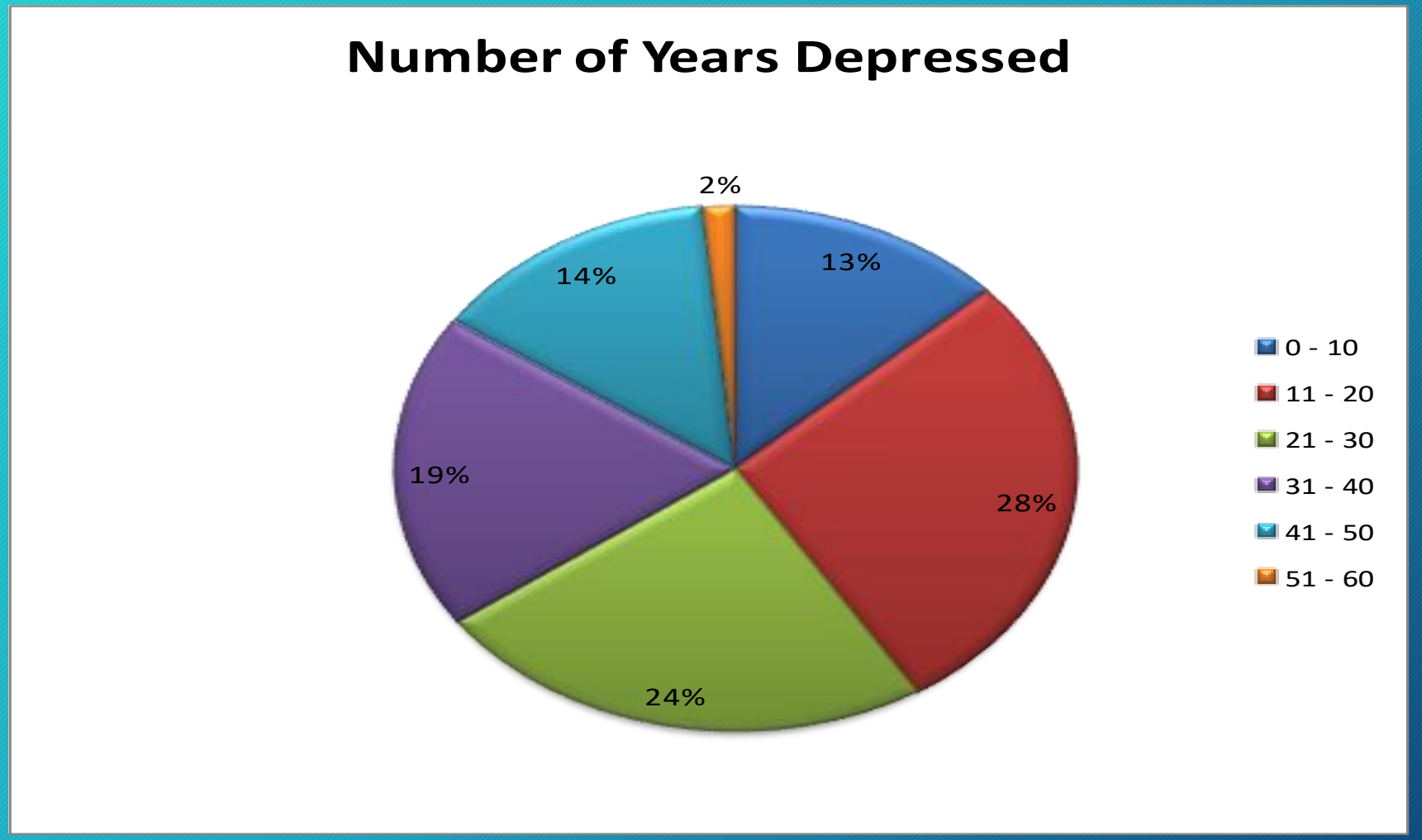
13% live with their children (no partner)



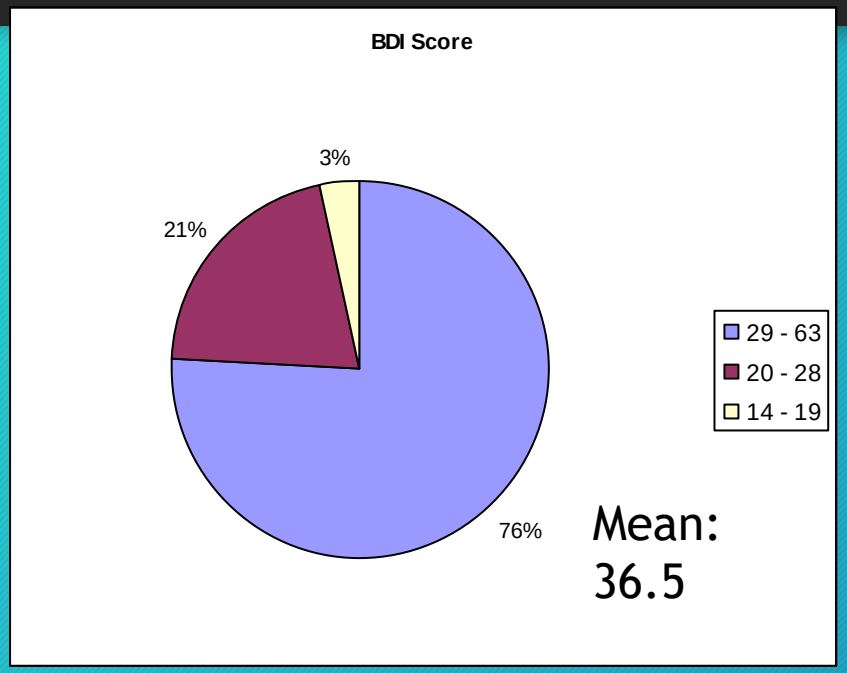
Comorbidity

- Is extremely high in this group.
- Only 9% have a single diagnosis of MDD, most frequent comorbid Axis I disorder is an anxiety disorder (GAD, panic disorder, social phobia).
- Considerable amount of physical health problems.
- 84% has at least 1 Personality Disorder.

Depression Onset and Numbers of Years Depressed



Severity at Baseline

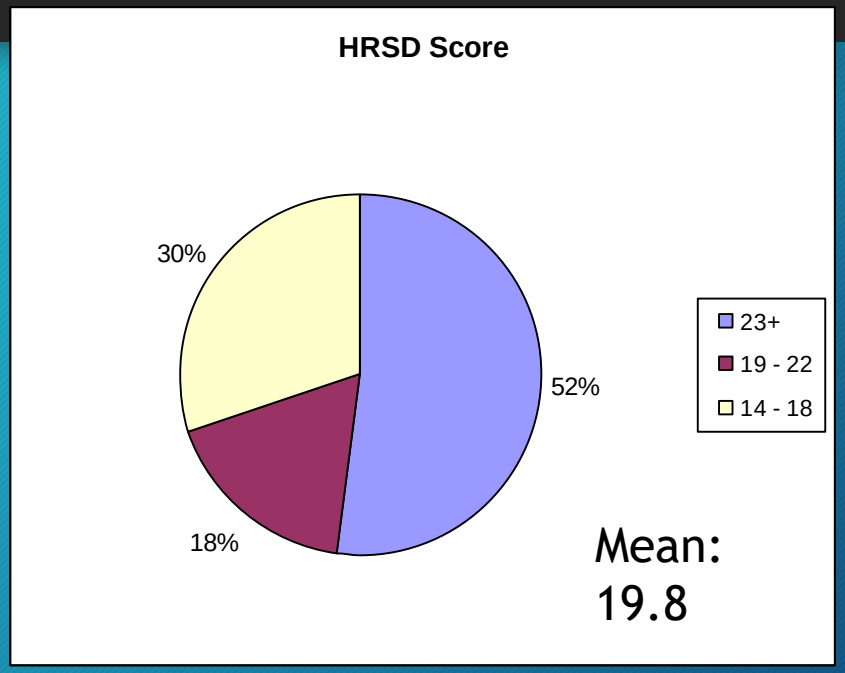


Beck Depression Inventory

76% scored 29 - 63 (severe symptoms)

21% scored 20 - 28 (moderate symptoms)

3% scored 14 – 19 (mild symptoms)



Hamilton Rating Scale for Depression

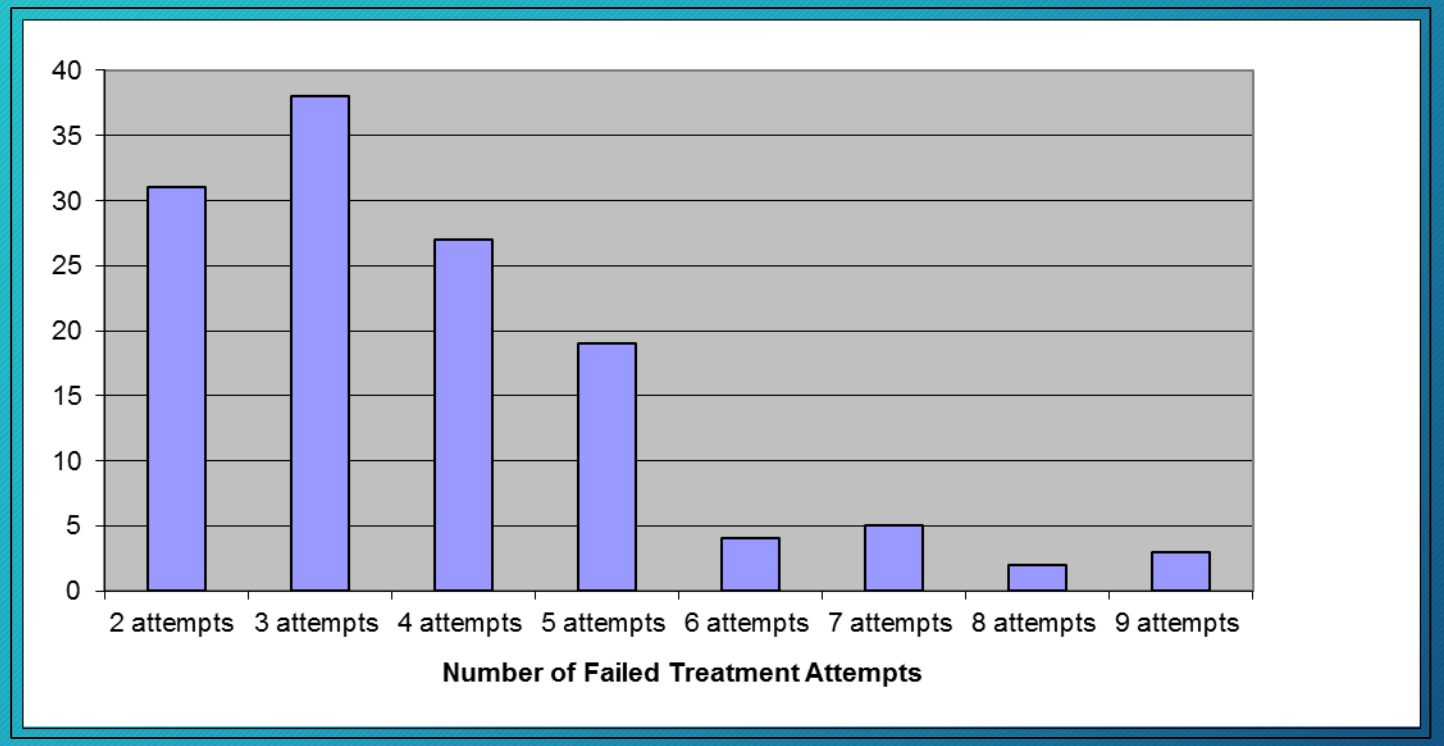
52% scored 23+ (very severe)

18% scored 19 – 22 (severe)

30% scored 14 – 18 (moderate)

Failed Treatment Attempts

- Including ADM, counselling, psychotherapies, CBT, CMHT's, crisis teams and hospital admissions.



Treatment Conditions

TAU

- Managed in Primary Care by the referring clinician (the GP)
- Following the NICE guidelines (2009) for the treatment of depression in adults

LTTP

- 60 once-weekly sessions (50 minutes-long)
- 18-month duration
- Experienced clinicians accredited by the British Psychoanalytic Council.
- All sessions were audio-recorded

Basic Principles of Therapeutic Method

- Psychoanalytic using a model naturally grown at the Tavistock Clinic with particular emphasis on theories of depression (e.g. Freud, Klein, Bion, Balint, Rosenfeld, Joseph, Britton, Steiner).
- The ability to mourn is necessary for normative functioning & development.
- It has adaptive & developmental functions – personal growth
- Patients with TRD have been unable to mourn key areas of their lives and relationships to their objects

Basic Principles continued

- At a specific point in their life-history these patients have usually experienced an acute depressive breakdown
- In order to achieve a compromise they “consented to be robbed so as not to be murdered” as D. Taylor has termed it borrowing the phrase from Proust.
- It is possible to produce dynamic changes with 60 sessions of weekly therapy in some patients with TRD
- Thus, whilst symptom change is deemed important it is seen as arising out of the deeper, internal personality changes

Treatment Manual & Its approach

- Manual: Taylor (2015), The International Journal of Psychoanalysis, 96: 845-875

- Permissive not prescriptive: authorises the analyst to work as he/she decides
- No imposition of focus: not instrumental; follows the patient & the problematic of a point of contact

- Clinical supervision groups every fortnight

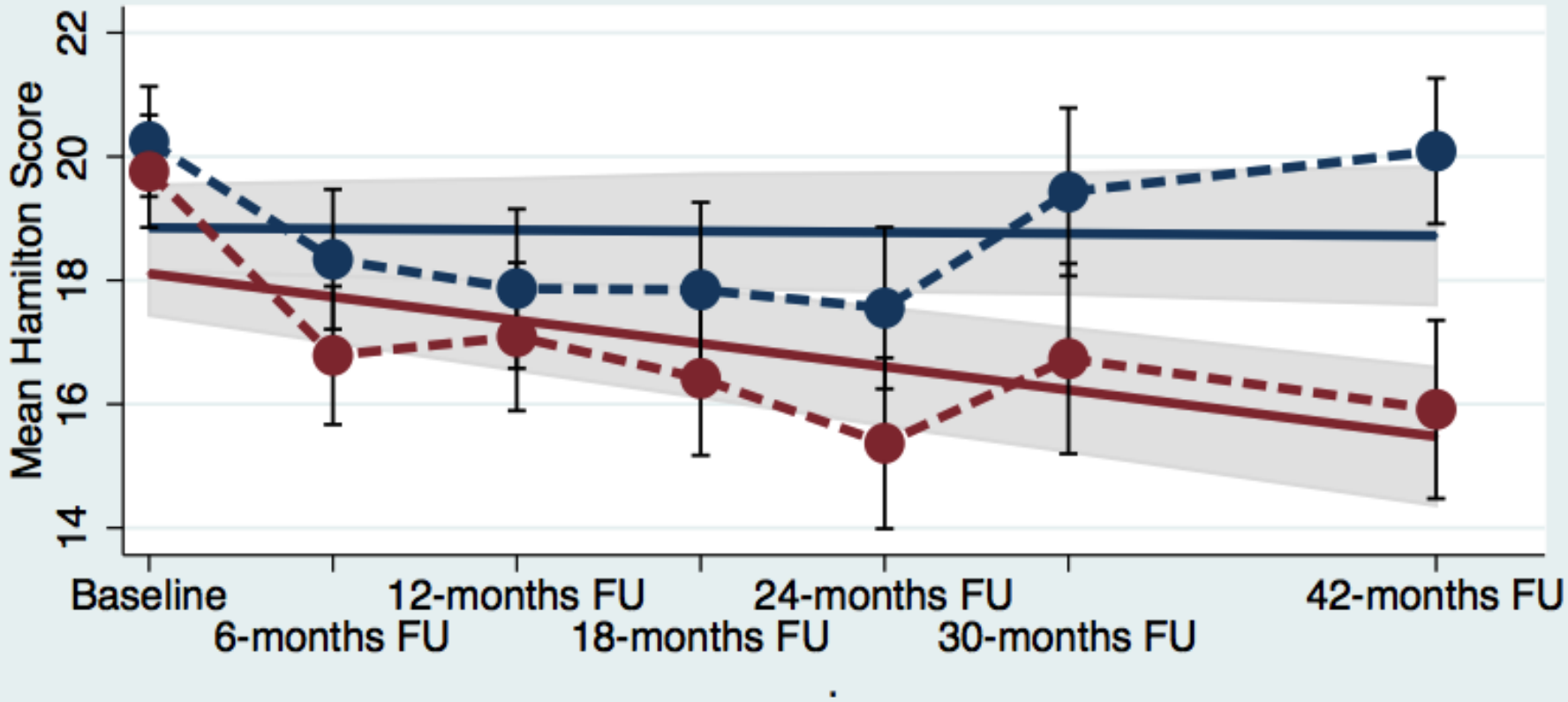
Primary Outcome Findings

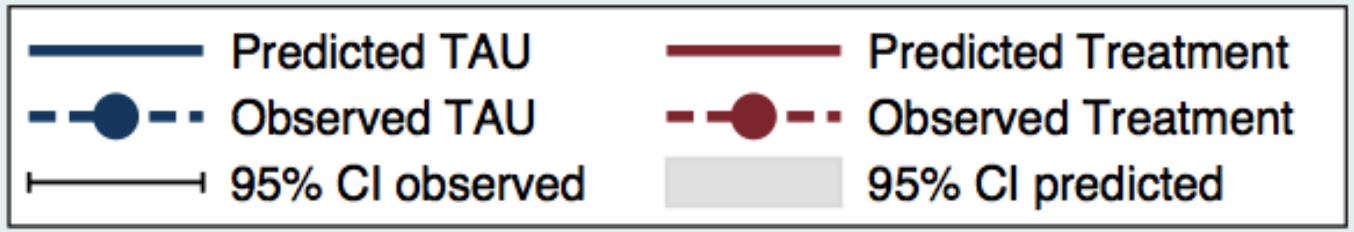
Statistical Analysis

- Intention-to-treat
- Mixed-effects (multilevel) models were used to compare the trajectory of depression between the two groups over time

Tavistock Adult Depression Study

Observed and Predicted Means for Hamilton_Depression_Score



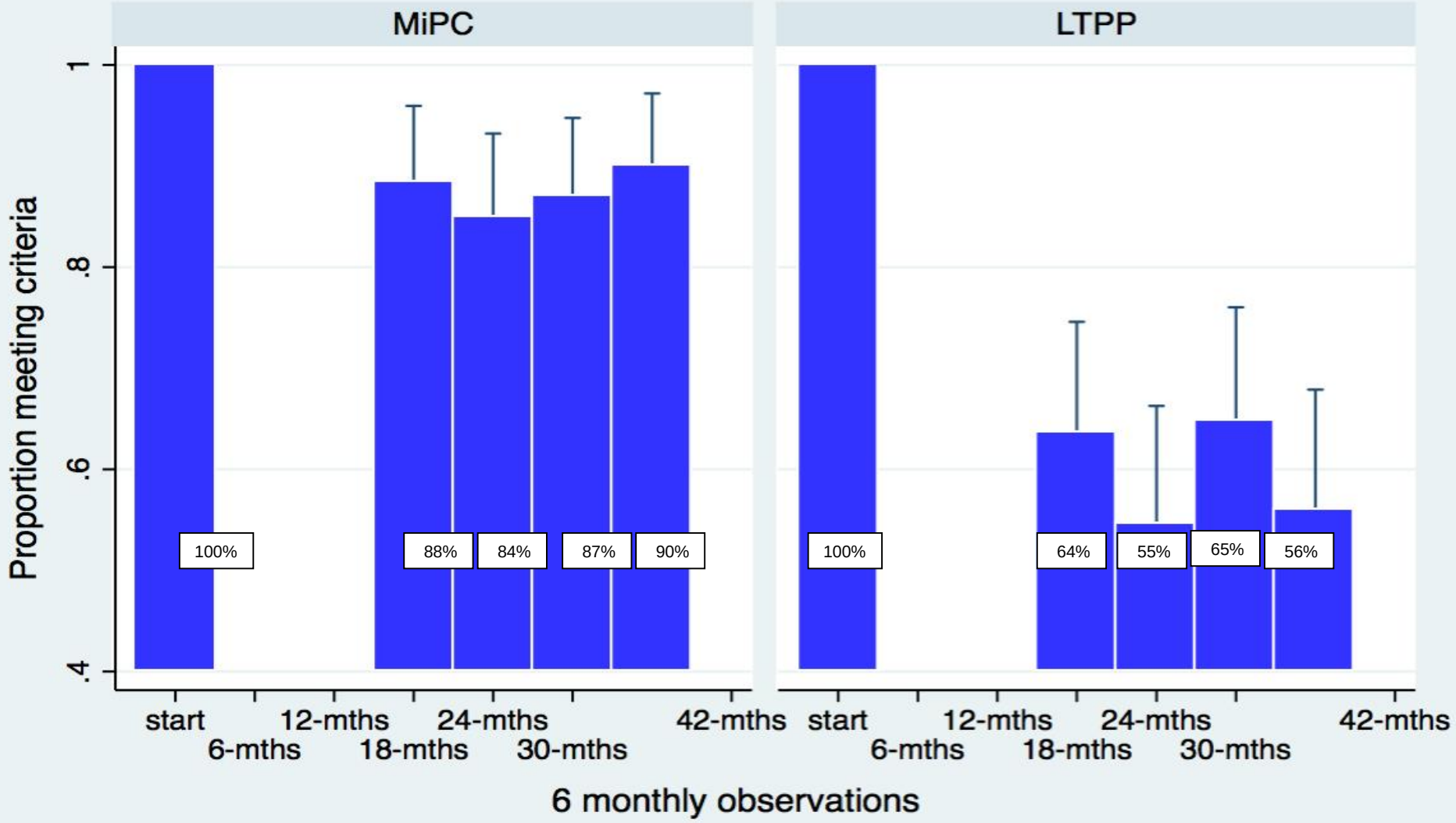


Adjusted for Demographic Factors (Employment, Benefits and Education): Random Slope

Partial recovery rates on HSDR-17 (HDRS ≤12)

	LTPP	MiPC/TAU	x2	p	RR	95% CI	NNT	Model Δ	95% CI	p
18 months	32%	24%	0.8	0.37	1.3	0.6-2.5	12	1	0.38-2.2	0.34
24 months	39%	19%	4.5	0.03	2.02	1.0-4.0	5.1	1.1	1.08-2.1	0.04
30 months	35%	12%	6.9	0.008	2.8	1.2-6.6	4.5	1.5	1.32-2.5	0.012
42 months	30%	4%	10.3	0.001	6.7	1.6-28.4	3.9	2.1	1.64-3.6	0.005

Proportion with SCID Diagnosis of MDD



Mixed effects logistic regression (random slope) OR=0.75, 95% CI: 0.45,1.0, p<0.06

Implications

- Significant **difference** between the conditions only fully emerged **2 years after treatment ended** (sleeper effect):

  also see similar pattern in a Finnish Longitudinal Study (Knekt, Lindfors & Harkanen, 2008) and Munich study (Huber et al.)

- End of treatment evaluations or too brief a follow-up might obscure underlying benefits of psychoanalytic treatments

- Given the chronicity and severity of TRD, expecting full recovery is unrealistic

In the words of the TADS patients:

"I saw obviously for me that I achieved what I wanted to achieve. I would say in the physical, maybe not completely in the emotional. But I am in a much better place than when I first started, and that's what…that's, that's I mean what you can hope for at the end of the day." (210-216)

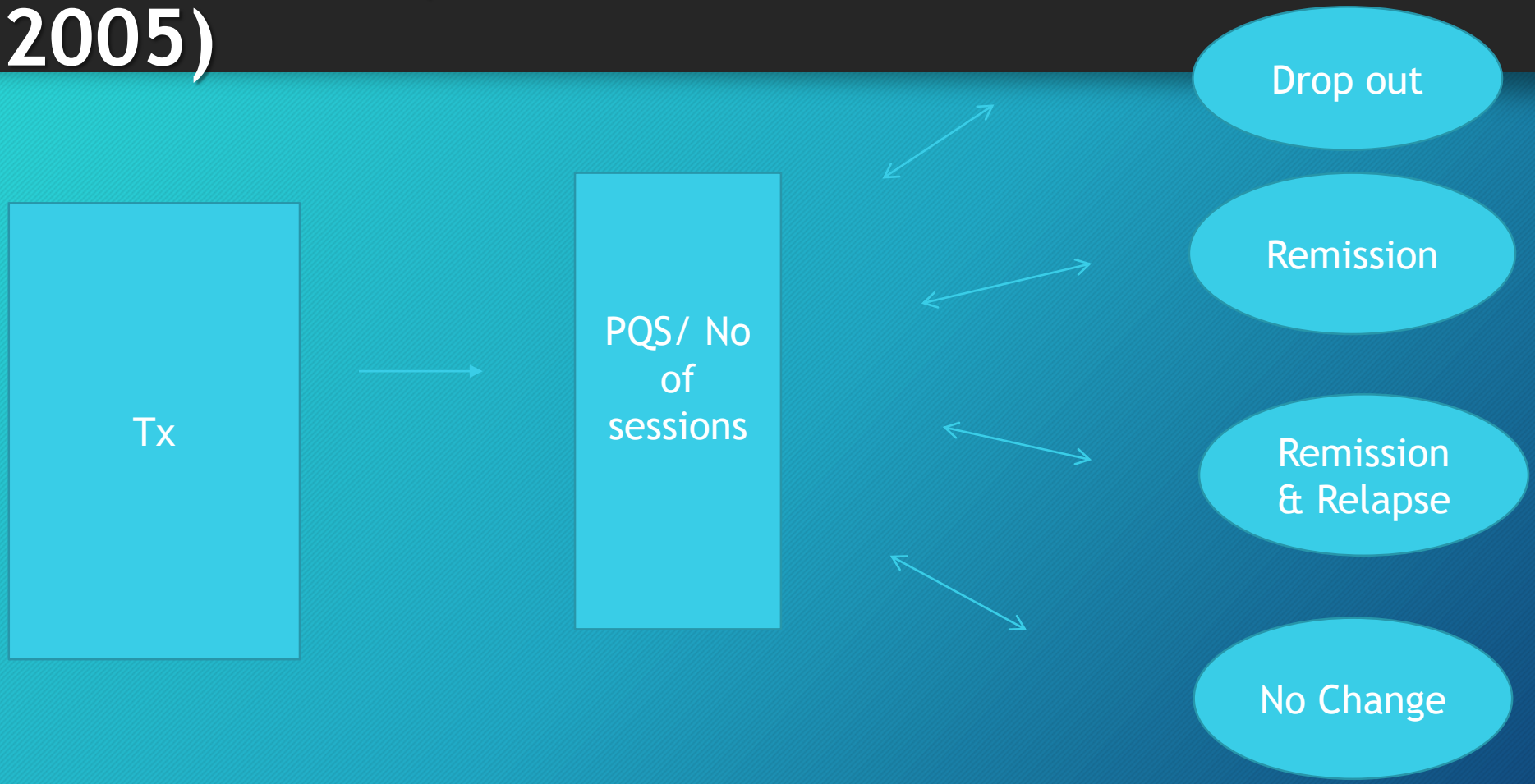
"I can tell a difference: I'm still sad sometimes and I cry sometimes and think I'm still depressed sometimes. But I haven't got that, I haven't got like a fuzzy head, the blackness around me, you know, …I can work things out generally, whereas I couldn't handle it at all, it was all just massive, everything seemed too difficult before ." (149-152)

Secondary Outcome Findings

Who Benefited How

	LTTP	TAU
Partial Remission (HRSD < 12)	18 (33%)	4 (9%)
PT Remission & Relapse	9 (14%)	11 (18%)
No Change	19 (29%)	38 (61%)
Drop Out	10 (15%)	6 (10%)

Therapeutic Technique as Moderator (PQS, Ablon & Jones, 2005)



Studying Therapeutic Change

- Major obstacle has been the assumption of a homogeneity among patients – they are more alike than different because they meet diagnostic criteria for MDD
- This “myth” needs to be abandoned (Beutler, 1976, Cronbach, 1965, Blatt & Felsen, 1993)
- Important differences need to be incorporated into research designs
- Important is to avoid creating and entering a ‘hall of mirrors’ given the complexity of all potential interactions (Cronbach, 1965, Blatt et al., 2010)

Sidney Blatt's Two-Configurations Model

Forming and maintaining satisfying inter-relationships (relatedness)

- **Anaclitic Depression**
- Issues with dependency and need-gratification.
- Feelings of emptiness, helplessness, loneliness.
- Intense fear of being abandoned and left unprotected
- Belief of being "unlovable"

Developing a stable, realistic and positive sense of self (self-definition)

- **Introjective Depression**
- Feelings of severe worthlessness, guilt, failure, self-blame, self-criticalness.
- Strive for great achievement and perfectionism but intense fear of losing other's approval and love

The Anaclitic – Introjective Depression Assessment (AIDA) Q-sort

Rost, Luyten & Fonagy, 2017

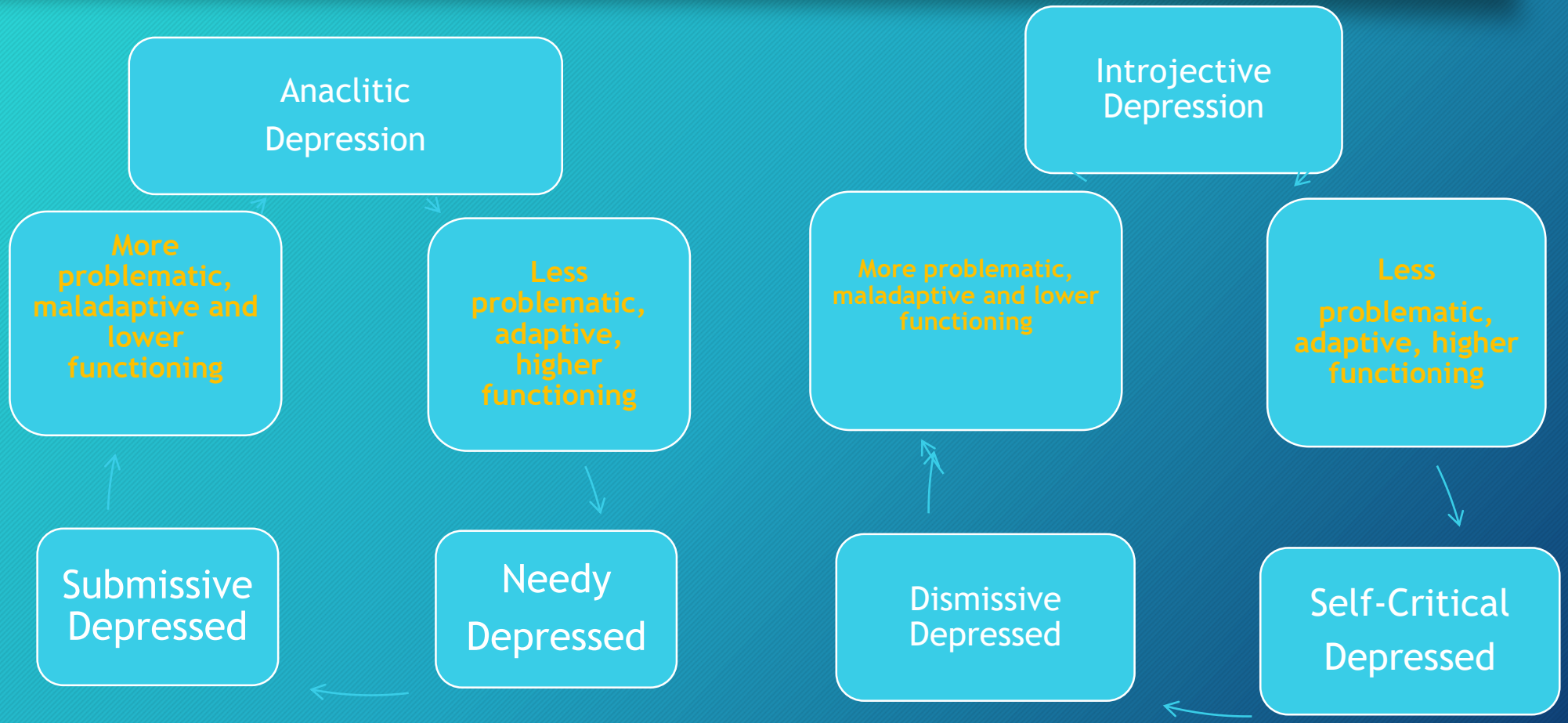
- 59 Items Q-sort measure
- 5-point rating scale
- Fixed asymptotic distribution

- Developed using the SWAP-II (Shedler & Westen, 2007) item pool and Expert Consensus Rating

Not at all Prototypical 1 (20)	Slightly Prototypical 2 (14)	Somewhat Prototypical 3 (11)	Next Most Prototypical 4 (8)	Most Prototypical 5 (6)
1	7	5	2	4
3	8	9	13	17
6	10	12	21	22
11	15	14	24	29
16	19	25	32	41
18	20	27	36	43
23	31	42	44	
26	33	46	54	
28	39	48		
30	47	51		
35	55	57		
37	59			
38	60			
40	61			
49				
50				
52				
53				

- Example items:
- Tends to feel guilty
- Tends to feel he/she is inadequate, inferior, or a failure
- Is prone to painful feelings of emptiness
- Has a pervasive sense that someone or something necessary for happiness has been lost forever

AIDA – Clusters of Depressed Patients (Rost et al, 2017)



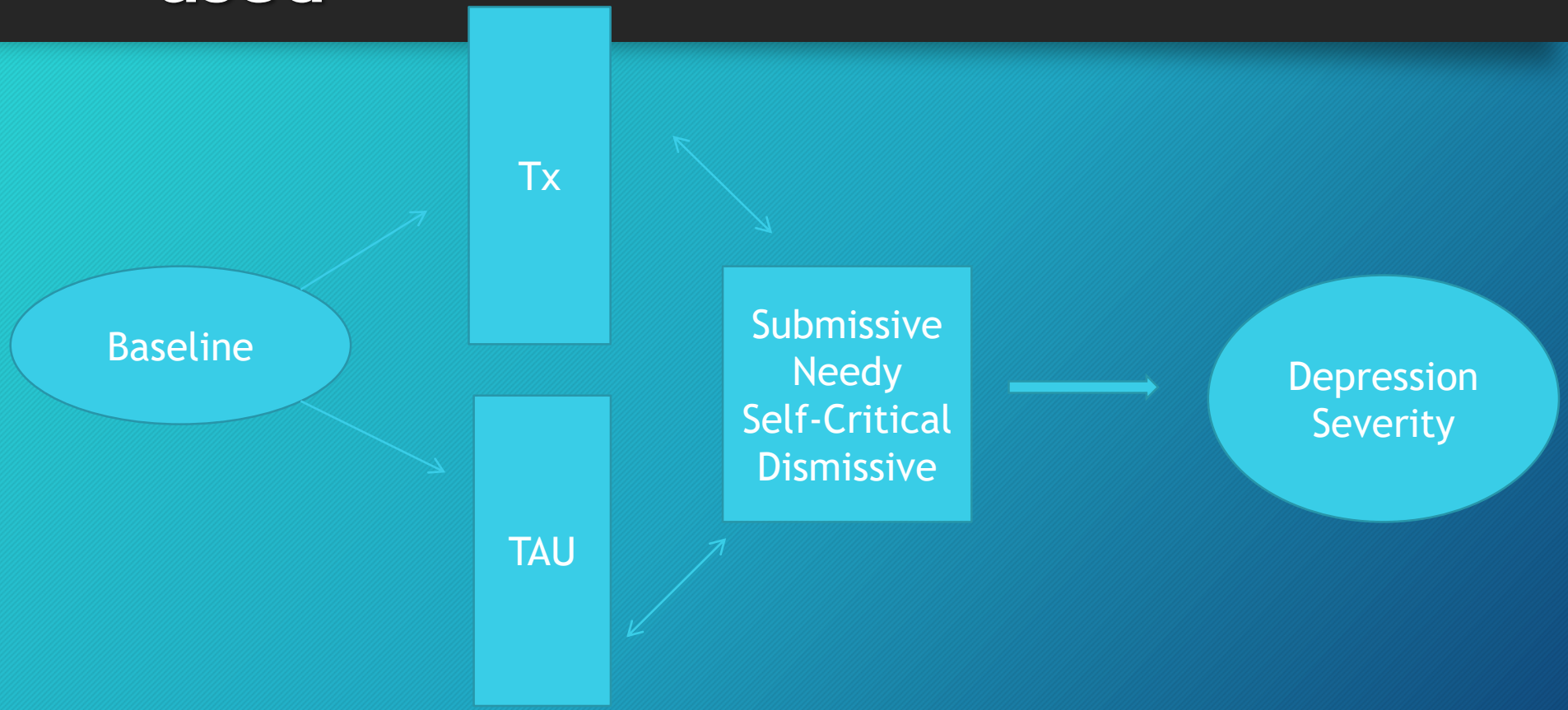
Two-Configurations and Treatment Response in the Literature

Anaclitic patients benefited more from structured supportive/directive Treatment

Introjective patients were found to benefit more from long-term, insight-oriented psychoanalytic Treatment

(e.g. Blatt, 1992; Blatt et al, 1995; Batt & Ford, 1994, 2004; Blatt & Shahar, 2004; Zuroff et al., 1988; Vermote et al, 2009, 2011. Werbart & Forststroem, 2014; Werbart & Levander, 2015)

AIDA Depression Clusters Moderating Outcome - The Model used



MLM = Yij = β_0+ β1 tij (TIME)+β(2-5) tij (AIDA group)+β6 tij (Treatment Conditon)+ μ_0j+ μ_1j tj +εij

Findings – please bare with me!

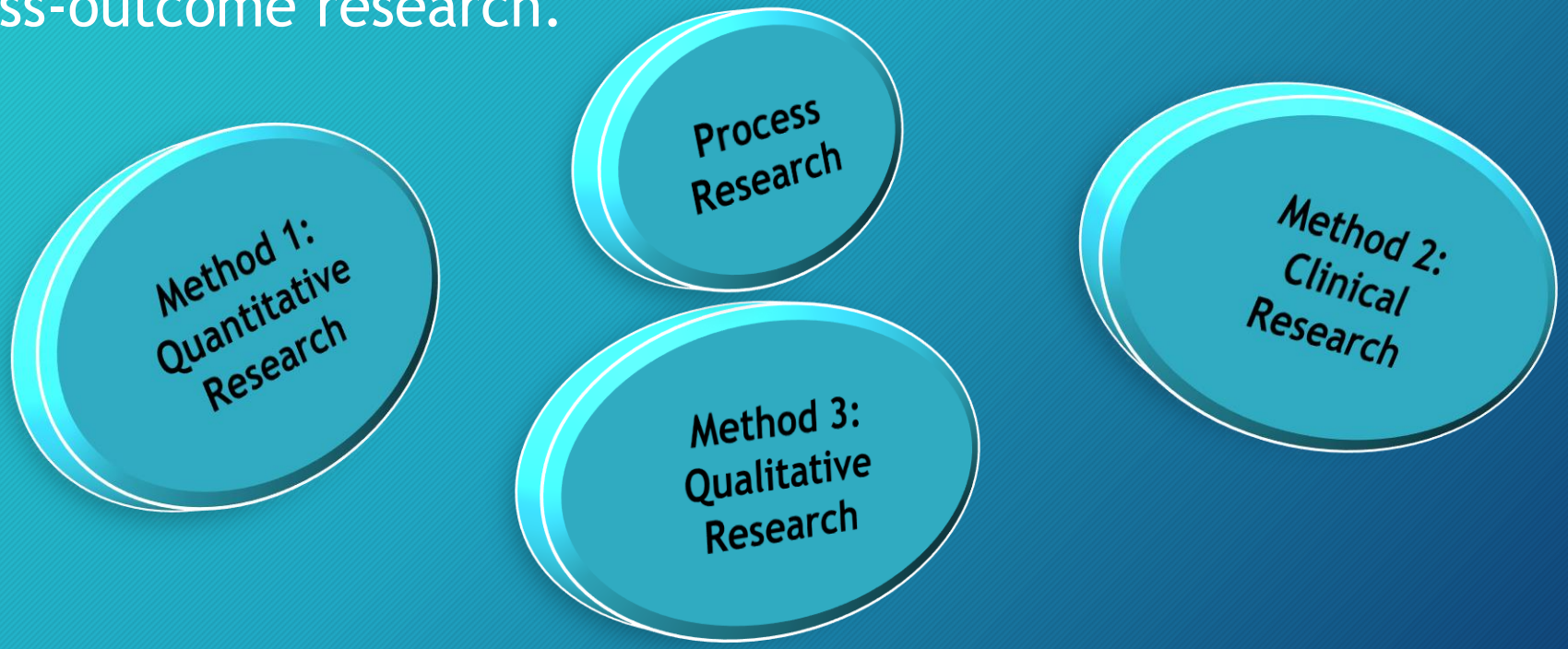
- Important differential treatment responses between the four groups were found.
- As the results have been submitted for publication, I regret that they can not be handed out at this stage.
- Please contact me at a later stage and I can direct you to the publication once it has been accepted.
- (Felicitas Rost 18.11.17)

Conclusion

- Using Q-methodology allowed the assessment of important sub-dimensions of treatment-resistant depression not preciously empirically identified.
- Further analysis of the TADS results yield important differential treatment effects and suggest that responsiveness to treatment might result as a function of these pre-treatment personality characteristics.
- If these results are replicated, they have important clinical implications for future conceptualization and treatment of depression.
- They raise the question of adapting therapeutic techniques in accordance to the patients particular needs, which in turn might lead to better outcome (e.g. Clarkin & Levy, 2004; Werbart and Levander, 2015).

Conclusion

- TADS is an important and unique trial in that it addresses a gap through a “trial-logue” between robust outcome research, clinical case studies, formal qualitative research methodology, and process-outcome research.



Thank YOU very much for your attention!

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