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The efficacy of Brief Object Relations Psychotherapy on major depressive disorder comorbid with cluster C personality disorders: a single subject study

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Abstract

Background: Personality disorders have essential roles in developing and maintaining depressive episodes, though psychotherapies must approach both symptoms and personality problems. This study examined the efficacy of Brief Object Relations Psychotherapy on depression severity and perceived quality of life of women suffer from major depressive disorder comorbid with cluster C personality disorders.

Methods: by purposive sampling method, 6 subjects which met the in/exclusion criteria, were participated in a single subject design study randomly. Interventions were arranged based on A/B with follow up design. Each subject completed Beck Depression Inventory (BDI-II) and original McGill Quality of Life Questionnaire (MQOL) every session during 3 baseline, 15 treatment and 3 follow up assessments sessions.

Results: Patients totally reached 55% remission in depression severity with mean effect size 1.92 and 43% remission in perceived quality of life with mean effect size 2.08. Gains were maintained in follow up.

Conclusion: The efficacy of Brief Object Relations Psychotherapy was statistically and clinically significant. Perceived quality of life reached to normal range, whereas cluster C personality disorders resistance remission from depression.

Keywords: object relations, depression, quality of life

Introduction

Over the years, increasing attention has been devoted to investigating the comorbidity between major depressive disorder (MDD), personality disorders (PDs) [1]. It is estimated that 50% to 85% of outpatients with a current MDD have an associated PDs [2]. Much of the works regarding this relation has come in the form of studies considering the role of PDs as vulnerabilities to depression or their impact on the course and treatment outcome of MDD [3]. In addition, comorbidity of MDD and PDs has been associated with poorer response to treatment in most but not all studies, and with higher risk of depressive recurrence [2]. Moreover, compared with MDD subjects without PD, those with comorbid PD reported significantly greater impairments in social and

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emotional functioning and lower well-being; higher levels of residual symptoms [4]; slower recovery; higher levels of psychotropic utilization at a 1-year follow-up; more frequent referral to psychiatric services and general low satisfaction of perceived quality of life [5].

Three PD clusters based on the Diagnostic and Statistical Manual (DSM) of mental disorders; (American Psychiatric Association 1987, 2000); may be differentially related to the course and outcome of depression [6]. It is assumed that PDs within each of the three clusters are more similar to one another than to PDs from other clusters [7]. More recent research has shown that while cluster B personality disorders (BPDs) predict severity and duration of depression, cluster C personality disorders (CPDs) predict depression chronicity [3]. The CPDs including avoidant, dependent, obsessive-compulsive and passive aggressive personality disorders with anxious features; are the most prevalent PDs in the general population (10.2%) and in outpatient populations (more than one of two patients) [8]. Moreover, in outpatient samples with MDD, CPDs are the most occurring PDs [9]. The few available studies indicate that MDD comorbid with CPDs show a poorer recovery from depression than patients with pure depression. [3]. For example, in a recent study, only 18% of those with MDD alone but 47% of those with CPDs comorbid with MDD, met the criteria for MDD at the end of the 24- month follow-up. Though, any effective psychotherapy of depression requires attention to personality problems producing and maintaining depressive symptoms and episodes [10].

Since the second half of the 20th century, different types of Short-Term Psychodynamic Psychotherapy (STPP) have been developed by Malan (1963), Mann (1973), Sifneos (1979), Davanloo (1980), Strupp and Binder (1984), Pollack and Horner (1985), de Jonghe (1994) and Stadter (1996) [11]. They share the common feature of being rooted in psychoanalytic theories such as drive psychology, ego psychology, object relations psychology, attachment theory and self psychology. These psychoanalytic perspectives consider the underlying personality structure to play an important role in the development and maintenance of symptom disorders such as depression. Hence, the STPP focuses on interpersonal relationships and unconscious feelings, desires, strivings and thoughts in order to understand the background, etiology and persistence of symptoms and treating symptom disorders [12].

The term "object" refers to both a real person in the external world and to the internal image of that person and may reflect either present interpersonal relationships, or images stemming from experiences in the past [13]. Brief Object Relations Psychotherapy developed to treat patients with depression and PDs through a relation- focused process. The therapist tries to understand a link between patient's symptoms and dynamics through the repetitive experiences and conflicts are being replayed by the patient in the relationship with the therapist in transference. This treatment helps the patient to overcome depression in regulating interpersonal problems and negative affects stemming from PDs and finally induces perceived well- being and quality of life because of insights accomplished [14]. In a randomized controlled trial STPPs produced superior antidepressant effects to a more cognitive form of psychotherapy in symptomatic patients with PDs. Recent meta- analyses found Brief Dynamic Psychotherapy methods including Object Relations effective in treating general psychiatric symptoms and in adding significant benefits to medication alone in MDD [15].

According to the 2001 World Health Organization (WHO) report, depression is the most common disease suffered by women when compared with other diseases. In the WHO's global burden of disease indices, the point prevalence of MDD is 1.9% for men and 3.2% for women; 5% of men and 9.5% of women experience a depressive episode in a 12-month period [16].

Also results indicate that a series of personality variables cause women to be more

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vulnerable to depression than men, thus the sample of this research were women [17]. This single subject study is the first to examine the efficacy of Brief Object Relations Psychotherapy on reduction of depression severity and induction of perceived quality of life for women who suffered from MDD in spite of morbid CPDs.

Methods

Current study was an experimental single subject design. Interventions were arranged based on A/B with follow up design which A was baseline and B an intervention with follow up assessment of measures. Single subject designs are developed to fill the gap between researches and practice in clinical psychology, permitting clinicians to examine the efficacy of psychotherapies in small samples in a cost benefit, more sensitive and experimental way. For appropriate efficacy, therapeutic change must be visible in at least three subjects [18].

Instruments

Patient's self-report measures including the original McGill quality of life Questionnaire (MQOL, Cohen et al. 1996) [19] and Beck Depression Inventory (BDI- II, Beck, Steer, & Garbin, 1988) [20] were completed every session. The MQOL consists of 16 items and a global Quality of Life (QOL) question, with numerical rating scale from 0 to 10 with anchor ends. Five domains of MQOL are physical symptoms, physical well-being, psychological well-being, existential well-being and support issues. Total score was derived from the sum of all five domains with clinical significance of MQOL> 80. The original Questionnaire has good psychometric properties. In Iran, the obtained reliability coefficients were also consistently high, ranging between 0.60 to 0.88 [21]. The BDI-II is a widely used 21-item questionnaire measure of the severity of affective, cognitive, behavioral, and somatic symptoms of depression; scores range from 0 to 63. Internal consistency, validity, and test–retest reliability are high in psychiatric and non-psychiatric samples. In Iran Cronbach's alpha and test- retest reliability over two weeks were reported 0.78 and 0.73 respectively. Clinical significance was BDI<9 suggesting no depression [22].

Structured Clinical Interview for DSM, SCID (First, Spitzer, Gibbon, & Williams, 1996) was a flexible interview for diagnosis and screening mental and personality disorders [23]. In Persian translation total kappa coefficient achieved was 0.6 [24]. Applied manual as presented briefly in Table 1, is adopted from the book "Object Relations Brief Therapy: the therapeutic relationship in short- term work" [11]. This manual is also applied in other published researches [25]. Six selection questions checklist for brief psychodynamic psychotherapies (Stadter, 1996, 2009) contains six pragmatic selection criteria for brief psychodynamic psychotherapies. If the answers for these questions in initial intake interview by experienced psychodynamic psychotherapist were yes, the patient would be accepted for brief psychodynamic psychotherapies [11].

Table 1. Treatment process

The beginning phase (2-4 sessions)	Developing the working alliance agreed upon case formulation Setting a focus Linking symptoms to underlying conflicts
The middle phase I (4sessions)	Maintaining the focus Transference and counter transference interpretations
The middle Phase II (4 sessions)	Working through conflicts Anticipating termination
The termination phase (4 sessions)	Consolidating the gains Working through loss and ending issues Internalization of therapist and process

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Subjects

All females suffered from MDD comorbid with CPDs in Tehran were identified as potential participants for current study. Among them target population were women visited psychologic and counseling clinics. The sample of current study was 6 women diagnosed with MDD comorbid with CPDs selected by purposeful sampling based on in/exclusion criteria. Inclusion criteria were; a) MDD comorbid with CPDs based on psychiatric diagnostic interview by psychiatrist and SCID by clinical psychologist, b) age between 25 and 45, c) BDI-II score between 25 and 35 (moderate to severe depression), d) minimum 12 years education, e) no medical or psychological treatment in previous 6 months and f) meeting the criteria of Six Selection Questions Checklist for brief psychodynamic psychotherapies. Exclusion criteria were; a) presence of any other significant disorder in axis I psychiatric diagnosis, b) presence of any other significant somatic disorder attributable to MDD, c) presence of any psychotic symptoms, d) reporting any suicidal idea or attempt at any time in the duration of intervention and e) drug abuse or dependency in the time of research.

Procedure

At first, patients who met criteria of MDD and CPDs referred from psychological and counseling clinics were visited by a psychiatrist. Again psychiatrists-referred outpatients with MDD comorbid with CPDs were interviewed with SCID and by clinical psychologist to meet the in/exclusion criteria accurately. By purposeful sampling method until completion of the sample met the in/exclusion criteria; 6 out of 11 psychiatrists- referred outpatients were selected to participate in study. All participants received informed consent for psychological treatment based on ethics codes.

6 patients entered baseline assessment phase randomly, in three pairs, a week after each other. After assessing three baseline records, the pairs entered 15 sessions phase of treatment intervention, in the same order of baseline entrance. Three sessions of follow up assessment started 2 weeks after the last treatment session and carried out each for two weeks.

Statistical Analysis

In order to evaluate the efficacy of Brief Object Relations Psychotherapy on depression severity and perceived quality of life, data were analyzed by visual analysis of graphic displays of level, trend and variability of results. Cohen's d effect size coefficient was applied to examine statistical significance. Also, remission rate and diagnostic recovery which is being inside normal range of measures were applied to examine clinical significance [26].

$$Cohen's\ d = M1 - M2 / pooled$$

Where pooled = $\sqrt{}$ [(σ 1^2+ σ 2^2) / 2] remission rate = [baseline- post Therapy]/ post Therapy]

Results

Table 2 contains demographic information and Table 3 and graphic displays 1 and 2 are main outcome measures. The initial

Table 2. Demographic information of clinical sample

Cases	Age	Education	Marital status	Number of previous episodes	Suicide attempt	Previous treatment	predominant cluster C personality disorder
Case1	28	BA	Divorced	4	+	Medication	Obsessive- compulsive
Case2	26	BA	Married	2	-	Medication	Avoidant
Case3	26	MSc	Single	2	-	Medication	Avoidant
Case4	44	12 years	Married	5	-	Medication	Dependent
Case5	38	BA	Married	1	-	-	Passive- aggressive
Case6	32	MSc	married	3	+	consultation	Dependent
mean	32.3			2.83			

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mean BDI-II rating was 29.8(range, 27.3- 32.3) and MQOL rating was 56.3(range, 51.3- 62.6) suggesting moderate to severe depression and low satisfaction with perceived quality of life in all cases. Case 1 obtained 2.1 effect size (large>.80) and 52% remission (partially good> 50%) in BDI-II but clinically reached to mild depression. Case 1 also obtained 2.74 effect size and 52% remission in perceived quality of life which was clinically inside normal range. Both results were maintained in follow up. Case 2 obtained 1.97 effect size and 55% remission in BDI-II but clinically reached to mild depression. Effect size and remission rate in MQOL were 1.95 and 43.5% respectively and normal perceived quality of life was achieved. In spite of some resistance to termination in BDI-II, all results were maintained in follow up. Moreover case 3 gained 1.54 effect size and 57% remission and clinically reached to minimum depression. In addition, case 3 obtained 1.86 effect size and 47% remission in MQOL which was inside normal range clinically. Some resistance to termination in BDI-II graph was disappeared in follow up.

Case 4 showed 1.69 effect size and 55% remission but clinically reached to mild depression. On the other hand, 2.12 effect size and 47% remission in MQOL achieved which was clinically inside normal range. Despite some resistance to termination in BDI-II graph, results stayed consistent in follow up. Case 5 obtained 1.65 effect size and 55% remission and clinically reached to minimum depression. Case 5 also reached 2.06 effect size but 32% remission in perceived quality of life which was poor improvement. Results were maintained in Follow up, in spite of some elevations in BDI-II graphic display in termination.

Finally, Case 6 obtained 2.55 effect size and 55% remission and clinically reached to minimum depression. Also MQOL effect size and remission were 1.8 and 32% respectively. In spite of poor remission rate, the case was clinically inside normal range for perceived quality of life. The results were maintained in follow up. In general, total mean BDI-II rating was 13.26 (range, 12- 5), effect size and remission rate were 1.92 and 55% respectively. The MQOL rating was 100(range, 92- 107), effect size and remission rate were 2.08 and 43% respectively suggesting minimum to mild depression but normal perceived quality of life in general. Graphic displays and assessments indicated that results were maintained in follow up.

Discussion

Ingram, Hayes and Scott criteria for as-

Table 3. Main outcome measures

Measure	Baseline M(SD)	Therapy M(SD)	Post therapy M(SD)	Follow up M(SD)	Effect size (Cohen's d)	Remission rate
BDI-II case 1	32.3(2.5)	22.2(6.3)	15.5(1.9)	15(1)	2.1	%52
BDI-II case 2	30.6(2)	21.1(6.5)	13.75(1.5)	13.6(0.5)	1.97	%55
BDI-II case 3	29(2)	20.4(7.6)	12.25(1.7)	12(1)	1.54	%57
BDI-II case 4	32(2.6)	22.2(7.7)	13.75(1.9)	14.7(0.6)	1.69	%57
BDI-II case 5	27.7(2)	19.3(6.8)	12.25(2.6)	12.3(1.5)	1.65	%55
BDI-II case 6	27.3(0.6)	17.6(5.3)	12.25(0.5)	12(1)	2.55	%55
mean	29.8	20.46	13.29	13.26	1.92	%55.5
MQOL case 1	51.3(0.6)	87.6(18.7)	107(2.9)	107(2)	2.74	%52
MQOL case 2	60(2)	85.8(18.6)	106(2.1)	104.6(1.5)	1.95	%43.5
MQOL case 3	53.6(5.7)	79.8(19.1)	101(2.4)	102.6(2.5)	1.86	%47
MQOL case 4	51.3(1.5)	77.7(17.5)	98(1.3)	98(1.7)	2.12	%47
MQOL case 5	62.6(3)	80.6(11.9)	92(3)	92.6(2.08)	2.06	%32
MQOL case 6	59(3.4)	78.4(14.8)	93(2.6)	95(2)	1.8	%32
mean	56.3	81.65	100	100	2.08	%43

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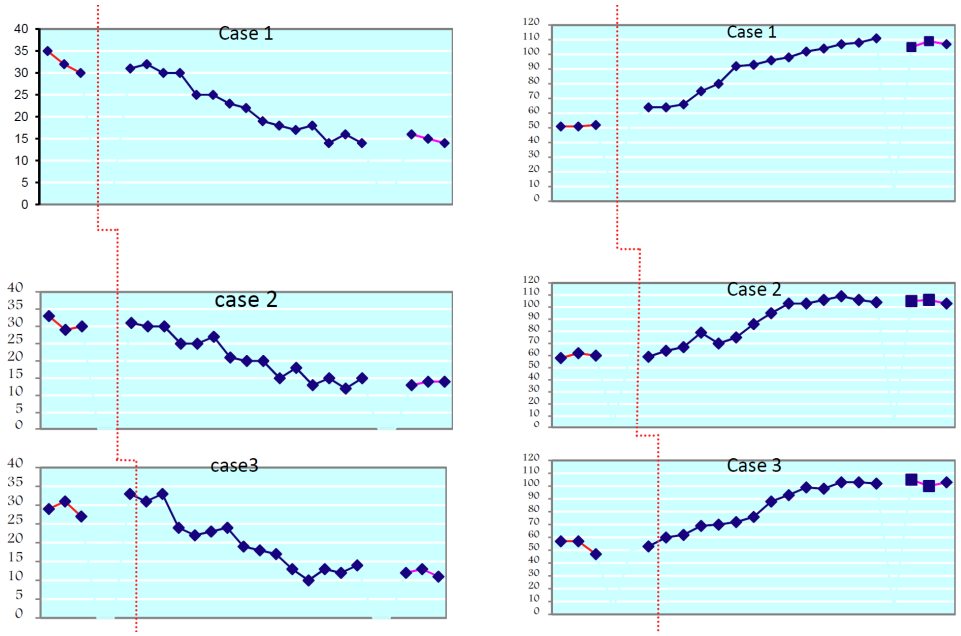


Fig. 1. Graphic displays of BDI-II (left) and MQOL (right) of cases 1, 2 and 3.

sessing the efficacy of interventional researches were used to assess the efficacy of brief object relations psychotherapy of MDD comorbid with CPDs [27].

1- Magnitude of change: depression severity and perceived quality of life were target variables. At the end of treatment perceived quality of life reached to normal range, whereas depression went from moderate to sever to minimal to mild. Hence, in overall, all patients met the criteria for response but they did not recover from depression. These findings corroborate other researches showing that presence of CPDs was associated with poorer recovery from depression because of resistance of CPDs. A parallel study of intensive short term dynamic psychotherapy with treatment resistant depression patients showed a greater effect size (d= 3.39) than our findings [28]. Whereas our effect size (d= 1.92) was close to a recent meta- analysis of efficacy of STPPs for depression in which, pre-treatment to post-treatment changes at depression level were large (d =1.34), and maintained until 1-year follow-up [12]. In brief Object Relations Psychotherapy of depression internalized conflictual relationships with objects and its related negative effects were interpreted after being replayed in transference and patients' relationships. It seems like this process increased the patient's susceptibility for depression and maintenance [13]. It seems like, as a result of such insights depression reduced and perceived quality of life which is highly depends on psychological condition induced [14].

2- Universally of change: all cases met criteria of mild depression but 3 had more elevation. Case 1, was divorced, had a history of a suicide attempt in the past, 4 previous episodes of MDD and diagnosed as obsessive- compulsive PD that affects her recovery from depression [9].

Cases 2 and 4 also had relational problems with their husbands. On the other hand, all 6 cases reported their perceived quality of life as normal as general population at the end of study. Case 5 diagnosed as passive-aggressive PD which was predominant in transference with therapist and marital relationships. The significant effect of cluster C predicting chronicity could reflect more cluster C individuals increasingly demanding for negative feedback and/or reassurance, eventually frustrating those close to them and increasing the likelihood that they will eventually be rejected. The resulting

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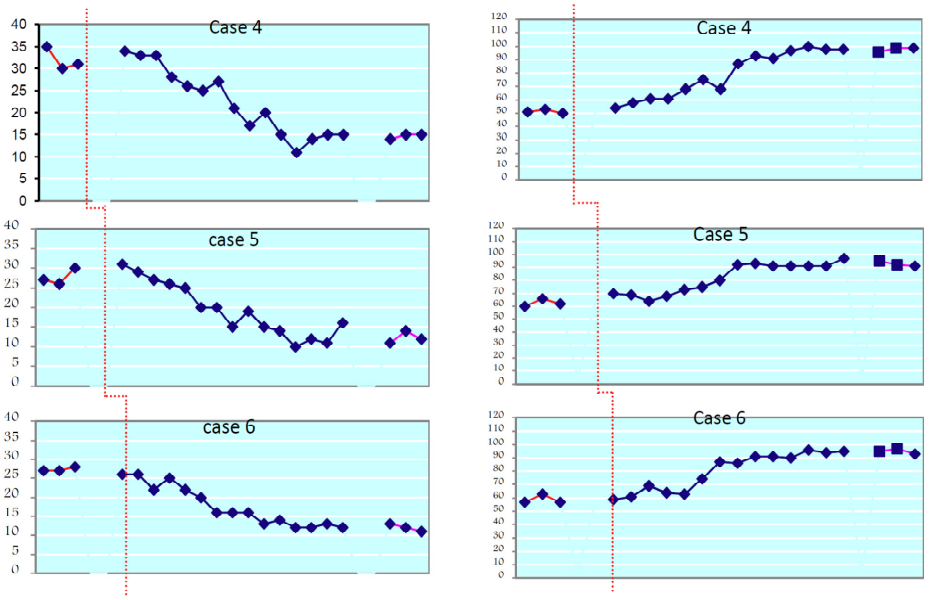


Fig 2. Graphic displays of BDI-II(left) and MQOL(right) of cases 4, 5 and 6.

rejection would theoretically worsen the depressive's condition, insofar as the loss of the previously supportive individual both present as another "reason" to be depressed and results in fewer social supports and perceived quality of life to act as resources to help the recovery of depressed individual. Such a process could explain why individuals scored higher on cluster C would experience more chronic depressions [10,29].

3- Generality of change: the observation that depression severity and perceived quality of life changed simultaneously suggests that personality change due to Brief Object Relations Psychotherapy may be necessary in MDD comorbid with PDs to eliminate the depression [28]. The finding that 3 patients were maintained with mild depression but reported normal perceived quality of life suggests that there is a relationship between patient's conflicts in relationships and perceived quality of life and depression severity [13,14].

4- Stability: as it was shown in graphic displays, the trend of graphs started to change in the middle of the treatment phase. 5 out of the 6 cases showed resistance in the initial phase of treatment with therapy focused on alliance making and linking symptoms to underlying personality conflicts. This process usually increases depression severity because of rapid understanding of case formulation and realizing the role of self and others interpersonal problems and symptoms [30]. Furthermore, 4 out of 6 patients showed elevation in depression but their perceived quality of life was not close to termination, which disappeared in follow up. Graphic displays obtained in this study were similar to other findings in STPPs (S shape) indicating primary resistance and then dropping down of symptoms in STPPs [28,31,32]. In STPPs it's expected to experience some elevation in symptoms or even relapse in termination phase. This is to some extant because of the perceived fear of termination with therapist and relapse of symptoms, and a kind of protest to termination [13,14,28].

5- Acceptability: all cases completed the study. The STPPs including Object Relations Psychotherapy are dynamic therapies which provoke patient's curiosity and interest to discover unconscious reasons of their symptom's development and maintenance through insights [13].

6- safety: post therapy and follow up showed improvement and none of the cases had any problem with intervention; the claim that must be examined with standard measures in future.

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Conclusion

Thus in general efficacy of Brief Object Relations Psychotherapy of MDD comorbid with CPDs appears to be feasible and beneficial in this single subject study. The MQOL seems to be an adequate measure to serve as marker of outcome. This study has the limitations of single therapist and short baseline and follows up duration so coincidental improvement cannot be ruled out easily.

The therapist was an experienced practitioner of this therapy. Thus, results may not be repeatable with non-experienced therapists. This treatment warrants further study including randomized control trial, other clinical samples and treatment factor analysis.

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