Treating depression and its comorbidity

From individualized Internet-delivered cognitive
behavior therapy to affect-focused psychodynamic
psychotherapy

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Till Barbro, Bo och Richard – min familj
Jag är en del av er

Och solen och havet finns alltid kvar

Abstract

Depression is a major health problem which lowers the quality of life for the individual and generates huge costs for society. Comorbidity between depression and anxiety disorders seems to be the rule rather than the exception. Evidence shows that comorbidity has consistently been associated with a poorer prognosis and greater demands for professional help. Prevalence studies show that many individuals with depression lack access to adequate treatment. Delivering psychological treatments through the Internet in the format of guided self-help is an innovative treatment strategy that has the potential to reach a large number of people. A majority of these treatments have been Internet-delivered cognitive behavior therapy (ICBT). The treatments contain structured material and interventions in the form of self-help text and are accompanied with online support from a therapist.

The overarching goal of this thesis has been to enhance Internet-delivered psychological treatments for depression and its comorbidity. To this end, three randomized controlled trials (Study II, III and IV) with a total of 313 participants were conducted. A prevalence study (Study I) was also conducted to provide an up-to-date estimate of the prevalence of depression, anxiety disorders, and their comorbidity in the Swedish general population.

In Study II, the efficacy of an individualized ICBT intervention that directly targeted depression and comorbid symptoms was tested. The treatment was compared to a standardized ICBT protocol and an active control group in the form of an online discussion group.

Recent meta-analyses support the efficacy of psychodynamic psychotherapy in the treatment of depression. An Internet-based treat-

ment protocol for depression, which was based on psychodynamic psychotherapy rather than CBT, was developed. In Study III, the efficacy of that protocol was evaluated in the treatment of depression.

Preliminary evidence indicates that a focus on affect experience and expression may enhance psychodynamic therapies. In Study IV, a new Internet-based psychodynamic protocol was developed that had a strong focus on affect. It targeted both depression and anxiety disorders. The efficacy of that treatment was evaluated in a sample with mixed depression and anxiety.

Study I showed that more than every sixth individual in Sweden suffers from symptoms of depression and/or anxiety. Comorbidity between depression and anxiety was substantial and associated with higher symptom burden and lower health-related quality of life. Study II showed that the tailored ICBT protocol was effective in reducing symptoms of depression when compared to the control group. Among individuals with more severe depression and comorbidities, the tailored ICBT treatment worked better than standardized ICBT. Study III showed that the psychodynamic Internet-based psychotherapy was highly effective in the treatment of depression, when compared to a group who received psychoeducation and online support. In Study IV, the Internet-delivered affect-focused psychodynamic psychotherapy proved to have a large effect on depression and a moderately large effect on anxiety disorders.

In conclusion, this thesis shows that in the context of treating depression and its comorbidity, Internet-delivered psychological treatments can be potentially enhanced by psychodynamic psychotherapy and by individualization.

List of publications

- I. Johansson, R., Carlbring, P., Heedman, Å., Paxling, B., & Andersson, G. (2013). Depression, anxiety and their comorbidity in the Swedish general population: Point prevalence and the effect on health-related quality of life. *PeerJ*, 1, e98.
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1 Introduction

Habib Davanloo, the developer of the psychotherapeutic system called 'Intensive Short-Term Dynamic Psychotherapy' wrote in the first volume of the journal that he started in 1986: *"I believe that dynamic psychotherapy can be not merely effective but uniquely effective, that therapeutic effects are produced by specific rather than nonspecific factors, and that the essential factor is the client's experience of his true feelings about the present and the past"* (Davanloo, 1986, p. 2). When Davanloo began his research in the 1960's, he was convinced that psychotherapy could be made far more effective. After more than 40 years of research, he claims to have developed techniques that enable 'total removal of resistance in a single interview' (Davanloo, 2008) for at least 60% of psychiatric patients. An exciting future awaits the field of psychotherapy research in the pursuit of verifying Davanloo's claims.

This thesis is concerned with broadening and enhancing the field of Internet-delivered psychological treatments for depression. In my first attempt to achieve this (Study II), depression and comorbid anxiety were targeted by moving from standardized to individually tailored Internet-delivered cognitive behavior therapy.

If Davanloo was correct in his assertion, then psychodynamic models could potentially enhance Internet-based treatments. This thesis also aims to take the first steps to investigate this possibility. When I began this research, it was not known whether an Internet-delivered psychological treatment for depression could be based on psychodynamic psychotherapy. My second attempt to enhance Internet-delivered psychological treatments for depression (Study III) involved

moving from cognitive behavior therapy to psychodynamic therapy as a base for Internet-delivered treatments.

The third project in this thesis (Study IV) is the synthesis of the previous work. I moved to an affect-focused model derived from Davanloo's work and used it to develop a psychodynamic Internet-based protocol that addressed not only depression but also comorbid anxiety disorders.

The future will be an exciting time for psychotherapy researchers and practitioners.

2 Depression - a description of the phenomenon

*Maybe she laughs
and maybe she cries,
and maybe you would be surprised
at everything she keeps inside.*

Unknown

Depression is a disorder of mood, so mysteriously painful and elusive in the way it becomes known to the self - to the mediating intellect - as too verge close to being beyond description. It thus remains nearly incomprehensible to those who have not experienced it in its extreme mode, although the gloom, "the blues" which people go through occasionally and associate with the general hassle of everyday existence are of such prevalence that they do give many individuals a hint of the illness in its catastrophic form.

William Styron in *Darkness visible: A memoir of madness*

2.1 Symptoms and diagnosis

According to the DSM-IV, symptoms of depression include depressed mood, loss of interest and enjoyment (anhedonia), feeling tired or having little energy, disturbed sleep, poor appetite or overeating, reduced self-esteem and self-confidence and/or ideas of guilt and unworthiness, reduced concentration and attention, increased fatigue,

and ideas or acts of self-harm. A *depressive episode* is defined as a time period lasting at least two weeks where five out of the nine symptoms listed above have been present for at least half of the time. At least one of the symptoms must then have been depressed mood or anhedonia. These symptoms must cause significant suffering and/or impairment at work, home, and/or in other significant areas of functioning. The symptoms must not be due to recent bereavement or caused by a drug (e.g. substance abuse or change in medication) or a somatic illness. To fulfill DSM-IV criteria for *major depression* or *major depressive disorder*, at least one depressive episode must have been observed as well as no signs of mania or psychosis. This thesis uses the DSM-IV definition of depression. The terms *depression*, *major depression* and *major depressive disorder* are used interchangeably.

2.2 Prevalence

Depression is a very common psychiatric condition. It is twice as common among women than among men. It can begin at any age but the average age of onset is in the late 20's or early 30's (R. C. Kessler et al., 2005). Lifetime prevalence has been estimated to be 16.6% (95% CI: 15.6 – 17.6) in the National Comorbidity Survey Replication (NCS-R), a large US population survey (R. C. Kessler et al., 2005). In the same survey, 12-month prevalence of depression was 6.7% (95% CI: 6.1 – 7.3). This figure tends to be similar around the world, for example in population surveys from the Australia (6.3%; Andrews, Henderson, & Hall, 2001) and the Netherlands (5.8%; Bijl, Ravelli, & van Zessen, 1998).

2.2.1 Prevalence of depression in Sweden

In Sweden in 1957 the point prevalence of depression was estimated to be 4.7% based on data from the total population ($n = 2612$) of Lundby, a small rural area in southern Sweden (Rorsman et al., 1990). Using the national Swedish Twin Registry, lifetime prevalence for depression was estimated to be 13.2% among men and 25.1% among

women (Kendler, Gatz, Gardner, & Pedersen, 2006). In the Lundby study, lifetime prevalence for depression was 27% among men and 45% among women, when participants were followed from 1957 up to 1972 (Rorsman et al., 1990). Importantly, the Lundby study did not use DSM criteria for major depression, which makes comparisons to prevalence rates from other countries complicated (Rorsman et al., 1990). To my knowledge, there exist no up-to-date point estimates of DSM-IV depression from the Swedish general population.

2.3 Comorbidity

Among individuals with lifetime depression in the NCS-R, close to 75% also meet criteria for at least one other DSM-IV disorder (R. C. Kessler et al., 2003). This number includes 59.0% with at least one lifetime comorbid anxiety disorder. Among 12-month cases with depression, comorbidity with anxiety was 57.5%. Other epidemiological data shows that 59.0% of individuals with GAD fulfill criteria for major depression (Carter, Wittchen, Pfister, & Kessler, 2001) and seem to suggest that comorbidity between depression and anxiety disorders is the rule rather than the exception. Comorbidity has consistently been associated with a poorer prognosis and greater demands for professional help (Albert, Rosso, Maina, & Bogetto, 2008; Schoevers, Deeg, van Tilburg, & Beekman, 2005). In addition, comorbidity between depression and anxiety seems strongly associated both with role impairment and higher symptom severity (R. C. Kessler et al., 2003). There is also research to suggest that comorbidity between anxiety and depression implies a higher risk of suicidal ideation than for anxiety disorders alone (Norton, Temple, & Pettit, 2008). Psychiatric comorbidity is also known to affect various aspects of health-related quality of life (Carpentier et al., 2009; Saarni et al., 2007; Sherbourne et al., 2010).

2.4 Costs to society

Depression is a large problem for society, not only in terms of suffering for the affected individuals and their families, but also in terms of societal costs. More than 50% of individuals with depression develop a recurrent or chronic disorder after a first episode and are likely to spend more than 20% of their lifetime in a depressed condition (Cuijpers, Beekman, & Reynolds, 2012). Depression and its comorbidity generates a substantial loss of quality of life and also leads to considerable additional damage (e.g., increased risk of cardiovascular disease, dementia, and early death). When economic costs to society are taken into account, depression is ranked third among disorders responsible for global disease burden and will rank first in high-income countries by 2030 (Mathers & Loncar, 2006). Hence, development of effective means of treating and preventing depression should be a high priority for society.

2.5 Treatment alternatives

2.5.1 Pharmacological treatments for depression

There are several treatment alternatives for depression, among which pharmacological treatments are effective and the most common (Hollon, Thase, & Markowitz, 2002). Newer agents such as selective serotonin reuptake inhibitors (SSRIs) and serotonin norepinephrine reuptake inhibitors (SNRIs) seem generally more effective than for example Tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs) (Cipriani et al., 2009). There is also some evidence that escitalopram and sertraline (two SSRIs) have better acceptability, leading to significantly fewer discontinuations than other antidepressants (Cipriani et al., 2009).

It is a well established fact that maintaining patients on antidepressant medications after they have recovered can reduce the risk of relapse and it can be considered standard practice to keep patients

with various forms of depression on pharmacotherapy indefinitely (APA, 2010). Importantly though, there is no evidence to suggest that treatment with antidepressants has any long term effects once medication is discontinued (Cuijpers, Hollon, et al., 2013; Hollon et al., 2002).

The efficacy of antidepressant medication and its widespread use in health care can be questioned. In a patient-level meta-analysis, Fournier et al. (2010) found that the differential efficacy of antidepressants compared to placebo varied as a function of initial symptom severity. For patients with mild to moderate depression, no differences were found compared to placebo. Among patients with a Hamilton Depression Rating Scale raw score below 23 ('very severe depression' according to Rush (2000)), the difference between medication and placebo was non-existing or very small (less than 0.20 in terms of effect size Cohen's *d*). Hence, to have an effect of antidepressants, a patient had to be severely depressed (Fournier et al., 2010). An overall effect size (mean standardized difference) of antidepressants relative to placebo has been estimated to 0.41 (95% CI: 0.36 – 0.45; Turner, Matthews, Linardatos, Tell, & Rosenthal, 2008). Importantly, when controlling for studies that are not published (i.e. publication bias), the effect is 0.31 (95% CI: 0.27 – 0.35). In summary, antidepressants seem to have a small effect in general, but differences against placebo may only apply to severely depressed patients.

2.5.2 Psychological treatments for depression

Several psychological treatments for depression exist. A large meta-analysis investigated the comparative efficacy of seven psychotherapies that each had been examined against other psychotherapies in at least five randomized controlled trials (Cuijpers, van Straten, Andersson, & van Oppen, 2008). The seven treatments investigated were cognitive behavior therapy, nondirective supportive treatment, behavioral activation treatment, psychodynamic treatment, problem-solving therapy, interpersonal psychotherapy, and social skills training. Few

differences between different psychological treatments were found, with the exception that interpersonal psychotherapy (IPT) may be more effective than other psychotherapies, and nondirective supportive therapy may be less effective (Cuijpers, van Straten, Andersson, et al., 2008). However, a later meta-analysis did not find any support for IPT being more effective than other psychotherapies (Cuijpers, Geraedts, et al., 2011). The finding that nondirective supportive therapy is less effective than other therapies has been corroborated (Cuijpers, Driessen, et al., 2012).

The overall effect size of psychotherapy (any kind) for depression has been estimated to be Cohen's $d = 0.69$ (95% CI: 0.60 – 0.79) when compared to (any type of) control (Cuijpers, van Straten, Warmerdam, & Smits, 2008). A recent analysis that only investigated psychotherapies compared to placebo medication estimated the effect to be Hedge's $g = 0.25$ (95% CI: 0.14 – 0.36). When adjusting for publication bias, the effect was $g = 0.21$ (95% CI: 0.10 – 0.32). Hence, psychotherapy seems to have only small effects beyond placebo medication in the treatment of depression.

CBT has been found to have an enduring effect that lasts beyond the end of treatment (Hollon et al., 2005; Hollon, Stewart, & Strunk, 2006). A recent meta-analysis compared CBT to continued and discontinued pharmacotherapy with a focus on preventing relapse (Cuijpers, Hollon, et al., 2013). This analysis found that CBT was significantly more effective than discontinued pharmacotherapy (Cuijpers, Hollon, et al., 2013). The authors also found close to significant ($p = .07$) evidence of that CBT prevents relapse more effectively than continued antidepressant medication (Cuijpers, Hollon, et al., 2013).

3 Cognitive behavior therapy

Cognitive behavior therapy (CBT) is an umbrella term that incorporates several different treatment paradigms. Generally, CBT can be said to be based on two theoretical frameworks, behavior therapy and cognitive therapy. Behavior therapy is grounded in the philosophy of radical behaviorism (Skinner, 1953, 1974) and the experimental analysis of human behavior (Ferster & Skinner, 1957; Skinner, 1953). The first application of behavior therapy for depression was based on the seminal paper 'A Functional Analysis of Depression' by Charles Ferster (1973). Behavior therapy (BT) for depression is generally called behavioral activation and involves the early work of Peter Lewinsohn (Lewinsohn, Biglan, & Zeiss, 1976) and contemporary work of Jacobson, Martell and colleagues (Martell, Addis, & Jacobson, 2001; Martell, Dimidjian, & Herman-Dunn, 2010). Cognitive therapy (CT) was developed by Aaron Beck and the application for depression was described in his book 'Cognitive Therapy of Depression' (Beck, Rush, Shaw, & Emery, 1979). CBT is a combination of CT and BT and typically contains treatment interventions from both.

The efficacy of CBT for depression is well established, as evidenced by an overall effect size Cohen's d in the range 0.61 to 0.92 (moderate to large) for various CBT implementations (Cuijpers, Berking, et al., 2013). Importantly, the effect of CBT for depression is smaller when compared to placebo conditions (Cuijpers, Berking, et al., 2013; Cuijpers, Turner, et al., 2013). When CBT is compared to other psychological treatment alternatives for depression, there is no evidence of superior efficacy (Cuijpers, Berking, et al., 2013; Lynch, Laws, & McKenna, 2010). Compared to antidepressant medication,

there are no indications of differential efficacy (Cuijpers, Berking, et al., 2013). However, the combination of CBT and pharmacotherapy is more effective than pharmacotherapy alone, with a between-group Cohen's $d = 0.49$ (95% CI: 0.29 – 0.69) (Cuijpers, Berking, et al., 2013).

3.1 Comorbidity and CBT

Work with 'evidence-based psychological treatments' typically involves adhering to an established treatment protocol. This could for example involve working with Beck's depression manual (Beck et al., 1979) to treat a patient who fulfills the diagnostic criteria of major depression. But, what about when a patient also meets the criteria for an anxiety disorder such as generalized anxiety disorder (GAD)? As mentioned above, this is not an uncommon occurrence with depression. How can a clinician use 'evidence-based' treatments with such a patient? One way would be to work *either* with a protocol designed for depression, *or* for GAD. However, many clinicians make individualized treatments to address multiple problems. There are different ways of working with psychotherapy to individualize treatments as in the case of comorbidity. Below, I will review both tailored/individualized CBT and transdiagnostic/unified treatments.

3.1.1 Tailored and individualized CBT variants

There are several approaches to tailoring a treatment to fit an individual client's need (Persons, 2008). This section will describe treatments that in some way tailor the treatment (e.g. selecting a set of interventions from a larger set of available components) instead of following a standardized protocol. One such approach is case formulation-driven CBT, as described by Jacqueline Persons (2008). In this approach, the therapist develops an individualized case formulation and uses it to select and adapt interventions from empirically supported CBT protocols to fit the individual case. The therapist relies on a hypothesis-testing approach to treatment in which the patient and therapist

set treatment goals that are measurable, monitor the process and outcome of treatment at each session, and make adjustments as indicated. An example of such hypothesis testing methodology might be one in which cognitive restructuring is initially selected as a mean of addressing depressive thinking but as the work continues continuous monitoring reveals that the intervention does not seem to be working. Perhaps the therapist notices an increase in depressive rumination and worrying after working with cognitive restructuring. Typically in case formulation-driven CBT, a therapist would then apply another evidence-based component to address negative cognitions, for example a mindfulness intervention to “learn to watch your thoughts like clouds passing by”.

Importantly, the case formulation-driven CBT approach can rely on different foundational explanations, for example learning theory, cognitive theory or emotion-focused theories (Persons, 2008). Working with a treatment component such as behavioral activation can be used to illustrate this approach. In a cognitive case conceptualization (e.g. Beck's cognitive therapy for depression; Beck et al., 1979), the role of BA in the overall CT package is described as follows, “The ultimate aim of these techniques in cognitive therapy is to produce change in the negative attitudes” (p118). In a behaviorally oriented conceptualization, behavioral activation would instead be described as an intervention that enables a patient to access sources of positive reinforcement in their lives which serve a natural antidepressant function (Jacobson, Martell, & Dimidjian, 2001).

Almost no evidence exist that support case formulation-driven CBT. Persons, Roberts, Zalecki, and Brechwald (2006) did an uncontrolled study investigating the effectiveness of this approach in an outpatient sample with mixed depression and anxiety. Within-group effects in that study were $d = 1.33$ on the BDI and $d = 0.98$ on the Burns Anxiety Inventory. Persons et al. (2006) benchmarked these results to established protocols targeting single mood and anxiety disorders and concluded that the effects of case formulation-driven CBT in a mixed sample were comparable, in general, to those of psychological treatments targeting single disorders.

Another approach to tailored CBT is behavior therapy, which is based on a functional analysis of a client's presenting problems (Sturmey, 2008). In behavior therapy, the functional analysis of the presenting problem is considered essential to the development of a treatment plan (Haynes & Williams, 2003). Such functional analysis is typically conducted to describe how various classes of problematic behavior are related. For example, depressive rumination and worrying could both be examples of negatively reinforced covert behavior that serves an avoidant function. Then, based on that analysis, interventions such as exposure with response prevention could be carried out to address the problematic pattern (e.g. avoidance) in various contexts. Further details on behavior therapy based on functional analysis can be found elsewhere (Sturmey, 2008).

There are studies that compare this individualized approach of behavior therapy against standardized protocols. For example, Jacobson et al. (1989) compared an individualized behavioral couples therapy to a manualized treatment. Contrary to expectations, no differences were found between treatments at post-treatment. However, the individualized protocol led to somewhat larger maintenance of gains at a six-month follow-up (Jacobson et al., 1989). In another study by Schulte and Künzel (1992), 120 participants with phobias were randomized to either manualized exposure treatment, individualized treatment, or a control condition in which a participant got a treatment based on another participant's individualized treatment plan. The results showed that the manualized approach outperformed the other conditions (Schulte & Künzel, 1992). This finding was replicated for OCD patients by Emmelkamp, Bouman, and Blaauw (1994), who provided evidence that a manualized behavior therapy was more effective than an individualized approach. Another study by Ghaderi (2006) showed that participants with bulimia nervosa who were randomized to an individualized treatment based on functional analysis had better outcomes than participants who received a standardized treatment. This finding was true for abstinence from bulimic episodes, eating concerns, and body shape dissatisfaction, but

not for measures of self-esteem, perceived social support from friends, and depression (Ghaderi, 2006).

In conclusion, while case conceptualization and individualization of cognitive behavioral treatments are standard procedures for many clinicians, the evidence for the effect of tailoring on treatment outcome in CBT is very limited. For specific disorders such as phobias and OCD, there is even evidence that a standardized approach may be more effective. For depression and its comorbidity, there is a paucity of research that investigates tailored treatments which address comorbidity.

3.1.2 Transdiagnostic and unified treatments

In addition to the 'tailored' approach described above, there is a class of treatments called *transdiagnostic*. In the models underlying those treatment protocols, it is assumed that different disorders share properties and that treatment should be constructed to address such common processes across disorders. Hence, a transdiagnostic treatment could potentially treat a condition (e.g. depression) as well as its comorbidities with other conditions (e.g. various anxiety disorders).

A transdiagnostic protocol that has a growing evidence base is David Barlow's *Unified Protocol* (Barlow, Fairholme, & Ellard, 2011). The Unified Protocol is a transdiagnostic, emotion-focused CBT designed to be applicable to anxiety disorders and depression, and also to other disorders with strong emotional components such as somatoform disorders (Farchione et al., 2012). The treatment incorporates principles of emotion regulation, motivational interviewing, mindfulness techniques, exposure and restructuring of maladaptive cognitions. A recent randomized controlled trial (Farchione et al., 2012) and previous open trials (Ellard, Fairholme, Boisseau, Farchione, & Barlow, 2010) indicate that the Unified Protocol has promising effects in the treatment of anxiety disorders. Besides the Unified Protocol, there exist other transdiagnostic CBT protocols, where most of these have been developed to target anxiety disorders (McEvoy, Nathan, & Norton, 2009). In general, these treatments seem effective when

compared to wait-list controls and the treatments are generally associated with improvements in comorbid disorders (McEvoy et al., 2009).

4 Psychodynamic therapy

As evidenced from recent meta-analyses on the efficacy of psychotherapy, a large portion of the empirical psychotherapy studies are based on CBT (Cuijpers, van Straten, Warmerdam, et al., 2008; Cuijpers, Turner, et al., 2013). Psychodynamic psychotherapy is another psychotherapeutic approach that has a prominent position due to its widespread use (Norcross, Karpiak, & Santoro, 2005). Importantly, psychodynamic psychotherapy is a very heterogeneous class of treatments. Theoretically, the underlying model of psychopathology includes a range of different psychoanalytical theories such as ego psychology, object relations psychology, attachment theory, and self psychology (Driessen et al., 2010; Summers & Barber, 2010). Different psychodynamic psychotherapies can be of almost any length, ranging from a single or a few sessions (Abbass, Joffres, & Ogrodniczuk, 2009; Barkham, Shapiro, Hardy, & Rees, 1999) to fixed lengths such as 12, 16 or 24 sessions (Barber, Barrett, Gallop, Rynn, & Rickels, 2012; Leichsenring et al., 2013; Mann, 1973), and up to 2-3 times a week for several years (Knekt, Lindfors, Sares-Jäske, Virtala, & Härkänen, 2013). The activity of the therapist varies from highly active (as for example in Intensive Short-term Dynamic Psychotherapy; Abbass, Town, & Driessen, 2012; Davanloo, 2000) to significantly less active in classical Freudian psychoanalysis. Interventions range from supportive (e.g. to soothe distress and provide support) to highly exploratory (e.g. providing an interpretation concerning aggression in the therapist-patient relationship). While the relationship between therapist and patient tend to be important in dynamic therapies, various models differ in how the relationship is used. Examples include resolving

alliance ruptures (Safran & Muran, 2000) or actively exploring the feelings mobilized towards the therapist (Davanloo, 2000).

Central to psychodynamic theory are the notion of unconscious *conflicts* in mental life (Summers & Barber, 2010). Large portions of unhealthy (and healthy) mental life can be conceptualized as consisting of conflicting wishes, drives, fears, thoughts, feelings, as well as attempts to resolve such conflicts. Importantly, it is not conflicts per se that are assumed to constitute psychopathology. Instead, pathology is seen as resulting from maladaptive attempts to cope with the conflicts (Summers & Barber, 2010). A problem such as depression can be understood as maladaptive coping attempts in various ways. For example, a conflict involving aggression and love in intimate relationships could result in self-directed aggression instead of assertiveness, with the anger directed to the self potentially functioning to avoid abandonment. The essence of psychodynamic psychotherapy could be said to be an exploration of intrapsychic conflicts and their historical underpinnings in order to understand how they are affecting present relationships, including one with the therapist. Furthermore, psychodynamic therapies include identifying recurring patterns that result from conflicts. The therapist-patient relationship constitutes a safe place for a collaborative effort to make such unconscious conflicts and patterns conscious (Summers & Barber, 2010). The focus on conflict and its resolution and the use of the transference to achieve this, may be what distinguishes psychodynamic therapies most from other therapies.

Despite over a hundred years of development of psychoanalytic thought and psychodynamic therapy, CBT, a much younger form of psychotherapy, has a substantially larger evidence base (Cuijpers, van Straten, Andersson, et al., 2008). This fact is evident when considering the amount of psychodynamic research that fulfills the criteria for high-quality evidence as set by Chambless & Hollon (1998). The 2008 review by Gibbons, Crits-Christoph, and Hearon (2008) focused on this piece by investigating psychodynamic treatment studies that 1) targeted a specific disorder, 2) had been evaluated in random-

ized controlled trials, 3) had used a treatment manual, and 4) used valid assessments and appropriate data analytic procedures. For a treatment to be classified as *efficacious*, according to Chambless and Hollon (1998), there must be two independent randomized trials (superior to a waiting-list, placebo condition, or another treatment) supporting the efficacy of the treatment. Treatments with support from only one RCT were classified as *possibly efficacious*. Gibbons et al. (2008) concluded that psychodynamic psychotherapy could not be classified as *efficacious* for *any* Axis I or II disorder. However, in the context of medication usage, dynamic therapy (as an adjunct) was classified as efficacious. For treatment of geriatric depression, it was classified as possibly efficacious due to the study by Thompson, Gallagher, and Breckenridge (1987), despite the use of a specified treatment manual and adequate design in that study. Other disorders for which dynamic therapy were classified as possibly efficacious were panic disorder, borderline personality disorder, and substance abuse/dependence.

4.1 Evidence for psychodynamic therapy for depression

In a 2010 meta-analysis by Driessen et al. investigating the efficacy of short-term psychodynamic psychotherapy for depression, the authors concluded that psychodynamic therapy was more effective than control conditions. The authors also found evidence for dynamic therapy to be equivalent to other psychotherapies at follow-up, but significantly less effective in the acute phase. Later re-analyses attributed this difference to the inclusion of psychodynamic therapy in group format (Abbass & Driessen, 2010). Hence, for individual therapy, no indications for differential efficacy between psychodynamic therapy and other psychotherapies were found in the treatment of depression.

Importantly, in the Driessen et al. (2010) meta-analysis, no single published study with adequate power was found that showed that a psychodynamic monotherapy (i.e. not as an adjunct to medication)

was more effective than another condition in the treatment of depression. A possible exception was the very small study (10 per condition) by Maina, Forner, and Bogetto (2005) that treated minor depression and unpublished data by Carrington (1979) with an equally small sample size.

Since the Driessen et al. (2010) meta-analysis was published, more studies have been published that investigate the efficacy of dynamic therapy in the treatment of depression. Maina, Rosso, and Bogetto (2009) found that psychodynamic therapy, based on Malan (1976), combined with antidepressant medication was more effective in reducing relapse in the long term than antidepressants alone. The same group of researchers also investigated the same form of psychotherapy as monotherapy and compared it to a supportive intervention (Rosso, Martini, & Maina, 2013). There were no differences at the end of the treatment period, but the authors found that significantly more patients reached a state of remission at the 6-month follow-up after psychodynamic treatment compared to the supportive intervention (75.8% compared to 47.3%). Subgroup analyses did also reveal significant differences (favoring the dynamic treatment) on the outcome measures among patients with higher depression severity (Rosso et al., 2013).

Barber and colleagues (2012) recently completed a randomized trial that compared a 16-week psychodynamic psychotherapy with antidepressant medication and placebo. The study implemented Luborsky's Supportive-Expressive treatment (Luborsky, 1984), adapted for depression (Luborsky, Mark, Hole, & Popp, 1995). While the study fulfilled the aforementioned quality criteria (e.g., manualized, adequate diagnostic procedures, power and study design), Barber and colleagues (2012) found no differences between conditions. While gender and minority status moderated outcome, there were no indications that psychodynamic therapy (or the antidepressant medication) was more effective than placebo. As mentioned above, recent evidence points out that the overall effect of psychotherapy compared to pill placebo is $g = 0.25$ (Cuijpers, Turner, et al., 2013), which

indicates that it is a large challenge for current psychotherapies to perform better than a placebo condition. Another recent study that implemented Supportive-Expressive therapy in the treatment of depression was that of Gibbons et al. (2012) who performed a pilot RCT in which participants from primary care were randomized to either dynamic therapy or treatment as usual. While the authors found significant differences on a measure of depression (the BASIS-24; Eisen, Normand, Belanger, Spiro, & Esch, 2004), they failed to find any difference on the Hamilton Depression Rating Scale (Hamilton, 1960), which was the primary outcome measure of depression in the study (Gibbons et al., 2012).

Very recently, Driessen et al. (2013) compared psychodynamic psychotherapy to CBT among outpatients with depression. Both treatments lasted for 16 weeks. No differences were found between treatment groups. In the total sample, only 22.7% responded to treatment (having had at least a 50% symptom reduction at post-treatment). The authors conclude that the time-limited versions of dynamic therapy and CBT that were evaluated may not be sufficient in a psychiatric outpatient population with depression (Driessen et al., 2013).

In summary, there is recent meta-analytic evidence (Abbass & Driessen, 2010; Driessen et al., 2010) that supports the efficacy of psychodynamic psychotherapy in the treatment of depression. Dynamic therapy seems to be more effective than control conditions and roughly equally effective as other psychotherapies, when given as individual therapy. However, psychodynamic psychotherapy would probably still not be classified as *efficacious* according to the criteria by Chambless and Hollon (1998). This fact can be contrasted to other psychotherapies such as CBT, behavioral activation, interpersonal psychotherapy and problem-solving therapy, all of which have been classed as efficacious in the treatment of depression (Hollon & Ponniah, 2010). Importantly, it is a fact that there still does not exist a single randomized controlled trial that proves superiority of a psychodynamic monotherapy that targets depression based on a specified

treatment manual and where the study has adequate power and design. To provide well-controlled and methodologically sound studies for depression is a crucial task for psychodynamic researchers if dynamic therapy is to survive in the age of evidence-based medicine.

4.2 Psychodynamic models and manuals

As mentioned above, the field of psychodynamic therapy is very broad and treatments tend to be quite different. Below, I will describe two general models that are relevant to this thesis.

4.2.1 Supportive-Expressive psychotherapy

Lester Luborsky developed Supportive-Expressive Psychotherapy (Luborsky, 1984) after work from the Psychotherapy Research Project of the Menninger Foundation (Leichsenring & Leibing, 2007). This model of therapy contains both supportive and expressive interventions (as defined above). Examples include alliance building (primarily a supportive intervention) and providing interpretations (primarily expressive) of how an underlying 'Core Conflictual Relational Theme' (CCRT; described below) is related to the patient's presenting problem. The specific application of supportive and expressive interventions are adapted for each patient during therapy. For example, for patients with low anxiety tolerance, supportive interventions may be needed to build capacity for the rest of the treatment. In the words of Luborsky (1984): "The supportive relationship will allow the patient to tolerate the expressive techniques of the treatment [...] that are often the vehicle for achieving the goals" (p. 71).

As described above, psychiatric problems from a psychodynamic perspective are assumed to be consequences of unresolved conflicts and dysfunctional means of handling such conflicts. In SE therapy, this phenomena is conceptualized as the Core Conflictual Relational Theme. A CCRT consists of three components: A *Wish* (e.g., "I wish I was respected by X"), a *Response from other* (e.g. "But X do not care

about me”), and a *Response from the self* (e.g. “I feel unworthy of love, hate myself and avoid approaching X and other people”). Here, the response from the self represents a patient's presenting symptom (e.g., negative thinking, self-directed anger, and detachment from others in the case of depression). The task of the therapy is to identify CCRTs that are related to the presenting problems which might include relationship patterns that are played out within therapy (in the transference) and outside of therapy. That is, the CCRT from the example could happen in relation to a friend and result in withdrawal, but the same CCRT could happen in therapy (e.g., “I wish that my therapist respected me”, “But he thinks I'm silly and does not care about me”, “I'm unworthy of love and hate myself” in which the response from self could be associated with, for example, closing into oneself). An interpretation of this CCRT from the therapist could be “I see you detach from people for whom you long for closeness to” and “You could see me as one of those people”. Accurate interpretations of CCRTs are assumed to be the central in SE therapy (Leichsenring & Leibing, 2007) and self-understanding through CCRTs are assumed to be a central mechanism of change in SE therapy (Connolly et al., 1999).

SE therapy has been tested in randomized controlled trials for a range of conditions, for example in the treatment of depression (Barber et al., 2012; Gibbons et al., 2012), generalized anxiety disorder (Leichsenring et al., 2009), social phobia (Leichsenring et al., 2013) and personality disorders (Vinnars, Barber, Norén, Gallop, & Weinryb, 2005). Results in these studies have been mixed. For depression, significant within-group effects were observed but, as mentioned above, the Barber et al. (2012) study failed to show differential efficacy compared to placebo and the Gibbons et al. (2012) study failed to show any effect on the primary outcome measure of depression when compared to treatment as usual. In the study on GAD and social phobia the therapies tended to perform well, but somewhat less well than CBT. For personality disorders, the SE therapy performed equally well as community delivered psychodynamic treatment (Vinnars et al.,

2005).

The expressive interventions of CCRT have been shown to be related to treatment outcome (Leichsenring & Leibing, 2007). For example, accurate interpretations (as defined as congruence between a patient's CCRT statement and a therapist's interpretation; Crits-Christoph, Cooper, & Luborsky, 1988) of a CCRT by the therapist have been shown to be predictive of outcome in several studies and have been shown to explain between 9% and 25% of variance in treatment outcome in SE therapy (Leichsenring & Leibing, 2007). There is also evidence that expressive interventions (e.g. interpretations) delivered by a competent therapist (as rated by judges) are correlated ($r = -.53$) with treatment outcome (self-report at post-treatment) in SE therapy (Barber, Crits-Christoph, & Luborsky, 1996). Importantly, this was only true for competent delivery of expressive techniques, and not for supportive techniques (Barber et al., 1996). This suggests that the specific techniques in SE therapy have an effect beyond that of nonspecific supportive interventions.

4.2.2 Experiential Dynamic Therapy

Experiential dynamic therapy (EDT) is a class of treatments that share the overall goal of affect experience and affect expression. Examples include Davanloo's Intensive Short-Term Dynamic Psychotherapy (ISTDP; Abbass et al., 2012; Davanloo, 2000), Fosha's Accelerated Experiential-Dynamic Psychotherapy (AEDP; Fosha, 2000), McCullough's Affect Phobia Therapy (APT; McCullough et al., 2003) and Malan's Brief Psychotherapy (Malan, 1963, 1976). These treatments descend from the work by Alexander and French (1946), who were among the first to attempt to shorten psychoanalytic therapy and increase its efficacy. Alexander and French (1946) regarded the experience of warded off affect a major therapeutic factor. By focusing on affect, Alexander and French were moving the therapeutic task from interpretation on a cognitive level to actively promoting expression and experience of buried feelings within the therapeutic relationship (Osimo & Stein, 2012). This intensive experiencing of previously

buried feelings was called the *corrective emotional experience* (Alexander & French, 1946) and has been assumed to be fundamental for therapeutic change in experiential dynamic therapy (Osimo & Stein, 2012).

EDT is *experiential* in that it promotes and deems essential the direct experience of emotions within session. As stated by Malan (1995): "The aim of every moment of every session is to put the patient in touch with as much of his true feelings as he can bear" (p. 84). Moreover, EDT is *dynamic* as it makes use of the psychoanalytic theory of conflict and transference phenomena to explain psychopathology. In essence, this theoretical orientation can be summarized by the 'Triangle of Conflict' (Ezriel, 1952) and the 'Triangle of Person' (Menninger, 1958), combined by Malan to represent what he called 'the universal principle of psychodynamic psychotherapy' (Malan, 1995). The triangles illustrate how defenses (D) and anxieties (A) block the expression of true feelings (F) and how these patterns began with past persons (P), are maintained with current persons (C), and are often enacted with the therapist (T). While different EDTs can differ in technique, they all emphasize the triangles as a way of understanding the psychodynamics of a patient.

One form of EDT is Affect Phobia Therapy by (McCullough et al., 2003). In this psychotherapy, which draws both from behavior therapy and from psychodynamic theory, inner conflict is conceptualized as an *affect phobia*, or, in other words, a phobia of one's feelings. For someone with depression, it may be possible to talk about several affect phobias. For example in the case of grief and sadness: Past experiences and environments (P, in the Triangle of Person) may have associated the expression of sadness with punishment. Hence, the feeling of sadness (F) generates anxiety (A) in the person in current relationships (C) and possibly also in relation to the therapist (T). Unconscious (and conscious) defenses (D), (e.g., excessive talking, rationalizing or minimizing, etc.) may function to regulate anxiety and suppress feelings. In Affect Phobia Therapy, the rationale of the treatment is exposure with response prevention. That is, the therapist helps the

client be present with the experience of feared affect (“How did you feel when your husband passed away?”), regulate associated anxiety (e.g. by stomach breathing), and drop the use of defenses (“Do you notice that you tend to minimize how important this experience was for you? What happens if you stay with the feeling, here with me?”).

As evident from the description above, there is variation among the dynamic therapies to the degree in which they focus on expression and experience of affect. Diener, Hilsenroth, & Weinberger (2007) conducted a meta-analysis of high-quality studies that examined the role of therapist focus on affect in psychodynamic psychotherapy. The results indicated that the more therapists facilitated affective experience/expression in psychodynamic therapy, the more patients improved (Diener et al., 2007). Thus, keeping a focus on affect may be one way of enhancing psychodynamic psychotherapies. For depression, in the Driessen et al. (2010) meta-analysis, the authors did not find any significant difference between affect-focused dynamic therapies (within-group Cohen's $d = 1.71$) and other dynamic therapy (within-group Cohen's $d = 1.26$).

There are about 30 RCT studies that use a treatment manual based on either Malan or Davanloo. Out of these, 11 studies targeted depression with or without comorbid anxiety. Examples include the studies by Maina and colleagues (Maina et al., 2005, 2009; Rosso et al., 2013) as mentioned above, and the study by Bressi, Porcellana, Marinaccio, Nocito, and Magri (2010) where a therapy based on Malan (1963, 1976) was more effective (on two out of three primary outcome measures) than treatment as usual in a sample of mixed depression and anxiety. Two studies by Piper and colleagues (Piper, Azim, McCallum, & Joyce, 1990; Piper, Debbane, Bienvenu, & Garant, 1984) exist that tested the efficacy of dynamic therapy based on Malan (1963, 1976) in mixed samples with depression, anxiety and Axis-II disorders. In the first of these, the dynamic treatment was more effective than long-term dynamic individual therapy and short-term group therapy, but not more effective than long-term group therapy (Piper et al., 1984). In the second study, the treatment was

showed to be more effective than waiting-list (Piper et al., 1990). Two other studies found no differences between dynamic treatment based on Malan's manual in similar samples when compared to family doctor visits (Brodaty & Andrews, 1983) and solution-focused therapy (Knekt & Lindfors, 2004). A study that targeted moderately to severely depressed children and young adolescents (9-15 years) used a treatment manual that was based on the work by Malan and Davanloo (Trowell et al., 2007). The treatment had very good effect (100% of participants had recovered from depression at follow-up), but there was no differences to the comparison treatment (family therapy, in where 81% no longer were depressed). Using the same manual, Bloch et al. (2012) found no differences between dynamic therapy + antidepressants compared to dynamic therapy + placebo in a sample of participants with postpartum depression. However, within-group effects were very large on the primary outcome measure of depression ($d = 3.78$ and $d = 2.56$ for dynamic therapy plus antidepressants and placebo, respectively). Finally, Salminen et al. (2008) compared a treatment based on Malan (1976) and Mann (1973) to Fluoxetine in the treatment of depression. Once again, large within-group effects were found, but no differences were found between the groups. In summary, the amount of evidence for experiential dynamic therapies in samples of depression with or without comorbid anxiety seem promising. Still, there is no EDT study that targets depression specifically that also manages to show superiority of such treatment to a control condition or another treatment.

5 Guided and non-guided self-help treatments

5.1 Self-help treatments and bibliotherapy

When a form of psychotherapy is described in written material or book format and provided to a patient, it is called *bibliotherapy*. It is well-established that psychotherapy in the form of self-help can have an effect on depression (Cuijpers, Donker, et al., 2011; Johansson & Andersson, 2012), anxiety disorders (Andrews, Cuijpers, Craske, McEvoy, & Titov, 2010; Hirai & Clum, 2006), somatic conditions such as pain (Buhrman et al., 2013) and tinnitus (Hesser et al., 2012), and other health-related problems (Hedman, Ljótsson, & Lindefors, 2012). For depression, pure self-help treatments have a small but significant effect, $d = 0.28$ (95% CI: 0.14 – 0.42; Cuijpers, Donker, et al., 2011). A typical contemporary self-help treatment is delivered via the Internet. The material tend to be provided in parts, often called 'modules' and can be in any medium (e.g. text, video, audio recordings).

As evident from above, effects of self-guided treatments seem to be in the small range. A recent study by Titov et al. (2013) tested the efficacy of a self-guided transdiagnostic treatment with the addition of automatic e-mail reminders, but no contact with a therapist. This study seems to be more effective than self-guided treatments in general and reported effect sizes of $d = 0.68$ for depression and $d = 0.58$ for anxiety, when compared to a waiting list. The study also explored the specific effect of the addition of e-mail reminders and found that

among participants with comorbid depression and anxiety (as measured by elevated scores on the PHQ-9 and the GAD-7), there was a moderately large effect of adding the automatic reminders (Titov et al., 2013). Hence, this addition seems promising for enhancing self-guided treatments.

5.2 Psychotherapy as guided self-help

A *guided self-help treatment* is a psychological self-help treatment (as described above) with some form of guidance added. In a majority of studies on guided self-help this guidance has been in the form of approximately 10 minutes of contact with a therapist by e-mail. Importantly, there exist studies where the guidance has been provided by professionals other than therapists, for example nurses (Marks, Cavanagh, & Gega, 2007) and computer technicians (Robinson et al., 2010; Titov, Andrews, Davies, et al., 2010). Also, the amount of contact per week is not fixed. There are examples of treatments with longer (Klein, Richards, & Austin, 2006) and shorter (Clarke et al., 2005) duration of contact. An extreme example may be a study on panic disorder where the only guidance was in the form of a clear deadline set (Nordin, Carlbring, Cuijpers, & Andersson, 2010). In that study, there were no indications that the efficacy of the original guided self-help treatment was not preserved. The therapist support can be provided in any medium (e.g. e-mail, phone or even face-to-face).

In Sweden, guided self-help treatments are often described as *Internet-based* or *Internet-delivered psychological treatments*. This description reflects the fact that the majority of guided self-help studies conducted in Sweden have involved providing self-help material as modules (e.g. book chapters) through the Internet with therapist support delivered in a format similar to e-mail (typically messages sent via a secure treatment platform). However, there are also examples of other Internet-delivered treatments (from outside of Sweden), such as CBT in a format similar to Skype (D. Kessler et al., 2009). In this the-

sis, all treatment studies have been in the format of guided self-help through the Internet. Therefore, the terms guided self-help treatments and Internet-delivered/Internet-based treatments are used interchangeably.

For depression, it is an established fact that guided self-help treatments are more effective than non-guided (Andersson & Cuijpers, 2009; Cuijpers, Donker, et al., 2011; Johansson & Andersson, 2012). When comparing guided self-help to face-to-face psychotherapy, there is evidence for equal efficacy, at least for mild to moderate depression and anxiety disorders (Cuijpers, Donker, van Straten, Li, & Andersson, 2010).

An absolute majority of guided self-help treatments have been based on CBT. Most of these have been carried out through the Internet. Hence, Internet-based CBT (ICBT) and guided self-help treatments are often used synonymously. ICBT have been shown to be effective for a range of conditions including depression, anxiety disorders and somatic problems such as chronic pain and tinnitus (Andersson, 2009; Hedman et al., 2012; Johansson & Andersson, 2012).

5.3 Psychodynamic psychotherapy as guided self-help

As described above, one way of conducting Internet-delivered psychotherapy is to provide self-help text through the Internet and complement it with text-based therapist support (e.g. via e-mail). The fact that psychodynamic self-help books were available raised the question whether psychodynamic psychotherapy could be conducted in the format of guided self-help. Examples of psychodynamic self-help books are 'Make the Leap' by Farrell Silverberg (2005), 'Living Like You Mean It' by Ronald J. Frederick (2009), 'Unlearn Your Pain' by Schubiner and Betzold (2012), and 'Think Like a Shrink' by Zois and Fogarty (1993).

This thesis includes two studies that are based on the two of the books just mentioned. The book 'Make the Leap' has also been used

as a treatment manual in a study testing the efficacy of a psychodynamic guided self-help intervention in the treatment of GAD (Andersson, Paxling, Roch-Norlund, et al., 2012).

5.4 The therapeutic relationship in ICBT

It is a widely accepted fact in psychotherapy research that the therapeutic relationship is an important factor in relation to outcome. The therapeutic relationship has been defined as an emotional bond between therapist and client, and is typically characterized by warmth, trust and empathy, and agreement on the goals and tasks of the treatment (Bordin, 1994). Various psychotherapeutic models emphasize the relationship differently. In psychodynamic psychotherapy, the transference (and thereby the therapeutic relationship) tend to be regarded as a primary source of understanding and therapeutic change (Leichsenring & Leibing, 2007). This perspective is considered true, for example, in Supportive-Expressive therapy (Luborsky, 1984) and Davanloo's ISTDP (Davanloo, 1990, 2000). Importantly, the therapeutic relationship is also considered important in CBT (O'Donohue & Fisher, 2012). In the words of Chambless and Ollendick (2001) regarding empirically supported treatments (ESTs) in general: "it is important to note that the effective practice of evidence-based psychotherapy involves more than the mastery of specific procedures outlined in EST manuals. Almost all ESTs rely on therapists' having good nonspecific therapy skills." (p. 712).

The therapeutic relationship is also present in ICBT. Several studies show evidence of how this relationship also develops in guided self-help treatments as in the form of a working alliance (Andersson, Paxling, Wiwe, et al., 2012; Cavanagh & Millings, 2013). Importantly though, a majority of studies investigating this association does not demonstrate any associations between the therapeutic relationship and treatment outcome (Andersson, Paxling, Wiwe, et al., 2012; Cavanagh & Millings, 2013). A recent exception is the study by Bergman Nordgren, Carlbring, Linna, and Andersson (2013) regarding individ-

ually tailored ICBT for anxiety disorders. The authors found that the working alliance with the therapist at week 3 correlated significantly with improvements on the primary outcome measure. Further research can illuminate how the therapeutic relationship is characterized in ICBT, and if any aspects of it are related to outcome.

Interestingly, the study by Richardson, Richards, and Barkham (2010) investigated aspects of the therapeutic relationship in self-help books. The authors argue that several so-called 'common factors' of the therapeutic relationship can be made available in texts, for example 'Generating belief in recovery' (e.g. by providing facts about how many people have successfully recovered from depression by reading the text), 'Empathy, warmth and genuineness' (e.g. writing in a style that conveys to the reader that the author understands what it is like to be depressed) and 'Guidance' (e.g. providing advice on how to handle aspects of depression in a certain situation). Further illustrations of aspects of the therapeutic relationship in self-help text can be found elsewhere (Richardson et al., 2010; Richardson & Richards, 2006).

5.5 Addressing comorbidity in ICBT

As described above, there are multiple approaches to addressing comorbidity in CBT. One example is to tailor an individual treatment plan based on evidence-based components. This approach has been used in several studies in guided self-help research. Tailoring has been carried out by using a 'prescribed' treatment plan. The first example of this was a study (Enström & Jonsson, 2008) for women diagnosed with breast cancer, who were treated for secondary (i.e. comorbid) problems of depression and anxiety. Results from that study indicated a moderate to large effect on symptoms of depression and anxiety (Enström & Jonsson, 2008). The second ICBT study to use this approach was a study testing the efficacy of 10-week tailored treatment in the treatment of mixed anxiety disorders (Carlbring et al., 2011). That treatment was compared to an active control group in the form

of a moderated discussion group. Mean treatment effect at post-treatment was $d = 0.69$ between conditions. A final example of tailored ICBT is the study by Silfvernagel et al. (2012) that tested a tailored treatment for young adults and adults with panic attacks. In that study, treatment effects were large when compared to waiting-list. In summary, tailored ICBT seems promising as a mean to address comorbidity.

Transdiagnostic ICBT treatments are available. The first example of a transdiagnostic ICBT was a treatment targeting anxiety disorders (Titov, Andrews, Johnston, Robinson, & Spence, 2010). A subsequent attempt from the same group was a similar treatment that in addition to anxiety disorders targeted depression. Both treatments were shown to be effective. This protocol has also been tested as a brief treatment (Dear et al., 2011) and, as mentioned above, a self-guided treatment with automated e-mail reminders (Titov et al., 2013).

The Australian group that developed the transdiagnostic treatment also conducted a re-analysis of the three trials with the transdiagnostic protocol for participants with GAD, social phobia and panic disorder (Johnston, Titov, Andrews, Dear, & Spence, 2013). The authors found that participants with comorbidity had greater reductions on measures of GAD, panic disorder, social anxiety, depression and neuroticism, when compared to participants with a single diagnosis. In addition, the transdiagnostic treatments significantly reduced the number of comorbid diagnoses. Hence, transdiagnostic ICBT seem promising in reducing comorbidity.

5.6 Using guided self-help to accelerate psychotherapy research

Close to 15 years of research has established the fact that cognitive behavior therapy can be delivered in the format of guided self-help via the Internet. These findings have implications for psychotherapy research as a whole. For example, new treatment protocols can be developed and tested in guided self-help format through the Internet

before implementing them as validated face-to-face treatments. With a national (or even international) recruitment, a large-scale randomized controlled trial can be conducted in 8 to 12 weeks. This format allows for cycles of testing in randomized trials and revision of protocols, for example, in the form of dismantling studies. In addition, psychotherapy process research can be accelerated by including various process measures in the treatment studies described. An example of a psychotherapeutic approach where the entire evidence base is derived from Internet-based treatment studies is a series of trials testing the efficacy (and effectiveness) of exposure-based cognitive behavior therapy for irritable bowel syndrome (IBS; Ljótsson et al., 2010, 2011). Recent research has confirmed that changes in IBS symptoms are mediated by a change in gastrointestinal symptom-specific anxiety. The latter has been shown to be an active mechanism in ICBT for IBS (Ljótsson et al., 2013).

The arguments above apply also to research concerning psychodynamic psychotherapy. If an implementation of a psychodynamic treatment manual to self-help format is considered valid, then we would have no reason to assume that the manual would perform worse in a face-to-face setting, at least not for most Axis-I diagnoses. Hence, psychodynamic psychotherapy in the format of guided self-help could potentially accelerate the development in the field of dynamic psychotherapy research.

6 Aims with the thesis

The course of this thesis changed over time. Initially, the overall aims were to develop and evaluate various aspects of individually tailored ICBT for depression and its comorbidity. Then, I changed my pursuit to develop and evaluate Internet-delivered psychodynamic treatment protocols. However, the overall aims have always been about broadening and enhancing Internet-based psychological treatments for depression. In particular, the aims of the thesis have been:

- Provide an up-to-date estimate of the prevalence of depression, anxiety and their comorbidity in Sweden (Study I)
- Develop a tailored version of ICBT that address depression and its comorbidity, and evaluate its efficacy (Study II)
- Develop a psychodynamic treatment protocol for depression and evaluate its efficacy (Study III)
- Develop an affect-focused psychodynamic treatment protocol that address depression and its comorbidity and evaluate its efficacy (Study IV)

7 The empirical studies

First, the common elements of the studies are presented. Then, each study is presented with details on participants, design, analysis, results, and methodological considerations.

7.1 Measures

The outcome measures used in the empirical studies are presented below. Details of the measures and psychometric properties can be found in the reference to each measure. Online assessment has been shown to be reliable and produces results very similar to traditional paper-and-pencil administration for various measures of depression and anxiety disorders (Carlbring et al., 2007; Holländare, Andersson, & Engström, 2010). The diagnostic interviews and assessment of global improvement were conducted by telephone.

7.1.1 Measures of depression

The 9-item Patient Health Questionnaire Depression Scale (PHQ-9; Kroenke, Spitzer, & Williams, 2001) is an established measure of depression. It can be used either with a diagnostic algorithm to make a probable diagnosis of depression or as a continuous measure with scores ranging from 0 to 27 and cutpoints of 5, 10, 15 and 20 representing mild, moderate, moderately severe and severe levels of depressive symptoms. To set a diagnosis using the algorithm, five out of nine must be present “more than half the days”, and one of the first two symptoms (depressed mood or loss of interest) must be present. In

Study I, the PHQ-9 was used with the algorithm to set a diagnosis of major depression. In that study, the PHQ-9 was also used to define 'clinically significant depression' as having a PHQ-9 score of 10 or higher. The PHQ-9 was also used as the primary outcome measure of depression in Study IV.

The Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996) could very well be the most common measure of depression in the world. It was used as the primary outcome measure in Study II and III. In addition, the Montgomery Åsberg Depression Rating Scale – Self report (MADRS-S; Svanborg & Åsberg, 1994) was used in Study II and III as a secondary measure of depression.

7.1.2 Measures of anxiety

The 7-item Patient Health Questionnaire Generalized Anxiety Disorder Scale (GAD-7; Spitzer, Kroenke, Williams, & Löwe, 2006) was used in Study I to provide an estimate of the prevalence of general anxiety in the Swedish community. 'Clinically significant anxiety' was defined as having a GAD-7 score of 8 or higher. In Study IV, the GAD-7 was used as the primary outcome measure of anxiety and in Study III, it was used as a secondary outcome measure.

The Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988) is a common measure of anxiety. It was used as an outcome measure of anxiety in Study II and III. Finally, the Generalized Anxiety Disorder Questionnaire-IV (GAD-Q-IV; Newman, Zuellig, & Kachin, 2002) was used in Study I to get an estimate of the prevalence of generalized anxiety disorder. The established cutoff of 5.7 points on the GAD-Q-IV was used to detect the presence of GAD.

7.1.3 Measures of general pathology and quality of life

All treatment studies (Study II, III and IV) used diagnostic interviews to assess the presence of psychiatric diagnoses at baseline. In Study II, the research version of the Structured Clinical Interview for DSM-IV - Axis I disorders (SCID-I; First, Gibbon, Spitzer, & Williams, 1997)

was used and in Studies III and IV, the MINI International Neuropsychiatric Interview (Sheehan et al., 1998) was used. Studies II, III and IV did also include the CGI-I (Guy, 1976) as a global measure of improvement from baseline to post-treatment and to follow-up.

To assess health-related quality of life in the general population (Study I), the EuroQol (EQ-5D; EuroQol Group, 1990) was used. General quality of life was also measured in Studies II and III, in which the Quality of Life Inventory (QoLI; Frisch, Cornell, Villanueva, & Retzlaff, 1992) was included.

7.1.4 Measures of treatment process variables

During treatment in Study IV, two processes that were assumed to be relevant were measured. The Emotional Processing Scale (EPS-25; Baker et al., 2010) was used to assess emotional processing deficits and the process of emotional change during treatment. In addition, the Swedish 29-item version (Lilja et al., 2011) of the Five Facets of Mindfulness Questionnaire (FFMQ; Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006) was included to measure the influence of general mindfulness skills.

7.2 Guided self-help

Studies II, III and IV used guided self-help as the mode of delivery for the treatments. A secure treatment platform was used, in which the participants could download the treatment material and communicate with their therapist. In all treatment studies, the material was presented as downloadable PDF files. Study III and IV did also present the same material through browsable web pages.

All treatment material was divided into treatment modules that included roughly one week of therapeutic work. The participants had an assigned online therapist. To progress through treatment, participants had to report that they had worked through a treatment step in order to gain access to the next module.

7.3 Inclusion criteria in the treatment studies

In Study II-IV, participants were recruited through self-referral. The following inclusion criteria were common: a) Reported unchanged dosage of medication for depression and anxiety during the last three months, b) no concurrent psychotherapy (some concurrent supportive interventions were allowed), c) no severe psychiatric condition that could interfere with the treatment (e.g. bipolar disorder or schizophrenia), d) being at least 18 years of age.

Study II and III also had the criteria of having a diagnosis of major depressive disorder according to the DSM-IV, with a current acute episode of depression or an episode in partial remission. In Study II, only participants with MADRS-S scores in the range of 15-35 were included. For Study III, the same lower limit on the MADRS-S was used, but there was no upper limit.

Study IV used the following diagnostic inclusion criteria: At least one of the following Axis-I diagnoses, specified by DSM-IV criteria: major depressive disorder, social anxiety disorder, panic disorder, generalized anxiety disorder, depressive and/or anxiety disorder not otherwise specified. In addition, a participant had to have a raw score of at least 10 on either the PHQ-9 or the GAD-7 to be included.

7.4 Data analyses

In Study II, III and IV, mixed-effects models for repeated-measures data, fitted with maximum likelihood estimation, were used for all continuous outcomes (Verbeke & Molenberghs, 2000). Mixed models takes into account all available data from all randomized participants, making it a full intention-to-treat analysis, provides unbiased estimates in the presence of missing data under a fairly unrestrictive missing assumption (i.e., missing at random), and adequately handles nested data structures inherent in repeated-measures data (Gueorguieva & Krystal, 2004; Mallinckrodt, Clark, & David, 2001). All models included random intercepts, with group, linear time and their interaction included as fixed predictors. For each of the continuous

outcome measures, differences in efficacy between groups were investigated by examining the fixed interaction term of group and linear time.

Recovery after treatment and at follow-up was investigated in the treatment studies. In Study II and III, recovery was defined as having a BDI-II score of 10 or less. In Study IV, treatment recovery was defined as having a score less than 10 on both the PHQ-9 and the GAD-7, and not fulfilling criteria for any DSM-IV diagnosis. To compare the proportion of participants who recovered, χ^2 -tests were used.

7.5 Study I

7.5.1 Context and aims

Twelve-month prevalence estimates of mood and anxiety range from 6.6% to 11.9% and 5.6% to 18.1% across surveys from Europe, Australia and the US (Baumeister & Härter, 2007). In Sweden in 1957, the point prevalence of depression was estimated to be 4.7%, based on data from the total population ($n = 2612$) of Lundby, a small rural area in southern Sweden (Rorsman et al., 1990). Using the national Swedish Twin Registry, lifetime prevalence for depression was estimated to be 13.2% among men and 25.1% among women (Kendler et al., 2006). In the Lundby study, lifetime prevalence for depression was 27% among men and 45% among women, when participants were followed from 1957 up to 1972 (Rorsman et al., 1990). Importantly, the Lundby study did not use DSM criteria for major depression, which makes comparisons to prevalence rates from other countries complicated (Rorsman et al., 1990). To my knowledge, there exist no up-to-date point estimates of DSM-IV depression from the Swedish general population.

The aim of the first study was to investigate the point prevalence of depression, anxiety disorders and their comorbidity in the Swedish general population. The impact of disorders and comorbidity on health-related quality of life was also investigated.

7.5.2 Participants

The data collection for Study I was done in the autumn of 2009. The questionnaires were sent out by surface mail. A total of 3001 participants aged 18–70 years were randomly selected from the Swedish population and address register (SPAR). The response rate was 44.3% after two reminders. Among those who responded, mean age was 46.2 years ($SD = 14.5$) and 745 participants (56.1%) were female. Fifty-two percent had post-secondary education.

7.5.3 Assessments

The study included measures of depression, anxiety and health-related quality of life. Depression was measured using the PHQ-9. The GAD-7 was used to measure anxiety in general and the GAD-Q-IV was used to have a specific measure of generalized anxiety disorder. For health-related quality of life, the EQ-5D was used.

'Clinically significant depression' was defined as having a score of 10 or more on the PHQ-9. Similarly, 'clinically significant anxiety' was defined as having 8 or more on the GAD-7. The cutoffs were chosen to have the optimal balance between sensitivity and specificity (Kroenke et al., 2001; Kroenke, Spitzer, Williams, Monahan, & Löwe, 2007). These definitions were not aimed to be equal to DSM diagnoses. Instead, the aim was to estimate the amount of people with conditions with symptoms of depression and anxiety, with a significant suffering. To have a measure of the DSM-IV diagnosis of major depressive disorder an established diagnostic algorithm for the PHQ-9 was used. For generalized anxiety disorder, a participant was classified to have the disorder if having more than 5.7 on the GAD-Q-IV. This is an established cutoff for optimizing sensitivity and specificity.

7.5.4 Results

We found that 17.2% of participants had any of depressive problems or anxiety, with 10.8% having clinically significant depression and 14.7% had clinically significant anxiety. Of those with any disorder,

48.3% had comorbid depression and anxiety. Among those with clinically significant depression, 76.9% had comorbid anxiety. For individuals with anxiety, 56.5% had comorbid depression. The point prevalence for major depression was 5.2% and 8.8% fulfilled criteria of GAD.

There were, generally, significant gender differences, with more women having a disorder compared to men. Among those with depression or anxiety, only between half and two thirds had any treatment experience. Comorbidity was associated with higher symptom severity and lower health-related quality of life.

7.5.5 Methodological considerations

The response rate was 44.3%. This is considered a limitation with the study as it could possibly have biased the results. Research on epidemiological methods in psychiatry suggest that individuals with mental illness might be more reluctant than others to participate in mental health surveys (Allgulander, 1989; Eaton, Anthony, Tepper, & Dryman, 1992). Hence, the prevalence estimates of depression and anxiety disorders in this study would be underestimated, if biased.

The use of self-report measures instead of diagnostic interviews is also considered a limitation. Importantly though, this enabled us to conduct a national survey with a relatively small cost.

7.6 Study II

7.6.1 Context and aims

Our group had developed a treatment protocol for depression, that had been proven to be effective in two published randomized controlled trials (Andersson et al., 2005; Vernmark et al., 2010). The group had also developed ICBT treatments for anxiety disorders that were tailored after individuals' unique symptom profile. Based on the group's experience in those projects, the idea was born to use a tai-

lored approach to treat patients with depression and comorbid anxiety.

The aim of the second study was to compare the efficacy of the tailored ICBT intervention to the previously evaluated protocol, and also to a control group in the form of a moderated discussion group.

7.6.2 Treatments

The overall principle of the tailored treatment was that each patient got an individualized treatment plan that lasted for 10 weeks. This prescribed plan was primarily based on the diagnostic interview and included a set of modules and a plan for how to work each week. A majority of participants in Study II got 10 modules prescribed for the 10 weeks. All prescribed plans included one introductory module and two modules based on general cognitive restructuring. In addition, all participants got the same concluding chapter. A description of the rest of the modules follows.

The material included modules to target panic symptoms (2 modules), agoraphobia (1 module), social anxiety (2 modules), generalized anxiety and worrying (3 modules), pain (2 modules), traumatic experiences (2 modules), stress (1 module), and insomnia (1 module). In addition, there were modules about behavioral activation (2 modules), assertiveness training (1 module), applied relaxation (1 module), mindfulness (1 module), focus and concentration (1 module), and problem solving (1 module). In all, there were 25 chapters from where 21 were used to create individualized treatment plans. All modules were based on CBT principles and included homework.

The standardized treatment consisted of eight modules, containing introduction (2 modules), behavioral activation (2 modules), cognitive restructuring (1 module), sleep management (1 module), general health advice (1 module) and relapse prevention (1 module). All modules were based on CBT principles and included homework. Even though the treatment contained eight chapters, it lasted for 10 weeks. Hence, participants stayed in contact with the therapists for all 10 weeks and could work with some chapters longer than a week and

still finish in time.

7.6.3 Participants

All participants were recruited through self-referral and had a diagnosis of major depressive disorder according to the DSM-IV, with a current acute episode of depression or an episode in partial remission. The diagnosis was established using the research version of the Structured Clinical Interview for DSM-IV axis-I disorders (First et al., 1997). Of the 255 who reported interest to the study, 121 was randomized to either tailored ICBT ($n = 39$), standardized ICBT ($n = 40$) and control group ($n = 42$). The sample included 86 women (71.1%) and 35 men (28.9%), and the mean age was 44.7 years ($SD = 12.1$). Fifty-two percent of the participants had a completed degree from college/university.

7.6.4 Assessments

The study included the SCID-I (research version) and the CGI-I as clinician-administered measures of general pathology. Self-report measures were the BDI-II, MADRS-S, BAI and the QOLI. All assessments were conducted at pre-treatment, post-treatment and at 6-month follow-up.

7.6.5 Subgroups

Participants were classified into either higher or lower severity of depression. These classes were formed based on median baseline scores on the BDI-II. Participants with an initial depression score of BDI-II > 24 ($n = 60$) were classified as higher severity and those with BDI-II < 25 ($n = 61$) as lower severity. The mean number of comorbid problems was higher in the high severity group ($M=2.32$ compared to $M=1.39$; $t(119) = 5.44$, $p < .001$). Comorbid anxiety disorders were more prevalent in the high severity group (all χ^2 's > 6.19 and all p 's < 0.05). There were also significant differences on all outcome measures between the two classes (all t 's > 4.68 and all p 's $< .001$).

7.6.6 Results

Mixed-effect model analyses revealed a close to significant interaction effect of group and time on the BDI-II, when comparing the tailored ICBT treatment to standardized ICBT from pre-treatment to follow-up, $F(1, 274.5) = 3.48$, $p = .063$. Effect sizes (Cohen's d) on all continuous outcome measures between ICBT's at post-treatment and follow-up were in the range $d = 0.19$ to 0.39 , but we failed to reveal any significant interaction effects of group and time. Recovery rates at post-treatment and at follow-up were 44.4% (at both time points) for the tailored treatment and 29.7% and 40.5% for the standardized treatment. The differences were not significant. However, both the tailored and the standardized treatment were significantly more effective than control on all measures at post-treatment, with effect sizes in the range $d = 0.25$ to 0.84 . The results were maintained at the 6-month follow-up.

Subgroup analyses showed that the tailored treatment was more effective than the standardized treatment among participants with higher levels of depression and more comorbidity at baseline, both in terms of reduction of depressive symptoms and on recovery rates. In the subgroup with lower baseline scores of depression, few differences were seen between treatments and the discussion group.

7.6.7 Methodological considerations

The study was underpowered to detect differences between ICBT treatments. This implies that even if the tailored treatment indeed was more effective than the standardized, this finding could not be demonstrated with statistical certainty. As the study targeted depression and its comorbidity, it would have been optimal to measure comorbidity more than was actually done. The BAI probably does not capture all comorbidity in the sample. Furthermore, the subgroup analyses were conducted post-hoc and should be interpreted carefully. Finally, the use of self-referral may limit generalizability to other clinical settings.

7.7 Study III

7.7.1 Context and aims

During the same time period as Study II was developed, a psychodynamic self-help book was translated into a manual for use in guided self-help treatments. That manual was developed for GAD. The study that was subsequently conducted is published in Andersson, Paxling, Roch-Norlund, et al. (2012). It was known that short-term psychodynamic therapy had some evidence for treating depression (Driessen et al., 2010). Personally, I had an interest in different systems of psychotherapy and was intrigued by the question of whether a psychodynamic treatment in self-help format could be effective for a similar group of patients as those that I had worked with previously in Study II.

The aim of the third study was to compare the efficacy of the psychodynamic guided self-help treatment to a control condition in the form of a structured support treatment (psychoeducation + online support from a therapist).

7.7.2 Treatment and therapists

The psychodynamic treatment used in Study III was based on the book 'Make the Leap' (Silverberg, 2005), which was translated into Swedish and adapted to the guided self-help format. 'Make the Leap' is a psychodynamic manual in self-help format. In the manual, the reader is guided through a program called SUBGAP, which stands for 1) Seeing unconscious patterns that contribute to emotional difficulties, 2) Understanding these patterns, 3) Breaking such unhelpful patterns, and 4) Guarding Against Patterns and/or relapses in the future.

Briefly, the treatment modules covered 1) Introduction to the treatment in general and to the SUBGAP method in particular; 2) Systematic practice in discovering one's own unconscious patterns; 3) Understanding patterns from a historical perspective as well as a here-and-now perspective; 4) Different methods that can be used to break

the patterns that one discovers; 5) Minimizing the risk of falling back into one's old and unproductive patterns; 6) Applying the knowledge one gains about patterns with a focus on solving the dilemmas of working life; 7) Applying knowledge about patterns with a focus on improving personal relationships; 8) The relationship between unconscious patterns and depression, and; 9) Summary of the treatment and guidelines for the future. The main adaptations to the text regarded the eighth module, which was a completely new module. That module presented gave several examples of unconscious patterns in the lives of depressed individuals. These examples included unresolved grief, guilt about feelings of anger towards close ones, and a constant feeling of not being seen by other people. In total, the treatment consisted of 167 pages of text. Participants were given gradual access to the self-help modules and had continuous online support from a therapist using a secure online messaging system, similar to encrypted e-mail. Each module ended with a series of discussion themes about which the participants were encouraged to write and send such writings to the therapist. The main focus for the therapists was to guide the participants through the self-help program by giving feedback and encouragement in response to the weekly communications.

Therapists were six final-semester students from a five-year M.Sc. clinical psychologist program. Feedback was given as soon as possible, often within 24 hours. Except for the weekly online treatment contacts and diagnostic procedures, no other contact took place between therapists and participants. Supervision was provided by an experienced, psychodynamic oriented psychotherapist, who had previous experience with the treatment manual. Typically, supervision consisted of examination of specific online interactions as well as more general therapeutic issues.

7.7.3 Participants

The participants were recruited through self-referral and did all have a diagnosis of major depressive disorder according to the DSM-IV, with a current acute episode of depression or an episode in partial re-

mission. The diagnosis of depression was established using the MINI Neuropsychiatric Interview (Sheehan et al., 1998). Of the 135 who reported interest to the study, 121 was randomized to either psychodynamic treatment ($n = 46$) or to the control group ($n = 46$). The sample included 69 women (75.0%) and 23 men (25.0%), and the mean age was 45.6 years ($SD = 14.1$). Among the participants, 67.4% had a completed university degree from an education that was at least three years.

7.7.4 Assessments

The study included the MINI diagnostic interview to assess psychiatric diagnoses. Self-report measures were the BDI-II, MADRS-S, BAI, PHQ-9, GAD-7 and the QOLI. The BDI-II was given weekly during treatment. All assessments were conducted at pre-treatment, post-treatment and at a 10-month follow-up. In addition, the CGI-I was conducted at post-treatment and at follow-up.

7.7.5 Results

The mixed-effects model analyses showed a significant interaction effect of group and time on the BDI-II ($F(1, 109.8) = 37.2, p < .001$), indicating that the psychodynamic treatment was more effective than the control condition. The effect size between treatment and control at post-treatment was large ($d = 1.11$). Significantly more participants recovered (having a BDI-II score of 10 or less) after treatment in the psychodynamic treatment group than in the control group, 34.8% compared to 8.7%. At the 10-month follow-up this figure was 54.3% in the treatment group.

On secondary measures, there were significant interaction effects of group and time on the MADRS-S, PHQ-9, and the GAD-7, indicating superior efficacy after treatment compared to the control condition (all F 's > 6.9 , all p 's $< .05$). For the BAI and the QoLI, the interaction effects were close to significant (both F 's > 3.0 , both p 's $< .084$).

7.7.6 Methodological considerations

Study III tested the efficacy of a psychodynamic manual presented in self-help format. Some aspects of psychodynamic psychotherapy (e.g. the use of the transference) may not be possible to implement in self-help format, and hence the use of the word 'psychodynamic' to describe the treatment could be questioned. This matter is discussed further in the general discussion of this thesis. A further consideration includes the fact that a large number of participants had college- or university level education. This variable might bias generalizability of the results, since it is possible that guided self-help is especially well suited for educated clients. Furthermore, the lack of blinding in the post-treatment interviews may have biased the results.

7.8 Study IV

7.8.1 Context and aims

After completing Study III, I was impressed by the efficacy of the treatment tested. Clearly there was potential in the field of Internet-based psychodynamic psychotherapy. I found the book 'Living Like You Mean It' (Frederick, 2009) and was fascinated by the clarity of the text, its strong focus on techniques and that the book was so clearly grounded in the field of affect-focused psychodynamic therapy/experiential dynamic therapy, particularly in the affect phobia treatment model by McCullough et al. (2003). I saw the potential for a guided self-help treatment that could address several disorders at once (i.e. a transdiagnostic treatment).

The aim of Study IV was to compare the efficacy of the psychodynamic guided self-help treatment to a control condition (waiting-list with online support).

7.8.2 Treatment

The treatment modules were based on the book 'Living Like You

Mean It' by Ronald J. Frederick (2009) which follows a similar structure as the original affect phobia treatment manual. Throughout treatment, participants were taught how to practice 'emotional mindfulness' as a way of identifying, attending to, and being present with emotional experience. The treatment aimed to teach clients to gradually develop mindful presence as a response to the physical manifestation of emotions which, within the APT model, can be considered as exposure to one's feelings. Throughout the treatment, the affect phobia model as illustrated by Malan's triangle of conflict (Malan, 1995) was presented to illustrate the function of interventions and to clarify patient case stories. This approach included techniques to identify and relinquish maladaptive defenses (D), regulate anxiety (A), and approach and experience ward off feelings (F). The final part of the manual contained material on how to make use of experiencing one's core feelings, for example, expressing these feelings in interpersonal contexts. In the APT model, expressing feelings to others is seen as essential to shifting both the sense of self and others (McCullough et al., 2003). All modules contained homework exercises that needed to be completed before proceeding to the next module. The chapter structure of the manual was: (1) Introduction and problem formulation using the affect phobia model; (2) Historical understanding and explanation of the problem described; (3) Mindfulness practice to start approaching emotional experience; (4) Defense restructuring; (5) Anxiety regulation techniques; (6) Affect experiencing techniques; (7) Affect expression and self/other restructuring. Further details of the treatment and the manual are in Appendix A of this thesis.

7.8.3 Participants

Participants were recruited through self-referral and all had at least one of the following DSM-IV diagnoses: Major depressive disorder, social anxiety disorder, panic disorder, generalized anxiety disorder, depressive and/or anxiety disorder not otherwise specified. In addition, all participants had a baseline score of at least 10 on either the PHQ-9 or the GAD-7. Diagnoses were established with the MINI

Neuropsychiatric Interview (Sheehan et al., 1998). Of the 201 individuals who responded with interest to the study, 100 were randomized to either affect-focused psychodynamic treatment ($n = 50$) or to the control group ($n = 50$). The sample included 82 women (82.0%) and 18 men (18.0%), and the mean age was 44.9 years ($SD = 13.1$). Fifty-two percent of the participants had a university degree from an education of three years or longer.

7.8.4 Assessments

The MINI diagnostic interview was included to assess psychiatric diagnoses. The PHQ-9, GAD-7, EPS-25 and the FFMQ (Swedish 29 item-version) were given weekly during treatment and at a 7-month follow-up. In addition, the CGI-I was conducted at post-treatment and at follow-up.

7.8.5 Results

Mixed models analyses using the full intention-to-treat sample revealed significant interaction effects of group and time on all outcome measures, when comparing the psychodynamic treatment to the control group. A large between-group effect size of $d = 0.77$ was found on the PHQ-9 and a moderately large between-group effect, $d = 0.48$, was found on the GAD-7. The number of patients who recovered (had no diagnoses of depression and anxiety, and had less than 10 on both the PHQ-9 and the GAD-7) were at post-treatment significantly more in the treatment group compared to the control group, 52% compared to 24%. Treatment gains were maintained to the follow-up.

7.8.6 Methodological considerations

There was an explicit aim to maximize quality in Study IV, for example by using therapists who had a training in affect-focused psychodynamic psychotherapy, having the author of the treatment protocol as supervisor throughout the treatment, and by using blind assessors of outcome. Despite this aim, some limitations from Study II and III do

also apply to Study IV. Limitations include, for example, the fact that a large proportion of the participants had a university degree. This variable might have biased generalizability.

8 General discussion

This thesis is about broadening and enhancing Internet-delivered psychological treatments in the service of treating depression and its comorbidity. In this thesis I have described how we moved from individualized Internet-delivered cognitive behavior therapy to affect-focused psychodynamic psychotherapy. Below, I will discuss these studies further.

8.1 Prevalence of depression, anxiety and their comorbidity

In Study I, it was estimated that 17.2% of the Swedish general population suffer from problems related to depression and anxiety. These conditions are undertreated and are associated with lower health-related quality of life. Comorbidity between depression and anxiety was common and was associated with even worse quality of life. This association was measured using established self-report measures enabling us to sample a subset of the Swedish general population at low cost. A limitation of the study is the response rate of 44.3% which might have biased the results. If that is the case, the true prevalence rates are likely to have been underestimated. A further limitation is the use of self-report measures instead of diagnostic interviews. While the latter approach might have given us more accurate estimates of DSM-IV diagnoses of depression and anxiety disorders, I still believe that we have captured something important. I believe that people who score above established cutoffs of the PHQ-9 or the GAD-7, do indeed have significant suffering due to their psychiatric condition.

8.2 Psychotherapy through the Internet

Studies II, III and IV were all randomized controlled trials that investigated the efficacy of Internet-delivered psychotherapy in the format of guided self-help. Over 300 individuals participated in these studies. The studies were of high quality in general as they were RCTs, used diagnostic interviews to determine inclusion criteria, followed a specified treatment manual, therapists were given supervision throughout treatment, data were analyzed with intention-to-treat analyses, and randomization was done by people not involved in the research projects. Except for Study III, diagnostic interviewers at post-treatment were blind to allocation. Study III and IV were adequately powered. In Study IV, additional quality was obtained as the therapists were explicitly trained in the specific form of treatment and had supervision from the author of the treatment manual.

However, the studies still have limitations. All studies had psychologist students as assessors and therapists. This variable might have affected accuracy of psychiatric assessment and the efficacy of the treatments. I do not doubt that the treatments were effective in comparison to the control conditions. However, I acknowledge that the kind of therapies tested in the three trials could have been something *different* than if experienced psychologists or psychotherapists had conducted the treatments. To clarify, I believe that one possible role a therapist could have via the Internet is to coach the patient through the material. If one assume that the self-help treatment contains all working mechanisms, then a therapist in this case is more of a coach, and could also follow a pre-specified flowchart for this activity. However, another possible role of the therapist is to use the treatment material as their 'extended arm'. In that case, the therapeutic relationship is the central vehicle and the self-help material is a mean to achieve therapeutic change. Differences might be subtle, but I believe that in the latter case, the knowledge of an experienced psychotherapist could possibly be of more use. I can only speculate on this, but the kind of therapy conducted in the three trials might have been more of the former role described and in the hands of experienced

therapists, it could possibly have been more of the latter.

The fact that no aspects of the therapeutic relationship were measured in any of the studies could be seen as a limitation as it might have enabled us to draw conclusions on the nature of the relationship in the treatment studies. Also, as mentioned previously, a further limitation in all of the studies was that a large amount of patients had a university degree.

8.3 Tailored Internet-delivered cognitive behavior therapy

In Study II, a tailored ICBT protocol for depression and comorbidity was compared both to a standardized protocol for depression and to a control group. The size of the effect sizes indicated a small advantage of tailored ICBT over standardized ICBT on the primary outcome measure BDI-II ($d = 1.48$ compared to $d = 0.98$). However, no significant differences between the treatment groups were found on any outcome measure. Post-hoc subgroup analyses found that tailored ICBT indeed was more effective (on measures of depression) than the standardized treatment for participants that was classified as 'high severity' (having a baseline BDI-II score of > 24). For patients with a pre-treatment score of BDI-II < 25 , there were no differences between tailored ICBT, standardized ICBT or the active control group.

The major limitation in Study II is that it was seriously underpowered. If the study would have been done today, we might have been better off by choosing between testing the efficacy of the tailored ICBT compared to control *or* to the standardized ICBT. I would have chosen the latter today, as we had few reasons to believe that the tailored protocol would perform worse than previous ICBT treatments for depression. That is, to provide the best answer to the question if tailoring is a way of enhancing ICBT, we could have tested that with an equally large sample split over two groups instead of three. Furthermore, we failed to measure comorbidity in the study. We found no indications that tailored ICBT is more effective than standardized

ICBT in reducing symptoms as measured by the BAI. Likely, the BAI does not capture the comorbidity to depression in this sample of participants.

Still, I believe that tailored ICBT may have a place in the future. For clinicians who work with patients with depression and anxiety disorders, it may simply be more practical to use tailoring than to make a patient go through several separate protocols.

8.4 Psychodynamic psychotherapy through the Internet

Study III and IV both showed that psychodynamic psychotherapy in the form of guided self-help delivered through the Internet is effective in the treatment of depression.

8.4.1 The first Internet-based psychodynamic treatment for depression

A central concept in the first of the two dynamic studies was that of *patterns*. As described above, the rationale for the whole treatment was that psychopathology was a consequence of the use of unproductive patterns of behavior in daily life. For example, as in the case of depression, negative thoughts about oneself can be a consequence of a pattern in life of 'pushing oneself past one's healthy limits' (see Silverberg (2005) pages 63-69 for a thorough example of this). The manual used in Study III was written by a psychoanalytic therapist who claims that the material presented in the manual captured large parts of typical psychodynamic therapy. However, after the trial was completed, I encountered a lot of different reactions to our work. One question I met was "Is this really a psychodynamic treatment?". I will discuss this question below.

8.4.2 Is Study III psychodynamic?

From a theoretical perspective, it is indeed an interesting question

whether the SUBGAP treatment can be called psychodynamic. To try to answer this question, I quote Barber, Muran, McCarthy, and Keefe (2013) in how dynamic therapy can be described: “[Psychodynamic psychotherapy] can be captured by the following characteristics: focus on unconscious processes; focus on affect, cognitions, wishes, fantasies and interpersonal relationships; lack of traditional homework; relatively less guidance, use of open-ended questions; use of interpretation and clarification; consideration of the transference and countertransference; and use of the therapeutic relationship to increase self-awareness, self-understanding, and exploration.” (p. 444)

The SUBGAP treatment assumes the existence of unconscious processes. Hence, the rationale for the treatment is described as follows (Silverberg, 2005): “Some of our patterns help us in life, and others prevent us from reaching our goals. [...] Our patterns live in the 'unconscious' minds [...] and we become so accustomed to being controlled by our patterns that we cannot notice them unless someone teaches us how to do so. [...] If you are not fulfilling your potential, it is probably because an unproductive pattern in your unconscious mind is getting in the way, sapping your energy, or even taking over entire areas of your life. [...] When you make your patterns 'conscious' and learn to notice them, you can break the unproductive ones by applying a very clear step-by-step, do-it-yourself method. [...] When you break your unproductive patterns [...], you can make the leap to pursuing better opportunities in love, work, school, and anything else.” (p. 9-10).

Furthermore, the SUBGAP treatment specifies that patterns take any form (e.g. affective, cognitive, wishes, fantasies etc.). This perspective is illustrated throughout the treatment. For instance, in the section that describes 'Guarding against patterns' (Silverberg, 2005) the author writes: “[Developing] awareness of thoughts, feelings, and intuitions. You practice maintaining a lightly observing 'third eye' on your thoughts, feelings, and intuitions that can help you tell if you are living in a patterned or unpatterned way.” (p. 188). The interpersonal component is consistently made clear. For example, two separate

chapters (module 6 and 7) are dedicated to 'patterns at work' and 'patterns in relationships'. While not including homework in the classical sense, participants were encouraged to reflect on the material. For example, at the end of the first module, the following question was presented to the participants: "Which areas of life do you think possibly contain hidden patterns that are worth focusing on? That is, in which areas are you constantly having problems and/or noticing that things are not working as they should?". Some participants answered this question in only a few sentences, while other wrote several pages. A majority of questions given were similarly opened and invited participants to reflect on their own situation (and not present a 'correct' answer to questions given). There was also encouragement for the participants to do certain activities. For instance, participants were encouraged to analyze a situation in terms of patterns or try out a strategy to break a certain pattern.

In the paragraph above I have compared the SUBGAP self-help manual to the description of psychodynamic therapy given by Barber et al. (2013). This far in the description, I believe that the psychodynamic principles have been preserved. Barber et al. (2013) also described dynamic therapy to typically contain interpretations, the use of transference/countertransference and the use of the therapeutic relationship to increase self-understanding. Regarding self-understanding, I believe that developing understanding and awareness of the self in relation to others are at the core of the SUBGAP treatment and is a central mechanism of change in this treatment. I believe that clients taking part of SUBGAP develop self-understanding by reading and working with the text material, but also by discussing it with the therapist in a communication similar to e-mail.

In general, the therapists did not make use of the transference. While not prohibited from doing so, the role of the therapist was more of a supportive nature. The role of the therapist in Internet-delivered dynamic therapy is described in detail in Appendix A. Importantly, I do believe that typical patterns of client behavior occurred in the dialogue with the therapist (i.e. transference). However, this piece

was typically not addressed by the therapists. Similarly, there were interactions with clients that involved interpretations (e.g., a therapist pointed out how a pattern seemed evident in various aspect of a client's life). Once again, therapists were not explicitly instructed to do such interventions. Importantly, this does indeed constitute a fundamental difference between the SUBGAP treatment as we tested it, and many forms of psychodynamic psychotherapy.

In summary, I believe that SUBGAP can indeed be described as a psychodynamic treatment, despite the fact that no components from the treatment focused explicitly on the transference. Several other principles of dynamic therapy were included. The therapists worked mostly in a supportive manner. Importantly, I believe that it would be possible and interesting to include expressive interventions in the therapist dialogue. This is a topic for further research.

8.4.3 Is Study III a Supportive-Expressive psychotherapy?

While the SUBGAP treatment was developed on its own, there are similarities and differences to SE therapy that can be discussed. As described above, the treatment consisted of self-help text and therapist support. Supportive elements in the text would for example include creating positive expectancies, patient engagement and hope. The following passage from the first module illustrates this (Silverberg, 2005): “[By taking part in this material] you can learn how to uncover the moments of opportunity and weed out the traps. You can learn a method that shows you what to do to live a more successful and fulfilled life. You may want to learn this system to improve your entire life, or possibly you will want to learn it to improve one particularly clouded area of your life in which you feel your potential is not being met.” (p. 8). Supportive elements from the therapist have been described above and are thoroughly illustrated in Appendix A. Expressive elements in the text were mainly in the form of case examples. Throughout the treatment, various case stories and 'interpretations' on the consequence of their life patterns were presented. The ulti-

mate aim of these case stories was to enhance participants' self-understanding by reading about people's experiences in which they recognized themselves. Also, the questions at the end of the chapter invited further self-understanding. In a way, these questions can be said to invite expressive interventions in self-help format. This invitation can be illustrated by the questions presented at the end of module 7: "Based on what you have read in this module, what patterns can you see that happen for you in close relationships?" and "How are the relationships affected by such patterns?".

Hence, the SUBGAP treatment contained both supportive and expressive elements, both in the text and in the therapeutic relationship. While the treatment may seem similar to SE therapy in its underlying principles, the SUBGAP was never explicitly designed to 'copy' SE therapy. However, I see a possibility in refining the SUBGAP by incorporating elements from SE therapy and CCRT. This addition could for example include work with 'patterns' in more detail, by using the CCRT formulation of relationship patterns in the form 'Wish', 'Response from others' and 'Response from the self'. As mentioned above, I see few obstacles to explore how such core conflictual relational themes could be explored also in the therapist-client relationship in e-mail communication.

8.4.4 The second psychodynamic treatment for depression and anxiety

As mentioned above, Study III was criticized for not being based on a psychodynamic treatment. That was one of the reasons that I became interested in implementing another psychodynamic model for Study IV. One of the reasons for adopting the manual used in Study IV ('Living Like You Mean It') was because of it being so clearly rooted in the affect phobia model. Below I discuss how the second psychodynamic study was different.

8.4.5 Is Study IV psychodynamic?

The treatment used in Study IV is thoroughly described in Appendix A. Once again, the treatment acknowledged unconscious processes by implementing a model that assumed that unconscious (and conscious) feelings generate anxiety and defenses towards that experience. Affect-phobic patterns of everyday life were central to this treatment. One difference between Study III and Study IV was the larger focus on techniques in the latter. Several means to approach emotional experiences, regulate anxiety, and address defenses were presented. As the use of these techniques were assumed central, homework was included to increase the probability that patients worked with the techniques. The treatment also aimed to increase self-understanding which was very much done on an emotional level with the aim of making the patient have corrective emotional experiences (discussed below). The therapeutic relationship was mostly supportive (see Appendix A for a series of examples of therapist-client dialogue) and use of the transference was not standard procedure. As discussed in Appendix A, Affect Phobia Treatment view transference work as a possibility, but not a necessity. Hence, I believe that the treatment used in Study IV is psychodynamic despite inclusion of homework and little focus on the transference. The treatment implemented was close to Affect Phobia Treatment and differed from that model mainly in that it made ample use of self-help techniques instead of expressive work by the therapist.

8.4.6 Corrective emotional experiences in guided self-help

The goal of experiential dynamic therapies is to provide a self-understanding on an emotional level. This aim follows the work by Alexander and French (1946) who established the principle of a corrective emotional experience: “the main therapeutic result of our work is the that, in order to be relieved of his neurotic ways of feeling and acting, the patient must undergo new emotional experiences suited to undo

the morbid effects of the emotional experiences of his earlier life. Other therapeutic factors [...] such as intellectual insight, abreaction, recollection of the past, etc. [...] are all subordinated to this central therapeutic principle" (p. 338). This piece is often described as something happening within the therapeutic relationship (e.g. by Bridges, 2006). Importantly, corrective emotional experiences were described by Alexander and French (1946) as also happening outside of the therapeutic relationship: "Reexperiencing the old, unsettled conflict but with a new ending is the secret of every penetrating therapeutic result. Only the actual experience of a new solution in the transference situation *or in his everyday life* gives the patient the conviction that a new solution is possible and induces him to give up the old neurotic patterns" (p. 338, emphasis added). Furthermore, "In this connection it is important to remember that the patient's new emotional experiences are not confined to the therapeutic situation; outside the treatment he has emotional experiences which profoundly influence him" (p. 339).

These clarifications of the original work by Alexander and French (1946) are important for the work in this thesis. Despite the fact that the therapeutic relationship in guided self-help tends to be more supportive, there is no reason to believe that corrective emotional experiences do not occur. In fact, I have a firm belief that the techniques presented in our Affect Phobia Treatment enable patients to experience their true feelings by themselves, in relation to people in their everyday life and possibly also in relation to the therapist. Hence, I believe that treatment in Study IV is genuinely an experiential dynamic therapy in the sense that it derives from the work of Alexander and French (1946) and assumes similar mechanisms of change.

8.4.7 Mechanisms of change

As described above, I have assumed that a central working mechanism in the two dynamic treatments are self-understanding. In Study III I believe self-understanding takes place on an intellectual level, while in Study IV it is assumed to happen primarily on an emotion level. Fu-

ture research should investigate the validity of these assumptions.

8.5 The future of Internet-delivered psychodynamic therapy

The work presented in this thesis has both scientific and clinical implications for the future. I think personally that Internet-delivered psychodynamic psychotherapy can be further developed following two separate tracks.

First, I would like to see a development where experienced psychotherapists could use our Internet-based treatments as a mean to conduct psychodynamic therapies. This approach would involve adapting the treatments even more closely to current psychodynamic practices, for example, articulating CCRTs even more in the treatments and developing aspects related to the therapeutic relationship. Both the supportive and the expressive components of the latter can be further developed. Maybe the development I propose can be said to be have succeeded if experienced psychodynamic psychotherapists feel that they conduct their work using our treatments as a mean to 'extend their arms' with preserved (or enhanced) competence. I propose that this kind of development could possibly be called a mixture of dynamic therapy in the traditional sense and the guided self-help treatments presented in this thesis.

Second, I would like to see a development of dynamic therapies without a therapist at all. Such work could start by using existing research to enhance current text material by supportive aspects, as proposed by Richardson et al. (2010). Efforts could also be made to include more expressive components. In the age of modern information technology, a text is no longer just something that resides in books. Current technology makes it possible to present a text that is titrated to fit the reader. For example, a system could be constructed that is trained to recognize unique qualities of the reader (e.g., core conflictual themes and symptomatology, but also preferences regarding examples in text) with the aim of presenting a text that the reader

would experience as relevant and in which s/he would recognize himself/herself. As the largest portion of CCRT research has been conducted by analyzing narratives, it is fascinating to think of having a machine or a system that deliver 'interpretations' of core conflictual themes based on text narratives. Technology that could achieve this will probably soon be available for use to enhance psychodynamic self-help treatments.

The transference is indeed a fascinating concept. Both of the branches I propose above for further development of dynamic therapy could involve research on the transference. This research could both be in the form of exploring the transference when experienced dynamic therapists conduct psychodynamic treatments through the Internet, with synchronous and asynchronous communication, and when the client takes part of a therapy without a therapist being involved. Exploring transference aspects in relation to a 'narrator' and case stories presented in text or even in relation to an artificial system is a fascinating thought and such research could very well teach us something about the very nature of being a human.

Hence, there are numerous theoretical and clinical developments possible based on the work of this thesis.

8.6 Conclusions

In this thesis I have provided empirical data of several means of treating depression and its comorbidity using Internet-delivered psychotherapy in the form of guided self-help. I moved from individualized cognitive behavior therapy to two models of psychodynamic psychotherapy. The main conclusion of this development is that psychotherapy through the Internet is not just about CBT. In a way, dynamic therapy brings a new 'color' to the field of Internet-based treatments which my colleagues and I have proved can result in effective treatments. It is now time to explore different mechanisms of change in these treatments with the aim of understanding what brings about change and how treatments can be made more effective.

I end by quoting Alexander and French (1946): *"We believe and hope that our book is only a beginning, that it will encourage a free, experimental spirit which will make use of all that detailed knowledge which has been accumulated in the last fifty years in this vital branch of science, the study of the human personality, to develop modes of psychotherapy ever more saving of time and effort and ever more closely adapted to the great variety of human needs."* (p. 341).

The work presented in this thesis is a continuation of over a hundred years of psychotherapy research and 15 years of research in the field of Internet-based psychological treatments. But, it may also be a beginning of something new.

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10 References

- Abbass, A., & Driessen, E. (2010). The efficacy of short-term psychodynamic psychotherapy for depression: a summary of recent findings. *Acta Psychiatrica Scandinavica*, 121, 398.
- Abbass, A., Joffres, M., & Ogrodniczuk, J. (2009). Intensive short-term dynamic psychotherapy trial therapy: Qualitative description and comparison to standard intake assessments. *Ad Hoc Bulletin of Short-Term Dynamic Psychotherapy*, 13, 6–14.
- Abbass, A., Town, J., & Driessen, E. (2012). Intensive short-term dynamic psychotherapy: a systematic review and meta-analysis of outcome research. *Harvard Review of Psychiatry*, 20, 97–108.
- Albert, U., Rosso, G., Maina, G., & Bogetto, F. (2008). Impact of anxiety disorder comorbidity on quality of life in euthymic bipolar disorder patients: differences between bipolar I and II subtypes. *Journal of Affective Disorders*, 105, 297–303.
- Alexander, F., & French, T. M. (1946). *Psychoanalytic therapy: Principles and application*. New York: The Ronald press company.
- Allgulander, C. (1989). Psychoactive drug use in a general population sample, Sweden: correlates with perceived health, psychiatric diagnoses, and mortality in an automated record-linkage study. *American Journal of Public Health*, 79, 1006–10.
- Andersson, G. (2009). Using the Internet to provide cognitive behaviour therapy. *Behaviour Research and Therapy*, 47, 175–80.
- Andersson, G., Bergström, J., Holländare, F., Carlbring, P., Kaldö, V., & Ekselius, L. (2005). Internet-based self-help for depression: randomised controlled trial. *British Journal of Psychiatry*, 187, 456–61.

- Andersson, G., & Cuijpers, P. (2009). Internet-based and other computerized psychological treatments for adult depression: a meta-analysis. *Cognitive Behaviour Therapy*, 38, 196–205.
- Andersson, G., Paxling, B., Roch-Norlund, P., Östman, G., Norgren, A., Almlöv, J., ... Silverberg, F. (2012). Internet-based psychodynamic vs. cognitive behavioural guided self-help for generalized anxiety disorder: A randomised controlled trial. *Psychotherapy and Psychosomatics*, 81, 344–355.
- Andersson, G., Paxling, B., Wiwe, M., Vernmark, K., Felix, C. B., Lundborg, L., ... Carlbring, P. (2012). Therapeutic alliance in guided internet-delivered cognitive behavioural treatment of depression, generalized anxiety disorder and social anxiety disorder. *Behaviour Research and Therapy*, 50, 544–50.
- Andrews, G., Cuijpers, P., Craske, M. G., McEvoy, P., & Titov, N. (2010). Computer therapy for the anxiety and depressive disorders is effective, acceptable and practical health care: a meta-analysis. *PLoS ONE*, 5, e13196.
- Andrews, G., Henderson, S., & Hall, W. (2001). Prevalence, comorbidity, disability and service utilisation. Overview of the Australian National Mental Health Survey. *British Journal of Psychiatry*, 178, 145–53.
- APA. (2010). *American Psychiatric Association practice guidelines for the treatment of patients with major depressive disorder*. Arlington, VA: American Psychiatric Publishing, Inc.
- Baer, R. A., Smith, G. T., Hopkins, J., Krietemeyer, J., & Toney, L. (2006). Using self-report assessment methods to explore facets of mindfulness. *Assessment*, 13, 27–45.
- Baker, R., Thomas, S., Thomas, P. W., Gower, P., Santonastaso, M., & Whittlesea, A. (2010). The Emotional Processing Scale: scale refinement and abridgement (EPS-25). *Journal of Psychosomatic Research*, 68, 83–8.
- Barber, J. P., Barrett, M. S., Gallop, R., Rynn, M. A., & Rickels, K. (2012). Short-term dynamic psychotherapy versus pharmacotherapy for major depressive disorder: a randomized, placebo-

- controlled trial. *Journal of Clinical Psychiatry*, 73, 66–73.
- Barber, J. P., Crits-Christoph, P., & Luborsky, L. (1996). Effects of therapist adherence and competence on patient outcome in brief dynamic therapy. *Journal of Consulting and Clinical Psychology*, 64, 619–22.
- Barber, J. P., Muran, J. C., McCarthy, K. S., & Keefe, J. R. (2013). Research on dynamic therapies. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change*. Hoboken, N.J.: Wiley.
- Barkham, M., Shapiro, D. A., Hardy, G. E., & Rees, A. (1999). Psychotherapy in two-plus-one sessions: outcomes of a randomized controlled trial of cognitive-behavioral and psychodynamic-interpersonal therapy for subsyndromal depression. *Journal of Consulting and Clinical Psychology*, 67, 201–11.
- Barlow, D. H., Fairholme, C. P., & Ellard, K. K. (2011). *Unified protocol for transdiagnostic treatment of emotional disorders*. Oxford University Press.
- Baumeister, H., & Härter, M. (2007). Prevalence of mental disorders based on general population surveys. *Social Psychiatry and Psychiatric Epidemiology*, 42, 537–46.
- Beck, A. T., Epstein, N., Brown, G., & Steer, R. A. (1988). An inventory for measuring clinical anxiety: psychometric properties. *Journal of Consulting and Clinical Psychology*, 56, 893–7.
- Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford Press.
- Beck, A. T., Steer, R. A., & Brown, G. (1996). *Beck depression inventory-II: Manual*. Boston: Harcourt Brace.
- Bergman Nordgren, L., Carlbring, P., Linna, E., & Andersson, G. (2013). Role of the working alliance on treatment outcome in tailored internet-based cognitive behavioural therapy for anxiety disorders: randomized controlled pilot trial. *JMIR research protocols*, 2, e4.
- Bijl, R. V., Ravelli, A., & van Zessen, G. (1998). Prevalence of psychiatric disorder in the general population: results of The Nether-

- lands Mental Health Survey and Incidence Study (NEMESIS). *Social Psychiatry and Psychiatric Epidemiology*, 33, 587–95.
- Bloch, M., Meiboom, H., Lorberblatt, M., Bluvstein, I., Aharonov, I., & Schreiber, S. (2012). The effect of sertraline add-on to brief dynamic psychotherapy for the treatment of postpartum depression: a randomized, double-blind, placebo-controlled study. *Journal of Clinical Psychiatry*, 73, 235–41.
- Bordin, E. (1994). Theory and research on the therapeutic working alliance: New directions. In A. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 13–37). New York: Wiley.
- Bressi, C., Porcellana, M., Marinaccio, P. M., Nocito, E. P., & Magri, L. (2010). Short-term psychodynamic psychotherapy versus treatment as usual for depressive and anxiety disorders: a randomized clinical trial of efficacy. *Journal of Nervous and Mental Disease*, 198, 647–52.
- Bridges, M. R. (2006). Activating the corrective emotional experience. *Journal of Clinical Psychology*, 62, 551–68.
- Brodaty, H., & Andrews, G. (1983). Brief psychotherapy in family practice. A controlled prospective intervention trial. *British Journal of Psychiatry*, 143, 11–9.
- Buhrman, M., Skoglund, A., Husell, J., Bergström, K., Gordh, T., Hursti, T., ... Andersson, G. (2013). Guided internet-delivered acceptance and commitment therapy for chronic pain patients: a randomized controlled trial. *Behaviour Research and Therapy*, 51, 307–15.
- Carlbring, P., Brunt, S., Bohman, S., Austin, D., Richards, J., Öst, L.-G., & Andersson, G. (2007). Internet vs. paper and pencil administration of questionnaires commonly used in panic/agoraphobia research. *Computers in Human Behavior*, 23, 1421–1434.
- Carlbring, P., Maurin, L., Törngren, C., Linna, E., Eriksson, T., Sparthan, E., ... Andersson, G. (2011). Individually-tailored, Internet-based treatment for anxiety disorders: A randomized controlled trial. *Behaviour Research and Therapy*, 49, 18–24.

- Carpentier, P. J., Krabbe, P. F. M., van Gogh, M. T., Knapen, L. J. M., Buitelaar, J. K., & de Jong, C. A. J. (2009). Psychiatric comorbidity reduces quality of life in chronic methadone maintained patients. *American Journal on Addictions*, 118, 470–80.
- Carrington, C. (1979). A comparison of cognitive and analytically oriented brief treatment approaches to depression in black women. *Dissertation Abstracts International*, 40(6B).
- Carter, R. M., Wittchen, H. U., Pfister, H., & Kessler, R. C. (2001). One-year prevalence of subthreshold and threshold DSM-IV generalized anxiety disorder in a nationally representative sample. *Depression and Anxiety*, 13, 78–88.
- Cavanagh, K., & Millings, A. (2013). (Inter)personal computing: The role of the therapeutic relationship in e-mental health. *Journal of Contemporary Psychotherapy*.
- Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology*, 66, 7–18.
- Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: controversies and evidence. *Annual Review of Psychology*, 52, 685–716.
- Cipriani, A., Furukawa, T. A., Salanti, G., Geddes, J. R., Higgins, J. P., Churchill, R., ... Barbui, C. (2009). Comparative efficacy and acceptability of 12 new-generation antidepressants: a multiple-treatments meta-analysis. *Lancet*, 373, 746–58.
- Clarke, G., Eubanks, D., Reid, E., Kelleher, C., O'Connor, E., DeBar, L. L., ... Gullion, C. (2005). Overcoming depression on the Internet (ODIN) (2): a randomized trial of a self-help depression skills program with reminders. *Journal of Medical Internet Research*, 7, e16.
- Connolly, M. B., Crits-Christoph, P., Shelton, R. C., Hollon, S., Kurtz, J., Barber, J. P., ... Thase, M. E. (1999). The reliability and validity of a measure of self-understanding of interpersonal patterns. *Journal of Counseling Psychology*, 46.
- Crits-Christoph, P., Cooper, A., & Luborsky, L. (1988). The accuracy

- of therapists' interpretations and the outcome of dynamic psychotherapy. *Journal of Consulting and Clinical Psychology*, 56, 490–5.
- Cuijpers, P., Beekman, A. T. F., & Reynolds, C. F. (2012). Preventing depression: a global priority. *JAMA: Journal of the American Medical Association*, 307, 1033–4.
- Cuijpers, P., Berking, M., Andersson, G., Quigley, L., Kleiboer, A., & Dobson, K. S. (2013). A meta-analysis of cognitive-behavioural therapy for adult depression, alone and in comparison with other treatments. *Canadian Journal of Psychiatry*, 58, 376–85.
- Cuijpers, P., Donker, T., Johansson, R., Mohr, D. C., van Straten, A., & Andersson, G. (2011). Self-guided psychological treatment for depressive symptoms: a meta-analysis. *PLoS ONE*, 6, e21274.
- Cuijpers, P., Donker, T., van Straten, A., Li, J., & Andersson, G. (2010). Is guided self-help as effective as face-to-face psychotherapy for depression and anxiety disorders? A systematic review and meta-analysis of comparative outcome studies. *Psychological Medicine*, 40, 1943–57.
- Cuijpers, P., Driessen, E., Hollon, S. D., van Oppen, P., Barth, J., & Andersson, G. (2012). The efficacy of non-directive supportive therapy for adult depression: a meta-analysis. *Clinical Psychology Review*, 32, 280–91.
- Cuijpers, P., Geraedts, A. S., van Oppen, P., Andersson, G., Markowitz, J. C., & van Straten, A. (2011). Interpersonal psychotherapy for depression: a meta-analysis. *American Journal of Psychiatry*, 168, 581–92.
- Cuijpers, P., Hollon, S. D., van Straten, A., Bockting, C., Berking, M., & Andersson, G. (2013). Does cognitive behaviour therapy have an enduring effect that is superior to keeping patients on continuation pharmacotherapy? A meta-analysis. *BMJ Open*, 3.
- Cuijpers, P., Turner, E. H., Mohr, D. C., Hofmann, S. G., Andersson, G., Berking, M., & Coyne, J. (2013). Comparison of psychotherapies for adult depression to pill placebo control groups: a meta-analysis. *Psychological Medicine*, 1–11.

- Cuijpers, P., van Straten, A., Andersson, G., & van Oppen, P. (2008). Psychotherapy for depression in adults: a meta-analysis of comparative outcome studies. *Journal of Consulting and Clinical Psychology*, 76, 909–22.
- Cuijpers, P., van Straten, A., Warmerdam, L., & Smits, N. (2008). Characteristics of effective psychological treatments of depression: a metaregression analysis. *Psychotherapy Research*, 18, 225–36.
- Davanloo, H. (1986). Intensive short-term psychotherapy with highly resistant patients. I. Handling resistance. *International Journal of Short-Term Psychotherapy*, 1, 107–134.
- Davanloo, H. (1990). *Unlocking the unconscious: selected papers of Habib Davanloo*. New York: Wiley.
- Davanloo, H. (2000). *Intensive short-term dynamic psychotherapy: selected papers of Habib Davanloo*. Chichester: Wiley.
- Davanloo, H. (2008). The 29th Annual Audiovisual Immersion Course. Retrieved from <http://www.davanloo.org>
- Dear, B. F., Titov, N., Schwencke, G., Andrews, G., Johnston, L., Craske, M. G., & McEvoy, P. (2011). An open trial of a brief transdiagnostic internet treatment for anxiety and depression. *Behaviour Research and Therapy*, 49, 830–7.
- Diener, M. J., Hilsenroth, M. J., & Weinberger, J. (2007). Therapist affect focus and patient outcomes in psychodynamic psychotherapy: a meta-analysis. *American Journal of Psychiatry*, 164, 936–41.
- Driessen, E., Cuijpers, P., de Maat, S. C. M., Abbass, A., de Jonghe, F., & Dekker, J. J. M. (2010). The efficacy of short-term psychodynamic psychotherapy for depression: a meta-analysis. *Clinical Psychology Review*, 30, 25–36.
- Driessen, E., Van, H. L., Don, F. J., Peen, J., Kool, S., Westra, D., ... Dekker, J. J. M. (2013). The efficacy of cognitive-behavioral therapy and psychodynamic therapy in the outpatient treatment of major depression: a randomized clinical trial. *American Journal of Psychiatry*, 170, 1041–50.

- Eaton, W. W., Anthony, J. C., Tepper, S., & Dryman, A. (1992). Psychopathology and attrition in the epidemiologic catchment area surveys. *American Journal of Epidemiology*, 135, 1051–9.
- Eisen, S. V, Normand, S.-L., Belanger, A. J., Spiro, A., & Esch, D. (2004). The Revised Behavior and Symptom Identification Scale (BASIS-R): reliability and validity. *Medical Care*, 42, 1230–41.
- Ellard, K., Fairholme, C., Boisseau, C. L., Farchione, T. J., & Barlow, D. H. (2010). Unified protocol for the transdiagnostic treatment of emotional disorders: Protocol development and initial outcome data. *Cognitive and Behavioral Practice*, 17, 88–101.
- Emmelkamp, P., Bouman, T., & Blaauw, E. (1994). Individualized versus standardized therapy: A comparative evaluation with obsessive-compulsive patients. *Clinical Psychology & Psychotherapy*, 1, 95–100.
- Enström, M., & Jonsson, L. (2008). *ISIS: Internetbaserat stöd för individer med sekundära besvär - efter bröstcancer [ISIS: Internet-based support for individuals with secondary problems after breast cancer] (Unpublished Master's thesis)*. Linköping University.
- EuroQol Group. (1990). EuroQol--a new facility for the measurement of health-related quality of life. The EuroQol Group. *Health Policy*, 16, 199–208.
- Ezriel, H. (1952). Notes on psychoanalytic group therapy. II. Interpretation and research. *Psychiatry*, 15, 119–26.
- Farchione, T. J., Fairholme, C. P., Ellard, K. K., Boisseau, C. L., Thompson-Hollands, J., Carl, J. R., ... Barlow, D. H. (2012). Unified protocol for transdiagnostic treatment of emotional disorders: a randomized controlled trial. *Behavior Therapy*, 43, 666–78.
- Ferster, C. B. (1973). A functional analysis of depression. *American Psychologist*, 28, 857–70.
- Ferster, C. B., & Skinner, B. F. (1957). *Schedules of reinforcement*. New York: Appleton-Century-Crofts.
- First, M. B., Gibbon, M., Spitzer, R. L., & Williams, J. B. W. (1997). *Structured clinical interview for DSM-IV axis I disorders (SCID-I)*. Washington, D.C.: American Psychiatric Press.

- Fosha, D. (2000). *The transforming power of affect : a model for accelerated change*. New York: Basic Books.
- Fournier, J. C., DeRubeis, R. J., Hollon, S. D., Dimidjian, S., Amsterdam, J. D., Shelton, R. C., & Fawcett, J. (2010). Antidepressant drug effects and depression severity: a patient-level meta-analysis. *JAMA : Journal of the American Medical Association*, 303, 47–53.
- Frederick, R. J. (2009). *Living like you mean it: Use the wisdom and power of your emotions to get the life you really want*. San Francisco: Jossey-Bass.
- Frisch, M., Cornell, J., Villanueva, M., & Retzlaff, P. (1992). Clinical validation of the Quality of Life Inventory: A measure of life satisfaction for use in treatment planning and outcome assessment. *Psychological Assessment*, 4, 92–101.
- Ghaderi, A. (2006). Does individualization matter? A randomized trial of standardized (focused) versus individualized (broad) cognitive behavior therapy for bulimia nervosa. *Behaviour Research and Therapy*, 44, 273–88.
- Gibbons, M. B. C., Crits-Christoph, P., & Hearon, B. (2008). The empirical status of psychodynamic therapies. *Annual Review of Clinical Psychology*, 4, 93–108.
- Gibbons, M. B. C., Thompson, S. M., Scott, K., Schauble, L. A., Mooney, T., Thompson, D., ... Crits-Christoph, P. (2012). Supportive-expressive dynamic psychotherapy in the community mental health system: a pilot effectiveness trial for the treatment of depression. *Psychotherapy*, 49, 303–16.
- Gueorguieva, R., & Krystal, J. H. (2004). Move over ANOVA: progress in analyzing repeated-measures data and its reflection in papers published in the Archives of General Psychiatry. *Archives of General Psychiatry*, 61, 310–7.
- Guy, W. (1976). *Clinical global impressions. ECDEU assessment manual for psychopharmacology*. Rockville: NIMH.
- Hamilton, M. (1960). A rating scale for depression. *Journal of Neurology, Neurosurgery, and Psychiatry*, 23, 56–62.

- Haynes, S., & Williams, A. (2003). Case formulation and design of behavioral treatment programs: Matching treatment mechanisms to causal variables for behavior problems. *European Journal of Psychological Assessment*, 19, 164–174.
- Hedman, E., Ljótsson, B., & Lindefors, N. (2012). Cognitive behavior therapy via the Internet: a systematic review of applications, clinical efficacy and cost-effectiveness. *Expert Review of Pharmacoeconomics & Outcomes Research*, 12, 745–64.
- Hesser, H., Gustafsson, T., Lundén, C., Henrikson, O., Fattahi, K., Johnsson, E., ... Andersson, G. (2012). A randomized controlled trial of internet-delivered cognitive behavior therapy and acceptance and commitment therapy in the treatment of tinnitus. *Journal of Consulting and Clinical Psychology*, 80, 649–61.
- Hirai, M., & Clum, G. A. (2006). A meta-analytic study of self-help interventions for anxiety problems. *Behavior Therapy*, 37, 99–111.
- Hollon, S. D., DeRubeis, R. J., Shelton, R. C., Amsterdam, J. D., Salomon, R. M., O'Reardon, J. P., ... Gallop, R. (2005). Prevention of relapse following cognitive therapy vs medications in moderate to severe depression. *Archives of General Psychiatry*, 62, 417–22.
- Hollon, S. D., & Ponniah, K. (2010). A review of empirically supported psychological therapies for mood disorders in adults. *Depression and Anxiety*, 27, 891–932.
- Hollon, S. D., Stewart, M. O., & Strunk, D. (2006). Enduring effects for cognitive behavior therapy in the treatment of depression and anxiety. *Annual Review of Psychology*, 57, 285–315.
- Hollon, S. D., Thase, M., & Markowitz, J. (2002). Treatment and prevention of depression. *Psychological Science in the Public Interest*, 3, 39–77.
- Holländare, F., Andersson, G., & Engström, I. (2010). A comparison of psychometric properties between internet and paper versions of two depression instruments (BDI-II and MADRS-S) administered to clinic patients. *Journal of Medical Internet Research*, 12,

- Jacobson, N. S., Martell, C. R., & Dimidjian, S. (2001). Behavioral activation treatment for depression: Returning to contextual roots. *Clinical Psychology: Science and Practice*, 8, 255–270.
- Jacobson, N. S., Schmalings, K. B., Holtzworth-Munroe, A., Katt, J. L., Wood, L. F., & Follette, V. M. (1989). Research-structured vs clinically flexible versions of social learning-based marital therapy. *Behaviour Research and Therapy*, 27, 173–80.
- Johansson, R., & Andersson, G. (2012). Internet-based psychological treatments for depression. *Expert Review of Neurotherapeutics*, 12, 861–70.
- Johnston, L., Titov, N., Andrews, G., Dear, B. F., & Spence, J. (2013). Comorbidity and Internet-delivered transdiagnostic cognitive behavioural therapy for anxiety disorders. *Cognitive Behaviour Therapy*.
- Kendler, K. S., Gatz, M., Gardner, C. O., & Pedersen, N. L. (2006). A Swedish national twin study of lifetime major depression. *American Journal of Psychiatry*, 163, 109–14.
- Kessler, D., Lewis, G., Kaur, S., Wiles, N., King, M., Weich, S., ... Peters, T. J. (2009). Therapist-delivered Internet psychotherapy for depression in primary care: a randomised controlled trial. *Lancet*, 374, 628–34.
- Kessler, R. C., Berglund, P., Demler, O., Jin, R., Koretz, D., Merikangas, K. R., ... Wang, P. S. (2003). The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). *JAMA: Journal of the American Medical Association*, 289, 3095–105.
- Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62, 593–602.
- Klein, B., Richards, J. C., & Austin, D. W. (2006). Efficacy of internet therapy for panic disorder. *Journal of Behavior Therapy and Experimental Psychiatry*, 37, 213–38.

- Knekt, P., & Lindfors, O. (2004). *A randomized trial of the effect of four forms of psychotherapy on depressive and anxiety disorders. Design, methods, and results on the effectiveness of short-term psychodynamic psychotherapy and solution-focused therapy during a one-year follow-up*. Helsinki: Kela.
- Knekt, P., Lindfors, O., Sares-Jäske, L., Virtala, E., & Härkänen, T. (2013). Randomized trial on the effectiveness of long- and short-term psychotherapy on psychiatric symptoms and working ability during a 5-year follow-up. *Nordic Journal of Psychiatry*, 67, 59–68.
- Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16, 606–13.
- Kroenke, K., Spitzer, R. L., Williams, J. B. W., Monahan, P. O., & Löwe, B. (2007). Anxiety disorders in primary care: prevalence, impairment, comorbidity, and detection. *Annals of Internal Medicine*, 146, 317–25.
- Leichsenring, F., & Leibing, E. (2007). Supportive-Expressive (SE) psychotherapy: an update. *Current Psychiatry Reviews*.
- Leichsenring, F., Salzer, S., Beutel, M. E., Herpertz, S., Hiller, W., Hoyer, J., ... Leibing, E. (2013). Psychodynamic therapy and cognitive-behavioral therapy in social anxiety disorder: A multicenter randomized controlled trial. *American Journal of Psychiatry*.
- Leichsenring, F., Salzer, S., Jaeger, U., Kächele, H., Kreische, R., Leweke, F., ... Leibing, E. (2009). Short-term psychodynamic psychotherapy and cognitive-behavioral therapy in generalized anxiety disorder: a randomized, controlled trial. *American Journal of Psychiatry*, 166, 875–81.
- Lewinsohn, P., Biglan, A., & Zeiss, A. (1976). Behavioral treatment of depression. In P. O. Davidson (Ed.), *Behavioral management of anxiety, depression and pain* (pp. 91–146). New York: Brunner/Mazel.
- Lilja, J. L., Frodi-Lundgren, A., Hanse, J. J., Josefsson, T., Lundh, L.-G., Sköld, C., ... Broberg, A. G. (2011). Five Facets Mindfulness

- Questionnaire - reliability and factor structure: a Swedish version. *Cognitive Behaviour Therapy*, 40, 291–303.
- Ljótsson, B., Falk, L., Vesterlund, A. W., Hedman, E., Lindfors, P., Rück, C., ... Andersson, G. (2010). Internet-delivered exposure and mindfulness based therapy for irritable bowel syndrome - a randomized controlled trial. *Behaviour Research and Therapy*, 48, 531–9.
- Ljótsson, B., Hedman, E., Andersson, E., Hesser, H., Lindfors, P., Hursti, T., ... Andersson, G. (2011). Internet-delivered exposure-based treatment vs. stress management for irritable bowel syndrome: a randomized trial. *American Journal of Gastroenterology*, 106, 1481–91.
- Ljótsson, B., Hesser, H., Andersson, E., Lindfors, P., Hursti, T., Rück, C., ... Hedman, E. (2013). Mechanisms of change in an exposure-based treatment for irritable bowel syndrome. *Journal of Consulting and Clinical Psychology*.
- Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: A manual for supportive-expressive treatment* (Vol. 2000). New York: Basic Books.
- Luborsky, L., Mark, D., Hole, A., & Popp, C. (1995). Supportive-expressive dynamic psychotherapy of depression: A time-limited version. In J. P. Barber & P. Crits-Christoph (Eds.), *Psychodynamic Psychotherapies for Psychiatric Disorders (Axis I)* (pp. 13–42). New York: Basic Books.
- Lynch, D., Laws, K. R., & McKenna, P. J. (2010). Cognitive behavioural therapy for major psychiatric disorder: does it really work? A meta-analytical review of well-controlled trials. *Psychological Medicine*, 40, 9–24.
- Maina, G., Forner, F., & Bogetto, F. (2005). Randomized controlled trial comparing brief dynamic and supportive therapy with waiting list condition in minor depressive disorders. *Psychotherapy and Psychosomatics*, 74, 43–50.
- Maina, G., Rosso, G., & Bogetto, F. (2009). Brief dynamic therapy combined with pharmacotherapy in the treatment of major de-

- pressive disorder: long-term results. *Journal of Affective Disorders*, 114, 200–7.
- Malan, D. H. (1963). *A study of brief psychotherapy*. London: Tavistock.
- Malan, D. H. (1976). *Toward the validation of dynamic psychotherapy: A replication*. New York: Plenum.
- Malan, D. H. (1995). *Individual psychotherapy and the science of psychodynamics* (2nd ed.). Oxford: Butterworth-Heinemann.
- Mallinckrodt, C. H., Clark, W. S., & David, S. R. (2001). Accounting for dropout bias using mixed-effects models. *Journal of Biopharmaceutical Statistics*, 11, 9–21.
- Mann, J. (1973). *Time-limited psychotherapy*. Cambridge, MA: Harvard Univ. Press.
- Marks, I. M., Cavanagh, K., & Gega, L. (2007). *Hands-on help: Computer-aided psychotherapy*. Psychology Press.
- Martell, C. R., Addis, M. E., & Jacobson, N. S. (2001). *Depression in context: Strategies for guided action*. W W Norton & Company Incorporated.
- Martell, C. R., Dimidjian, S., & Herman-Dunn, R. (2010). *Behavioral activation for depression: A Clinician's Guide*. Guilford Press.
- Mathers, C. D., & Loncar, D. (2006). Projections of global mortality and burden of disease from 2002 to 2030. *PLoS Medicine*, 3, e442.
- McCullough, L., Kuhn, N., Andrews, S., Kaplan, A., Wolf, J., & Hurley, C. L. (2003). *Treating affect phobia: A manual for short-term dynamic psychotherapy*. New York: Guilford Press.
- McEvoy, P., Nathan, P., & Norton, P. (2009). Efficacy of transdiagnostic treatments: A review of published outcome studies and future research directions. *Journal of Cognitive Psychotherapy: An International Quarterly*, 23, 20–33.
- Menninger, K. A. (1958). *Theory of psychoanalytic technique*. New York: Basic Books.
- Newman, M., Zuellig, A., & Kachin, K. (2002). Preliminary reliability and validity of the Generalized Anxiety Disorder Questionnaire-

- IV: A revised self-report diagnostic measure of generalized anxiety disorder. *Behavior Therapy*, 33, 215–233.
- Norcross, J. C., Karpiake, C. P., & Santoro, S. O. (2005). Clinical psychologists across the years: the division of clinical psychology from 1960 to 2003. *Journal of Clinical Psychology*, 61, 1467–83.
- Nordin, S., Carlbring, P., Cuijpers, P., & Andersson, G. (2010). Expanding the limits of bibliotherapy for panic disorder: randomized trial of self-help without support but with a clear deadline. *Behavior Therapy*, 41, 267–76.
- Norton, P. J., Temple, S. R., & Pettit, J. W. (2008). Suicidal ideation and anxiety disorders: elevated risk or artifact of comorbid depression? *Journal of Behavior Therapy and Experimental Psychiatry*, 39, 515–25.
- O'Donohue, W. T., & Fisher, J. T. (2012). *Cognitive behavior therapy: Core principles for practice*. Hoboken, N.J.: John Wiley & Sons.
- Osimo, F., & Stein, M. J. (2012). *Theory and practice of experiential dynamic psychotherapy*. London: Karnac.
- Persons, J. B. (2008). *The case formulation approach to cognitive-behavior therapy* (p. 273). Guilford Press.
- Persons, J. B., Roberts, N. A., Zalecki, C. A., & Brechwald, W. A. G. (2006). Naturalistic outcome of case formulation-driven cognitive-behavior therapy for anxious depressed outpatients. *Behaviour Research and Therapy*, 44, 1041–51.
- Piper, W. E., Azim, H. F., McCallum, M., & Joyce, A. S. (1990). Patient suitability and outcome in short-term individual psychotherapy. *Journal of Consulting and Clinical Psychology*, 58, 475–81.
- Piper, W. E., Debbane, E. G., Bienvenu, J. P., & Garant, J. (1984). A comparative study of four forms of psychotherapy. *Journal of Consulting and Clinical Psychology*, 52, 268–79.
- Richardson, R., & Richards, D. (2006). Self-help: Towards the next generation. *Behavioural and Cognitive Psychotherapy*, 34, 13–23.
- Richardson, R., Richards, D. A., & Barkham, M. (2010). Self-help books for people with depression: the role of the therapeutic relationship. *Behavioural and Cognitive Psychotherapy*, 38, 67–81.

- Robinson, E., Titov, N., Andrews, G., McIntyre, K., Schwencke, G., & Solley, K. (2010). Internet treatment for generalized anxiety disorder: a randomized controlled trial comparing clinician vs. technician assistance. *PLoS ONE*, 5, e10942.
- Rorsman, B., Gräsbeck, A., Hagnell, O., Lanke, J., Ohman, R., Ojesjö, L., & Otterbeck, L. (1990). A prospective study of first-incidence depression. The Lundby study, 1957-72. *British Journal of Psychiatry*, 156, 336-42.
- Rosso, G., Martini, B., & Maina, G. (2013). Brief dynamic therapy and depression severity: a single-blind, randomized study. *Journal of Affective Disorders*, 147, 101-6.
- Rush, J. (2000). *Handbook of Psychiatric Measures*. Washington, D.C.: American Psychiatric Pub.
- Saarni, S. I., Suvisaari, J., Sintonen, H., Pirkola, S., Koskinen, S., Aromaa, A., & Lönnqvist, J. (2007). Impact of psychiatric disorders on health-related quality of life: general population survey. *British Journal of Psychiatry*, 190, 326-32.
- Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. New York: Guilford Press.
- Salminen, J. K., Karlsson, H., Hietala, J., Kajander, J., Aalto, S., Markkula, J., ... Toikka, T. (2008). Short-term psychodynamic psychotherapy and fluoxetine in major depressive disorder: a randomized comparative study. *Psychotherapy and Psychosomatics*, 77, 351-7.
- Schoevers, R. A., Deeg, D. J. H., van Tilburg, W., & Beekman, A. T. F. (2005). Depression and generalized anxiety disorder: co-occurrence and longitudinal patterns in elderly patients. *American Journal of Geriatric Psychiatry*, 13, 31-9.
- Schubiner, H., & Betzold, M. (2012). *Unlearn your pain: A 28-day process to reprogram your brain*. Mind Body Publishing.
- Schulte, D., & Kunzel, R. (1992). Tailor-made versus standardized therapy of phobic patients. *Advances in Behaviour Research and Therapy*, 14, 67-92.
- Sheehan, D. V., Lecrubier, Y., Sheehan, K. H., Amorim, P., Janavs, J.,

- Weiller, E., ... Dunbar, G. C. (1998). The Mini-International Neuropsychiatric Interview (M.I.N.I.): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *Journal of Clinical Psychiatry*, 59 Suppl 2, 22–33;quiz 34–57.
- Sherbourne, C. D., Sullivan, G., Craske, M. G., Roy-Byrne, P., Golinelli, D., Rose, R. D., ... Stein, M. B. (2010). Functioning and disability levels in primary care out-patients with one or more anxiety disorders. *Psychological Medicine*, 40, 2059–68.
- Silfvernagel, K., Carlbring, P., Kabo, J., Edström, S., Eriksson, J., Månson, L., & Andersson, G. (2012). Individually tailored internet-based treatment for young adults and adults with panic attacks: randomized controlled trial. *Journal of Medical Internet Research*, 14, e65.
- Silverberg, F. (2005). *Make the leap: A practical guide to breaking the patterns that hold you back*. Marlowe & Co.
- Skinner, B. F. (1953). *Science and human behavior*. New York: Macmillan.
- Skinner, B. F. (1974). *About behaviourism*. London: Cape.
- Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of Internal Medicine*, 166, 1092–7.
- Sturmey, P. (2008). *Behavioral case formulation and intervention: A functional analytic approach*. John Wiley & Sons.
- Summers, R. F., & Barber, J. P. (2010). *Psychodynamic therapy: A guide to evidence-based practice*. Guilford Press.
- Svanborg, P., & Åsberg, M. (1994). A new self-rating scale for depression and anxiety states based on the Comprehensive Psychopathological Rating Scale. *Acta Psychiatrica Scandinavica*, 89, 21–8.
- Thompson, L. W., Gallagher, D., & Breckenridge, J. S. (1987). Comparative effectiveness of psychotherapies for depressed elders. *Journal of Consulting and Clinical Psychology*, 55, 385–90.
- Titov, N., Andrews, G., Davies, M., McIntyre, K., Robinson, E., & Sol-

- ley, K. (2010). Internet treatment for depression: a randomized controlled trial comparing clinician vs. technician assistance. *PLoS ONE*, 5, e10939.
- Titov, N., Andrews, G., Johnston, L., Robinson, E., & Spence, J. (2010). Transdiagnostic Internet treatment for anxiety disorders: A randomized controlled trial. *Behaviour Research and Therapy*, 48, 890–9.
- Titov, N., Dear, B. F., Johnston, L., Lorian, C., Zou, J., Wootton, B., ... Rapee, R. M. (2013). Improving adherence and clinical outcomes in self-guided internet treatment for anxiety and depression: randomised controlled trial. *PLoS ONE*, 8, e62873.
- Trowell, J., Joffe, I., Campbell, J., Clemente, C., Almqvist, F., Soininen, M., ... Tsiantis, J. (2007). Childhood depression: a place for psychotherapy. An outcome study comparing individual psychodynamic psychotherapy and family therapy. *European Child & Adolescent Psychiatry*, 16, 157–67.
- Turner, E. H., Matthews, A. M., Linardatos, E., Tell, R. A., & Rosenthal, R. (2008). Selective publication of antidepressant trials and its influence on apparent efficacy. *New England Journal of Medicine*, 358, 252–60.
- Verbeke, G., & Molenberghs, G. (2000). *Linear mixed models for longitudinal data*. New York: Springer.
- Vernmark, K., Lenndin, J., Bjärehed, J., Carlsson, M., Karlsson, J., Öberg, J., ... Andersson, G. (2010). Internet administered guided self-help versus individualized e-mail therapy: A randomized trial of two versions of CBT for major depression. *Behaviour Research and Therapy*, 48, 368–76.
- Vinnars, B., Barber, J. P., Norén, 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, 1933–40.
- Zois, C., & Fogarty, P. (1993). *Think like a shrink: Solve your problems yourself with short term therapy techniques*. Grand Central Pub.

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