Internet-based psychotherapy: Current psychodynamic approaches

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KU Leuven & University College London
Overview

- Face-2-Face (f2f) psychotherapy for depression (and anxiety)
- Psychodynamic approaches to internet-based treatment
- Illustration: depressiehulp.be
- A multi-site pragmatic non-inferiority trial
Team

- **KU Leuven**: Prof Patrick Luyten (PI), Prof Stephan Claes (Co-PI) & Clinical Trials Center (CTC)
- **Erasmus University Rotterdam**: Prof Jan Van Busschbach (Co-PI)
- **CGG Kempen and CGG De Pont**: Wim Wouters (directeur), Bob Cools (directeur), Yoeri Coune and Katja Belmans (projectmedewerkers), Herwig Claeys and Vincent Verbruggen (IT), Tanja Gouverneur (patiëntenperspectief)
- **University College London & NHS Improving Access to Psychological Therapies (IAPT) programme**: Prof Peter Fonagy, Alessandra Lemma, Mary Target, Steve Pilling
f2f versus internet-based psychotherapy

Focus on depression (and anxiety)
Depression

- Highly prevalent (15-25% in men/women)
- Highly debilitating
  - Leading cause of suicide and suicide attempts
  - MDD second leading cause of years lived with disability worldwide
  - Second most serious disorder with respect to global disease burden
- High relapse rates (20-30% up to 70-80%)
- High risk of intergenerational transmission


Depression in clinical practice

- Most **common** reason for **referral**
  - dysthymia, followed by major depression and recurrent depression (often comorbid with personality pathology)

- Established **research base** for efficacy and effectiveness of brief and longer-term psychotherapy
  - As effective as medication in the short term
  - More effective in the **long run**?
  - Cost-effective?


Psychopharmacological treatment of depression

- Between 1997 and 2008 Daily Defined Doses (DDD) have more than doubled: from 109 to 251 M
- 341 M in 2015
- 320 M in 2016
- In 2008, 13% of the Belgian population older than 18 received at least one prescription of antidepressants

RIZIV 2014: prescription of antidepressants

<table>
<thead>
<tr>
<th>Leeftijdscategorie</th>
<th>Totaal aantal (unieke) patiënten</th>
<th>Aantal rechthebbenden</th>
<th>% van de rechthebbenden</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-24 jaar</td>
<td>36.425</td>
<td>1.300.175</td>
<td>2,8%</td>
</tr>
<tr>
<td>25-54 jaar</td>
<td>490.450</td>
<td>4.470.383</td>
<td>11,0%</td>
</tr>
<tr>
<td>55-64 jaar</td>
<td>224.982</td>
<td>1.364.386</td>
<td>16,5%</td>
</tr>
<tr>
<td>65-74 jaar</td>
<td>168.067</td>
<td>983.965</td>
<td>17,1%</td>
</tr>
<tr>
<td>≥ 75 jaar</td>
<td>241.000</td>
<td>1.018.411</td>
<td>23,7%</td>
</tr>
<tr>
<td>Totaal</td>
<td>1.160.924</td>
<td>9.137.320</td>
<td>12,7%</td>
</tr>
</tbody>
</table>

Bron: Farmanet, RIZIV
How can we improve access to psychotherapy?
Online psychotherapy and blended care

- **Pure online self-help** is effective only in a small subgroup of patients.

- However: meta-analyses suggest **blended care** may be as effective as f2f psychotherapy in depression (and anxiety).

- **No differences** between types of psychotherapy, most studies have focused on CBT and PDT.

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Equivalence of psychotherapies

- Meta-analysis of **high quality RCTs** comparing PDT and CBT
- N=23 trials, totaling 2,751 patients
- Depression, anxiety, PTSD, eating disorders, substance-related disorders, personality disorders
- Equivalence tested using Two One-Sided Test (TOST) procedure with small effect size difference ($d=.25$) as equivalence margin
- No evidence for researcher allegiance

Equivalence of psychotherapies

Hedges $g = -0.15$ (90% CI $-0.227$ - $-0.079$) at posttreatment
Hedges $g = -0.049$ (90% CI $-0.137$ - $-0.038$) at follow-up

FIGURE 1. Analysis of Effects of Psychodynamic Therapy Relative to Established Comparators on Target Symptoms at Posttreatment

<table>
<thead>
<tr>
<th>Study</th>
<th>Comparison</th>
<th>Hedges' $g$ and 95% CI</th>
<th>Relative Weight (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barber et al. (52)</td>
<td>PDT vs. Med</td>
<td></td>
<td>3.46</td>
</tr>
<tr>
<td>Connolly Gibbons et al. (51)</td>
<td>PDT vs. CBT</td>
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<td>11.28</td>
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<tr>
<td>Cooper et al. (53)</td>
<td>PDT vs. CBT</td>
<td></td>
<td>3.69</td>
</tr>
<tr>
<td>Driessen et al. (46)</td>
<td>PDT vs. CBT</td>
<td></td>
<td>9.53</td>
</tr>
<tr>
<td>Gallagher-Thompson and Steffen (54)</td>
<td>PDT vs. CBT</td>
<td></td>
<td>2.17</td>
</tr>
<tr>
<td>Salminen et al. (55)</td>
<td>PDT vs. Med</td>
<td></td>
<td>2.17</td>
</tr>
<tr>
<td>Shapiro et al. (56)</td>
<td>Combined</td>
<td></td>
<td>2.75</td>
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<tr>
<td>Thompson et al. (57)</td>
<td>Combined</td>
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<td>2.16</td>
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<tr>
<td>Bögels et al. (58)</td>
<td>PDT vs. CBT</td>
<td></td>
<td>1.96</td>
</tr>
<tr>
<td>Leichsenring et al. (59)</td>
<td>PDT vs. CBT</td>
<td></td>
<td>19.54</td>
</tr>
<tr>
<td>Leichsenring et al. (60)</td>
<td>PDT vs. CBT</td>
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<td>2.76</td>
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<tr>
<td>Milrod et al. (61)</td>
<td>PDT vs. CBT</td>
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<tr>
<td>Brom et al. (62)</td>
<td>PDT vs. CBT</td>
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</tr>
<tr>
<td>Garner et al. (63)</td>
<td>PDT vs. CBT</td>
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<td>2.32</td>
</tr>
<tr>
<td>Poulsen et al. (64)</td>
<td>PDT vs. CBT</td>
<td></td>
<td>2.38</td>
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<tr>
<td>Tasca et al. (65)</td>
<td>PDT vs. CBT</td>
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<td>3.54</td>
</tr>
<tr>
<td>Zipfel et al. (66)</td>
<td>PDT vs. CBT</td>
<td></td>
<td>5.30</td>
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<td>Crits-Christoph et al. (67)</td>
<td>Combined</td>
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<td>Woody et al. (68)</td>
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<td>Clarkin et al. (69)</td>
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<tr>
<td>Emmelkamp et al. (70)</td>
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<td>Muran et al. (71)</td>
<td>Combined</td>
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<td>1.81</td>
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<tr>
<td>Svartberg et al. (72)</td>
<td>PDT vs. CBT</td>
<td></td>
<td>2.39</td>
</tr>
</tbody>
</table>

Overall

Random effects Hedges' $g = -0.153$
Heterogeneity: $\chi^2=17.99$, df=22, $p=0.71$, $I^2=0.0018$
(90% equivalence CI= $-0.227$ to $-0.079$)
Test for equivalence: $z_1=2.15$, $z_2=-8.94$; $p=0.016$

* CBT=cognitive-behavioral therapy; Med=pharmacotherapy; PDT=psychodynamic therapy.
Equivalence in depression

Short-term psychodynamic therapy for depression

META-ANALYSIS

N=54 studies, totaling 3,946 patients

No significant differences found between brief PDT and other therapies at post-treatment
(d = -0.14)

No significant differences found between brief PDT and other therapies at follow-up
(d = -0.06)

CBT vs. PDT for Major Depression (N=341)

- **CBT**
  - 16 individual sessions
  - Manualised (Molenaar et al., 2009)
  - N= 164

- **Psychodynamic Therapy**
  - 16 individual sessions
  - Manualised (de Jonghe, 2005)
  - N=177

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Humanistic-experiential therapies

Total: $g = .08$

Active $g = -.10$ ; TAU $g = .51$

<table>
<thead>
<tr>
<th>Author(s) and Year</th>
<th>Researcher Allegiance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kay-lamkin et al., 2011</td>
<td>Con</td>
</tr>
<tr>
<td>Kocsis (a) et al., 2009</td>
<td>Con</td>
</tr>
<tr>
<td>Kocsis (b) et al., 2009</td>
<td>Con</td>
</tr>
<tr>
<td>Kosyzcki et al., 2012</td>
<td>Con</td>
</tr>
<tr>
<td>Magidson et al., 2011</td>
<td>Con</td>
</tr>
<tr>
<td>Sharp et al., 2010</td>
<td>Neutral</td>
</tr>
<tr>
<td>Morrell et al., 2009</td>
<td>Neutral</td>
</tr>
<tr>
<td>Heckman (a) et al., 2014</td>
<td>Neutral</td>
</tr>
<tr>
<td>Ogzuhanoglu et al., 2014</td>
<td>Neutral</td>
</tr>
</tbody>
</table>

RE Model for Active Comparison

<table>
<thead>
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<tr>
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<td>Neutral</td>
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<tr>
<td>Heckman (b) et al., 2014</td>
<td>Neutral</td>
</tr>
<tr>
<td>Galvin et al., 2010</td>
<td>Pro</td>
</tr>
</tbody>
</table>

RE Model for Treatment as Usual

RE Model for Total Sample

Sharbanee, Elliott, & Bergmann, 2017
Improving Access to Psychological Therapies (IAPT)

April 2014 - March 2015:

1,267,193 referrals
815,665 referrals entered treatment;
for which 32.0 days was the average (mean) waiting time

1,123,002 referrals ended;
of which 468,881 (41.8%) finished a course of treatment;
for which 6.3 was the average (mean) number of attended treatment appointments
Improving Access to Psychological Therapies (IAPT)

Figure 3: Recovery rates by therapy type for referrals with a problem descriptor of depression, 2014/15

- Interpersonal Psychotherapy (IPT): 53.9%
- Couples Therapy: 52.0%
- Guided Self Help: 47.8%
- Brief psychodynamic psychotherapy: 47.0%
- Counselling: 45.2%
- Other HI: 45.1%
- Behaviour Activation: 44.8%
- Cognitive Behavioural Therapy (CBT): 44.1%
- Psychoeducational peer support: 43.0%
Efficacy online treatment for depression

- Meta-analyses show **no difference** between internet-based treatment and f2f, particularly in mild to moderate depression

- **However:**
  - **Contact** with mental health professional is essential for most patients
  - Linear relationship between frequency of contact and outcome
f2f versus internet

ES difference of Hedges g = .05 (95% CI: -.19 to .30) between f2f psychotherapy and internet-based psychotherapy in studies targeting depressive symptoms only

Effect size in relation to clinician contact and support

Effect size in relation to clinician contact and support

For whom (not)?
For whom (not)?

- Bendelin et al. (2011): qualitative study
  - 3 groups of participants in E-Mental Health programmes:
    - readers
    - strivers
    - doers
  - Only ‘doers’ apply new insights in their daily lives and benefit from e-mental health interventions
  - Other groups emphasize the need for more support and benefit less (or not at all) from e-mental health interventions
<table>
<thead>
<tr>
<th>Groups</th>
<th>Working Process</th>
<th>Motivation</th>
<th>Attitude</th>
<th>Consequence of treatment</th>
</tr>
</thead>
</table>
| Readers | *read the material  
*Didn’t want or try to put their insights into practice | Unmotivated because:  
*Lack of support  
*Program is a burden/lack of time | Disappointment i.r.t. their high expectations | No change (although more insight): made them feel lonely, shameful, disappointed |
| Strivers | *Read and worked with the material in a practical way  
*Ambivalence regarding practising insights and working on their own | Unmotivated because:  
*Inadequate support  
*wish for more contact  
*expectations of therapist | Scepticism towards e-MH, CBT | Revision of themselves and depression, better understanding, better understanding, ambivalence (help would have made me feel better) |
| Doers | *Testing the material, applying it and putting insights into practice  
*Structured en methodical way of working | Motivated because  
*Proximal support if needed  
*responsibility, working on their own | Appreciate independence, useful, helpful | Better understanding, practiced skills and insights  
Stronger believe in own coping skills because they had beaten depression on their own |
Impairment
Externalizing
Internalizing
Male
Female
Gendered Style

Ungendered chronic Psychotic conditions

Partially gendered Personality disorder

Gendered ‘Neurotic’ conditions


Spectrum of patients

Attachment relationships

Epistemic hypervigilance/credulity

Development of epistemic trust needed

Epistemic mistrust

Capacity for salutogenesis can be reactivated

Epistemic trust

Capacity for salutogenesis can be used

The Guarded Cellar
The Fortified Castle
Terror in the Dungeon
Fractured and Frightened
Ondersteund door Vlaams Ministerie van Welzijn, Volksgezondheid en Gezin
Minister Jo Vandeurzen
Stepped care

Informatie
- Wat is een depressie?
- Kenmerken
- Zelftest
- Herstelverhalen
- Voor de omgeving
- Wat doe je als naaste?
- Op weg naar herstel
- Wat zijn je mogelijkheden?

Ga verder

Online zelfhulp
- In voorbereiding

Binnenkort zal je hier een aantal hulpmiddelen vinden om zelfstandig online aan de slag te gaan.

Lees meer

Online begeleiding
- Voor CGG cliënten

Cliënten die in begeleiding zijn bij CGG Kempen en CGG De Pont kunnen dit online programma volgen, in combinatie met gesprekken. Later zullen ook andere CGG hier gebruik van kunnen maken.

Online aanmelden is nog niet mogelijk. Dit is voorzien in 2018.
Stepped care

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- Wat is een depressie?
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Ga verder
2. Zelfhulp

- Voor iedereen gratis toegankelijk
- Screening + advies voor aanmelding
- Zelf aan de slag

1. 24/7 toegankelijk
2. Kosteloos en anoniem
3. Anoniem contact met andere deelnemers via een afgeschermd forum

Meer weten?

- Is deze zelfhulp geschikt voor mij?
- Hoe werkt deze online zelfhulp?
- Hoe zit het met mijn privacy?
- Ik heb nog andere vragen...

Login

Wachtwoord vergeten?
Problemen bij inloggen?
Modules

- **Voelen en denken**
  - OPEN
  - Bezig

- **In beweging komen**
  - OPEN
  - Bezig

- **Mijn relaties**
  - OPEN
  - Bezig

- **Wat is belangrijk?**
  - OPEN
  - Bezig
Stepped care

Informatie

Wat is een depressie?
Kenmerken
Zelftest
Herstelverhalen
Voor de omgeving
Wat doe je als naaste?
Op weg naar herstel
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Ga verder

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In voorbereiding

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Ga verder
Psychodynamic approaches

Affect-focused psychotherapy

Dynamic Interpersonal Therapy (DIT)

- Strongly relational: presenting problems are linked to threats to attachment relationships
- Double focus of treatment
  - Content: Interpersonal Affective Focus (IPAF)
  - Proces: increasing capacity for reflective functioning or mentalizing
Current applications

- Depression
- Anxiety
- Somatic symptoms (pain, fatigue)
- Transdiagnostic add-on in the context of inpatient treatment
- …
### Blended PDT: ‘model trajectory’

**Figure 1: Blended PDT**

| FTF session 1: Introduction Program and Exploration of depressive feelings |
| Online Module 1: Psycho-education and Assessment severity of complaints |
| FTF session 3: Relation between Depressive Feelings and Interpersonal Difficulties |
| Online Module 2: My Story and Moodslider |
| FTF session 4: Interpersonal Affect Focus (IPAF) |
| Online Module 3: My Relationships |
| FTF session 5: Recognizing IPAF in here-and-now |
| Online Module 4: My Relationship Pattern |
| FTF session 6: Recognizing IPAF in here-and-now |
| Online Module 7: Ending |
| FTF session 7: Experimenting with new ways of relating to others |
| Online Module 8: Relapse Prevention |
| FTF session 8: Looking back and looking forward |
Illustration: depressiehulp.be
Questions...