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CONCORDANCE AND DISCORDANCE IN HOW PATIENTS AND THERAPISTS EXPERIENCE THE PSYCHOTHERAPY PROCESS IN THE TREATMENT OF DEPRESSION

ABSTRACT

Despite the extensive literature on the outcome and process of psychotherapy in the treatment of depression, little is known about how the underlying factors of depression and the therapy process are experienced by the patients and therapists. In particular, the recognition of themes that are discordantly experienced by patients and therapists may have practical significance for how the therapy process should be conducted. We have previously developed a process description questionnaire to explore the views of patients with major depression and their therapists during the psychodynamic therapy process. In this study, we used factor analysis on the data collected with the process description questionnaire to explore the perceptions of the patients and therapists at different stages of the therapy process. We derived 15 clusters of variables from the questionnaire, on which we conducted primary and secondary factor analysis. The formation of the factors was found to be largely consistent between the patients and therapists regarding the alliance and affectively neutral aspects of the treatment process, whereas the variables of the patients vs. therapists concerning symptoms of depression and their underlying factors dispersed to a greater extent into separate factors. Dispersion was found especially in the experience of processing affectively laden themes and the developmental background factors underlying depression. Our findings refer to a defective insight of the patients into the developmental, interactional and affective factors underlying their symptoms. These factors should be especially targeted in psychotherapy of depression.

KEY WORDS: PSYCHOTHERAPY PROCESS, PSYCHODYNAMIC PSYCHOTHERAPY, DEPRESSION, INSIGHT

INTRODUCTION

Depression is one of the most common psychiatric disorders treated with psychodynamic psychotherapy. Despite the large field of psychotherapy studies, there are few studies on how depression manifests itself during actual treatment process and in the therapeutic relationship, especially concerning psychodynamic psychotherapy. The effects of past experiences on present behaviours (cognitions, affect, fantasies and actions) and the expression of emotions and avoidance of distressing thoughts and feelings are focused on in psychodynamic therapy, and furthermore, therapeutic and interpersonal relationships are also centrally targeted aspects (1,2,3). Concerning the treatment of depression, a meaningful emotional insight into contradictory, negative and inwardly-turned affect is often regarded to be clinically important (4,5). Even though these common features of depression and its treatment are widely described in literature and are well known among researchers and clinicians, their manifestations and how they are experienced by patients and therapists during the psychotherapy process has remained less studied.

No consensus has been reached on how or why psychotherapeutic interventions produce change (6,7,8). Psychodynamic psychotherapy is an effective treatment for depression (9,10,11), but the factors affecting change remain largely unknown. Many studies have suggested that the quality of the alliance is significantly related to improvement within psychotherapy (12,13,14). The alliance has also been suggested to be an active ingredient in therapy and therefore plausibly therapeutic in itself (15), and the alliance may play a more important role in psychodynamic psychotherapy than in other forms of therapy (16). Even though it is clear that the alliance is an important variable in the process of psychotherapy, its therapeutic value has remained controversial due to its complex nature and deficiencies in its conceptualization and measurement. Despite numerous studies on the therapeutic alliance, an absence of consensus in its definition, unifying model and rating scale still remains. Thus, the function and therapeutic value of the therapeutic alliance has been interpreted and discussed with several different perspectives and emphases (17,18). Understanding of the emergence, unfolding and meaning of intra- and interpersonal processes in psychotherapy for depression clearly requires further study (19).

In some studies, more specific factors that may produce change beyond the alliance have also been indicated. Cailhol et al. (20) suggested that in psychodynamic psychotherapy, specific ingredients, such as working out the meaning of present symptoms or behaviours in relation to past events, explain the outcome to a greater extent than the therapeutic alliance in the treatment of depression. Zimmermann et al. (21) have argued that intensive psychoanalytic therapy is effective in the treatment of major depression and may produce sustained therapeutic change, specifically due to its distinctive psychoanalytic technique rather than its intensity alone.

Less attention has been paid to how patients and therapists experience the therapy process and the underlying factors of depression. In particular, recognition of the elements of depression in which the views of the patients and therapists are discordant may have relevance for the therapeutic work with these patients. We have previously explored this issue by developing a process description questionnaire in order to compare patient and therapist evaluations of the psychodynamic therapy process for depression (22). We found depressive patients to have significant difficulty in expressing or getting in touch with affective and negatively loaded themes. The recognition of these themes may thus form an important practical challenge in psychotherapy for depression.

In the present study, we applied factor analysis to the data derived from the process description questionnaire to identify and conceptualize the factors at work in the treatment process for depression from the viewpoints of both patients and therapists. We focused on the impact of depression on the core elements of the psychodynamic psychotherapy process, such as the capacity to explore the effects of past experiences, express emotions, and the functioning of the psychotherapeutic relationship, as well as interpersonal relations. We hypothesized that identification of the core features of depression as they are experienced by the patients and therapists during the treatment process may shed light on the mechanism of change in patients during the psychotherapy process.

MATERIALS AND METHODS

PATIENTS AND SETTING

This study was performed as part of an investigation into the outcome of psychodynamic psychotherapy at the Department of Psychiatry of Kuopio University Hospital in Finland. Altogether, 60 outpatients were referred by healthcare centres, the student healthcare organization and occupational healthcare services in the Kuopio region for an examination

to participate in the study. Patients considered eligible for this study had to be drug naïve and to have received no previous psychiatric treatment. They were required to meet the DSM-IV-R (23) criteria for moderate or severe depression without psychotic symptoms. There was no limit to the duration of preceding depression. Psychotic symptoms, bipolar disorder, substance abuse, severe personality disorders such as antisocial personality disorder, and somatic illnesses were exclusion criteria.

Of the 60 patients referred to the project, 54 were assessed for eligibility at clinical evaluation and 40 of them, with a mean age of 27 years (range 19–51), were found to satisfy the criteria. During the waiting time (range 4–9 months) from the assessment of eligibility to treatment assignment, seven patients decided not to participate. Altogether, 33 patients (25 female, 8 male) were included in the intention-to-treat analysis. Five patients did not receive the allocated intervention due to moving elsewhere, having objections to the type of therapy, did not feel the need for the therapy or gave no reason not to start the psychotherapy. Three patients discontinued the treatment and one underwent atypical therapy (i.e. too low frequency of sessions). A total of 24 patients completed the study.

In the outpatient clinic where treatment was carried out, a six-month waiting time before treatment was common for patients expecting to start psychotherapy. The clinical safety and ethics of this study are also supported by earlier findings from comparable clinical research (24). All patients provided written informed consent. The study was approved by the Ethics Committee of the North Savo Hospital District.

THE PSYCHOTHERAPY AND THERAPISTS

The patients were offered psychodynamic psychotherapy, with the frequency of sessions being twice a week for one year. The treatment was provided in the outpatient clinic of the Department of Psychiatry of Kuopio University Hospital (25,26). The patients' motivation and aptitude for long-term psychodynamic psychotherapy without medication were assessed by an evaluation group consisting of a psychiatrist together with a psychologist and/or a specially trained nurse. Any patients not considered suitable for the treatment required by the research frame or in need of more immediate intervention were redirected elsewhere for appropriate treatment. In the evaluation meeting, the patients received more information on the study and the treatment contract was established. The treatment contract was made for one year of therapy, but the patients were informed that they would have an opportunity to continue the therapy for up to three years based on demand and clinical evaluation.

All the patients were treated by experienced psychodynamic psychotherapists with at least three years of postgraduate professional training in psychodynamic psychotherapy according to the prevailing Finnish standards. A total of eight therapists participated in the study: two of them were psychiatrists, three were psychologists and three were specially trained nurses. Their average length of experience as psychotherapists was 20 years. Filling out the questionnaires during the therapy process and meetings of the therapists once or twice a year supported a concordant dynamic therapeutic protocol between the therapists.

ASSESSMENTS

Systematic data collection for the outcome variables was performed during the initial one-year treatment period. The clinical scores have been described in detail earlier (27). Psychiatric diagnoses on axis I were assessed using the Structured Clinical Interviews for DSM-IV-R (SCID-1 and SCID-II) (23) at recruitment to the study and on axis II after 12 months of treatment. The assessments were conducted by a trained, experienced psychiatrist. Socioeconomic data and information on the psychiatric background (age at onset of the first episode of depression, diagnosis of depression in either parent) and somatic health were collected via a questionnaire (*Table 1*).

Table 1. Baseline characteristics of the patients intended to receive treatment

Number of patients	33
Socioeconomic variables	
Age (years)	26.8 (7.4)
Women	25/33
Living alone	23/32
Academic education	6/31
Employed or studying	21/33
Psychiatric diagnoses	
Major depressive disorder	33/33
One or more comorbid axis I diagnoses	18/33
One or more personality disorders*	9/24
Psychiatric background and health	
First episode of depression at <20 years of age	16/29
Depression diagnosed for either or both parents	18/32
Good or relatively good general health	19/30

*Diagnosis assessed after 12 months of treatment.

DESIGN OF THE CLUSTERS DERIVED FROM THE PROCESS VARIABLES

The data of this study were based on a specific process description questionnaire (22). The aim of this questionnaire was to assess the conceptions and experiences of different aspects of the patients' therapy experience, estimated by both the patients themselves and their therapists, and gathered at different stages of the therapy. The psychotherapy process was assessed by using the questionnaires, which were mailed to the patients and their therapists according to a specific protocol in six stages, during the first year of the psychotherapy. Completed questionnaires were returned by mail to an independent researcher, who did not participate in the psychotherapy of the patients.

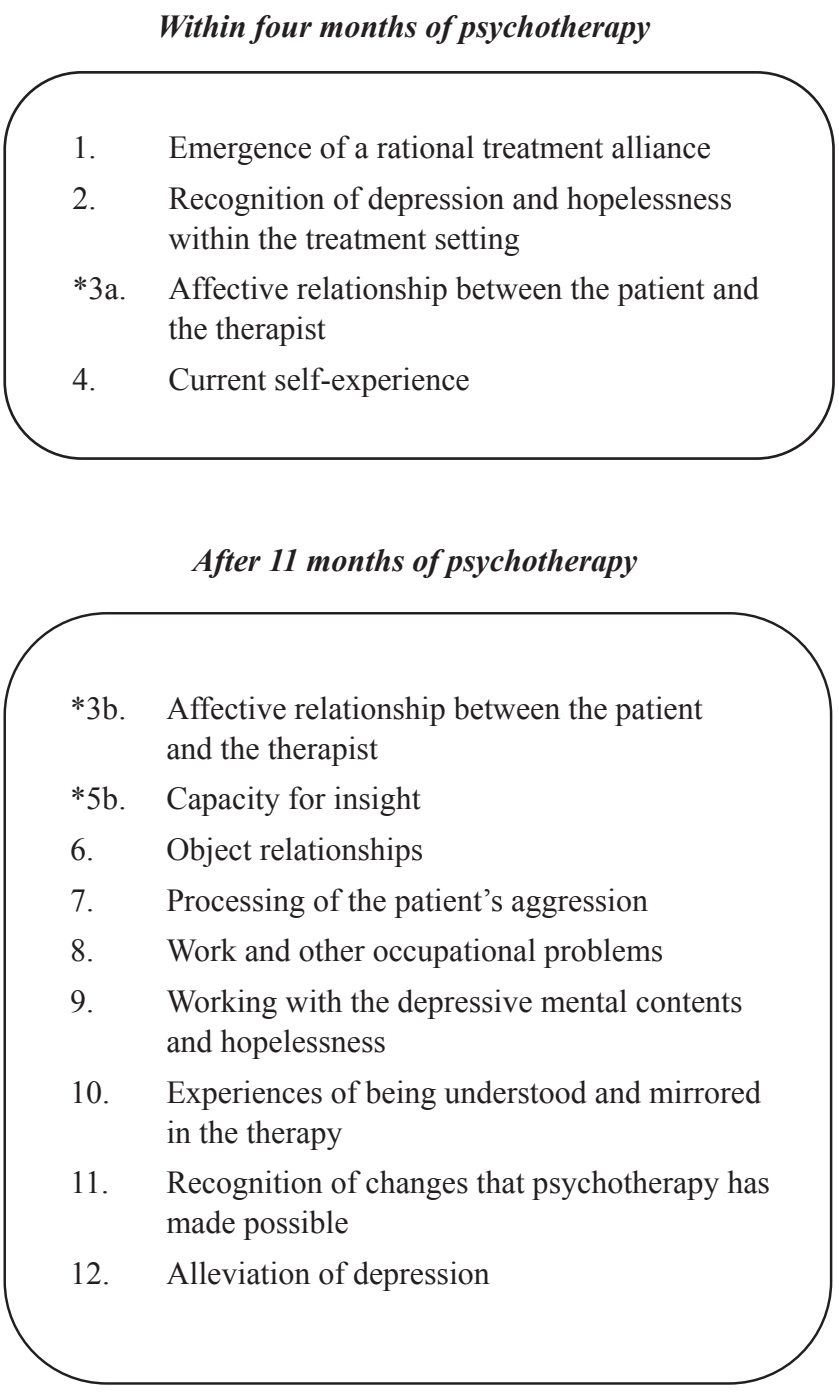
The questionnaires contained a total of 284 items for the patients and 282 items for the therapists. The questions were divided into 15 main scales covering subjects of the treatment process for depression regarded as essential by the authors and the psychotherapy team of the Department of Psychiatry, Kuopio University Hospital. This clinical judgement was based on the theoretical knowledge of the core dynamics of depression, clinical experience and theory of the course of psychodynamic psychotherapy process for depression. These subjects included evaluations by the patients and their therapists of the impact of depression on the patient's self-experience and life situation, the ongoing treatment process, life-management skills, working capacity, self-image and future opportunities of the patient. The scales used a 5-point Likert scale, with 1 indicating full agreement and 5 full disagreement. Not all items were the same for patients and therapists, as they were designed to consider the differences between the perspectives of patients and therapists in assessing the issues involved. The internal consistency of the original scales was assessed by Cronbach's alpha. The psychotherapy team of the Department of Psychiatry, Kuopio University Hospital reviewed the questionnaires to ensure the content validity and the timing of administration of the scales, and assessed whether they were coherent and reflected the issues relevant to the psychotherapy process for depressed patients.

For the factor analysis of this study, we selected the clinically most relevant variables related to the psychodynamics of depression from the material of the original scales, and from this material we produced 15 new clusters of variables to cover essential subjects of the treatment in two phases of the first year of treatment (*Figure 1*). The selection of the items for the clusters was based on the evaluation of the authors. Our basic premise in the selection of the variables was clinical relevance prior to statistical methods. Our clinical hypothesis was supported by the subsequent factor analysis. Five clusters consisted of data that were collected in an early phase during the first four months of the therapy process. The data for 10 clusters were collected after 11 months of the therapy process. Two of the clusters were estimated in both phases using different variables. The clusters contained a total of 233 variables of the patients and 233 variables of the therapists.

STATISTICAL METHODS

The factor analysis was based on varimax rotation, and each cluster of variables was analysed separately for patients and therapists, yielding 30 factor analyses. Factors with an eigenvalue below 3.0 were excluded based on the scree plot (data not shown) in order to obtain a small number of factors. The number of patients was relatively small. De Winter et al. (28) have, however, shown that even smaller sample sizes can suffice to recover the factor structure. Items with communality below 0.30 were excluded from the analyses, and the interpretation of the factors were based primarily on variables with communalities greater than 0.6. By this restriction of communalities, Hogarty et al. (29) noted that factor recovery was good in the case of three factors, ten variables and sample size n=30 based on their simulations. In our case the sample size was slightly lower, but the number of variables was about the same and number of factors at most three in the factor analyses, thus we believe that factor recovery was also good in our factor analyses. Also, the factors obtained in our analyses appeared to be highly overdetermined (there were high loadings on at least three to four variables and the factors exhibited good simple structure), which was also shown to improve the factor analysis solution. In the secondary factor analysis, all factor score variables from the clusters were analysed together in a single factor analysis, again with varimax rotation, to find possible latent variables explaining the factors of different clusters.

Figure 1.



*Clusters 3 and 5 were estimated in both phases by different variables

RESULTS

FIRST-ORDER FACTOR ANALYSIS

In total, 70% of the variables of the therapists and 69% of those of the patients were loaded in factor analysis when communality less than 0.30 was the exclusion criterion. From the variable composition of the 15 respective clusters, 13 formed at least one factor for both the patients and therapists when factors with an eigenvalue greater than 3.0 were included, thus suggesting factor analytic validity of the composition of the clusters. Altogether, 19 factors were formed using the patient variables and 16 factors using the therapist variables, with slightly differing compositions of variables. These factors were labelled in relation to the process of the therapy in order to describe the clinical and therapeutic content of the respective factor.

The data gathered at the 4-month point formed similar factors in both groups concerning the recognition of depression and hopelessness within the treatment, the affective relationship between the patient and the therapist and the current self-experience. The variables of the cluster "Emergence of a rational treatment alliance" only formed a factor for the therapists.

At the 11-month point, four variable clusters were loaded differently in the patients compared to the therapists (*Table 2*). The cluster "Affective relationship between the patient and the therapist" loaded into three factors labelled as "Confidence in the therapist's assistance", "Experience of the therapist as a person", and "Experience of one's own significance to the therapist", thus representing more detailed dimensions of the relationship as experienced by the patients. In the therapists, this cluster formed two factors labelled as "Confidence in the method in relation to the patient" and "Quality of the affective relationship between the patient and the therapist", indicating that the therapists' view differed regarding the content of the affective relationship.

A more detailed factor structure also emerged in three other clusters of the patients. The cluster "Object relationships" was divided into two factors labelled as "Functionality of the object relationships" and "Experience of the self in relation to objects". The clusters "Processing of the patient's aggression" and "Functionality of the therapeutic working relationship" were also divided into two factors. The factors derived from the former cluster were labelled as "Difficulties with aggression" and "Aggression in the service of self-esteem". The factors derived from the latter cluster were labelled as "Functionality of the therapeutic working relationship" and "Dependency on the therapist" as a separate satellite factor of the former.

The cluster "Capacity for insight" was loaded similarly in patients and therapists into two factors labelled as "Understanding of one's own mental functioning" and "Effects of one's developmental history on mental functioning". This cluster only loaded at the 11-month point of evaluation.

Table 2. Formation of the factors at the 11-month point when factors with an eigenvalue greater than 3.0 were included

Variable cluster	Factors	
	Patients	**Therapists**
3b. Affective relationship between the patient and the therapist	3bP1. Confidence in the therapist's assistance!	3bT1. Confidence in the method in relation to the patient!
	3bP2. Experience of the therapist as a person!	3bT2. Quality of the affective relationship between the patient and the therapist
	3bP3. Experience of one.s own significance to the therapist!	
5b. Capacity for insight	5bP1. Understanding of one.s own mental functioning	5bT1. Understanding of one.s own mental functioning
	5bP2. Understanding of the effects of one's developmental history on mental functioning	5bT2. Understanding of the effects of one's developmental history on mental functioning
6. Object relationships	6P1. Functionality of the object relationships	6T. Object relationships
	6P2. Experience of the self in relation to objects!	
7. Processing of the patient's aggression	7P1. Difficulties with aggression	7T. Processing of the patient's aggression
	7P2. Aggression in the service of self-esteem	
8. Work and other occupational problems	8P. Work and other occupational problems	8T. Work and other occupational problems
9. Working with the depressive mental contents and hopelessness	9P. Working with the depressive mental contents and hopelessness	9T. Working with the depressive mental contents and hopelessness
10. Experiences of being understood and mirrored in the therapy	10P. Experiences of being understood and mirrored in the therapy	10T. Experiences of being understood and mirrored in the therapy
11. Recognition of changes that psychotherapy has made possible	11P. Recognition of changes that psychotherapy has made possible	11T. Recognition of changes that psychotherapy has made possible
12. Alleviation of depression	12P. Alleviation of depression	12T. Alleviation of depression
13. Functionality of the therapeutic working relationship	13P1. Functionality of the therapeutic working relationship	13T. Functionality of the therapeutic working relationship
	13P2. Dependency on the therapist	

The factors "Functionality of the object relationships" and "Confidence in the therapist's assistance" had the highest eigenvalues in the patients. The first of these accounted for 56% of the variance and the second for 42%. In the therapists, the highest eigenvalues were recorded for the factors "Confidence in the method in relation to the patient" and "Object relationships". The first of these accounted for 58% of the variance and the second for 63% (*Table 3*).

The highest proportion of variance in the patients was accounted for by the factors "Alleviation of depression" and "Experiences of being understood and mirrored in the therapy", the respective percentages being 82% and 77%. In the therapists, the corresponding factors were "Emergence of a rational treatment alliance" and "Experiences of being understood and mirrored in the therapy". The former accounted for 81% and the latter for 80% of the variance (*Table 3*).

Table 3. Eigenvalues of primary factors, excluding factors with an eigenvalue below 3.0

Factor	Label	Eigenvalue	Proportion
	Within four months of psychotherapy		
1T	Emergence of a rational treatment alliance	4.45	0.81
2P	Recognition of depression and hopelessness within the treatment setting	8.79	0.72
2T	Recognition of depression and hopelessness within the treatment setting	4.96	0.50
3aP	Affective relationship between the patient and the therapist	4.23	0.46
3aT	Affective relationship between the patient and the therapist	3.03	0.58
4P	Current self-experience	6.06	0.54
4T	Current self-experience	6.49	0.59
	After 11 months of psychotherapy		
3bP1	Confidence in the therapist's assistance	10.02	0.42
3bP2	Experience of the therapist as a person	4.68	0.20
3bP3	Experience of one's own significance to the therapist	3.09	0.13
3bT1	Confidence in the method in relation to the patient	13.99	0.58
3bT2	Quality of the affective relationship between the patient and the therapist	3.11	0.13
5bP1	Understanding of one's own mental functioning	8.54	0.54

5bP2	Understanding of the effects of one's developmental history on mental functioning	4.01	0.25
5bT1	Understanding of one's own mental functioning	7.92	0.51
5bT2	Understanding of the effects of one's developmental history on mental functioning	3.96	0.26
6P1	Functionality of the object relationships	11.15	0.56
6P2	Experience of the self in relation to objects	3.41	0.17
6T	Object relationships	12.09	0.63
7P1	Difficulties with aggression	3.85	0.35
7P2	Aggression in the service of self-esteem	3.01	0.28
7T	Processing of the patient's aggression	6.66	0.52
8P	Work and other occupational problems	5.06	0.72
8T	Work and other occupational problems	5.80	0.71
9P	Working with the depressive mental contents and hopelessness	6.34	0.63
9T	Working with the depressive mental contents and hopelessness	5.80	0.65
10P	Experiences of being understood and mirrored in the therapy	6.89	0.77
10T	Experiences of being understood and mirrored in the therapy	6.93	0.80
11P	Recognition of changes that psychotherapy has made possible	3.83	0.54
11T	Recognition of changes that psychotherapy has made possible	5.86	0.71
12P	Alleviation of depression	5.84	0.82
12T	Alleviation of depression	5.76	0.78
13P1	Functionality of the therapeutic working relationship	4.26	0.35
13P2	Dependency on the therapist	3.24	0.27
13T	Functionality of the therapeutic working relationship	5.06	0.43

SECOND-ORDER FACTOR ANALYSIS

The combined analysis of all factors of the patients and the therapists yielded three second-order factors, which accounted for 80% of the variance. The primary factors of the therapists loaded into two of these second-order factors, and the primary factors of the patients loaded into all three second-order factors (*Table 4*). These factors were named, in an analogous way to the description of the primary factors, according to their feasible clinical content with respect to the therapeutic process.

Factor 1: Coping with depression

This factor had the highest eigenvalue and accounted for 46% of the total variance. Thirteen factors of the therapists and eight factors of the patients loaded into this second-order factor, six of which were the same in the patients and the therapists. Five of these six factors were related to working with the depressive mental contents within the therapeutic relationship, coping with depression, recovery from depression with the support of the therapist or the emotional relationship of the therapeutic alliance. The remaining factor identified current self-experience.

Seven other factors of the therapists loaded into this second-order factor. They represented themes that widely and more profoundly identified mental functioning and difficulties associated with depression or the treatment relationship, such as factors related to the quality of the emotional relationship of the therapeutic alliance or to the processing of aggression. The two remaining factors of the patients loaded into this second-order factor represented experience of the self in relation to others and confidence in the therapist's assistance. The factor "Alleviation of depression" had the highest communality in both the therapists and the patients for this second-order factor (*Table 4*).

Factor 2: Coping with present and past reality

The patient and therapist factors from the first-order analysis loaded differently on this second-order factor, and they accounted for 19% of the total variance. The three factors of the therapists were related to the effects of developmental history on mental functioning and on the underlying factors of depression, to the object relationships or to the rational treatment relationship. The two factors of the patients loaded into this second-order factor identified work and other occupational problems and problems with aggression.

The factors of the therapists "Understanding of the effects of one's developmental history on mental functioning" and "Object relationships" had the highest communalities for this second-order factor (*Table 4*).

Factor 3: Understanding of self-experience

This second-order factor was only composed of patient factors, accounting for 15% of the total variance. Three of the seven primary factors were loaded into this second-order factor and they had in common qualities related to the experience of depression and its underlying factors, such as the effects of one's developmental history on mental functioning. Four factors, representing experience of the self in relation to others and to the therapist, were also loaded into this factor.

The highest communalities for this second-order factor were in "Understanding of one's own mental functioning" and "Recognition of depression and hopelessness within the treatment setting" (*Table 4*).

Table 4. Second-order factor analysis of all factors of the patients and the therapists, excluding factors with communality below 0.30

Factor	Label	Communality
	Coping with depression (Eigenvalue = 12.66, Proportion = 0.46)	
12P	Alleviation of depression	0.90
12T	Alleviation of depression	0.88
10T	Experiences of being understood and mirrored in the therapy	0.87
11T	Recognition of changes that psychotherapy has made possible	0.84
13T	Functionality of the therapeutic working relationship	0.79
5bT1	Understanding of one's own mental functioning	0.77
13P1	Functionality of the therapeutic working relationship	0.70
11P	Recognition of changes that psychotherapy has made possible	0.70
10P	Experiences of being understood and mirrored in the therapy	0.68
9P	Working with the depressive mental contents and hopelessness	0.67
4P	Current self-experience	0.62
7T	Processing of the patient’s aggression	0.61
8T	Work and other occupational problems	0.57
3bT2	Quality of the affective relationship between the patient and the therapist	0.56
3bT1	Confidence in the method in relation to the patient	0.55
6P2	Experience of the self in relation to objects	0.52
5T	Current self-experience	0.49

3bP1	Confidence in the therapist's assistance	0.48
2T	Recognition of depression and hopelessness within the treatment setting	0.47
9T	Working with the depressive mental contents and hopelessness	0.45
3aT	Affective relationship between the patient and the therapist	0.43
	Coping with present and past reality (Eigenvalue = 5.16, Proportion = 0.19)	
5bT2	Understanding of the effects of one's developmental history on mental functioning	0.87
6T	Object relationships	0.81
8P	Work and other occupational problems	0.74
7P1	Difficulties with aggression	0.53
2T	Emergence of a rational treatment alliance	0.52
	Understanding of self-experience (Eigenvalue = 4.05, Proportion = 0.15)	
5bP1	Understanding of one's own mental functioning	0.85
2P	Recognition of depression and hopelessness within the treatment setting	0.80
13P2	Dependency on the therapist	0.69
6P1	Functionality of the object relationships	0.65
5bP2	Understanding of the effects of one's developmental history on mental functioning	0.60
3aP	Affective relationship between the patient and the therapist	0.48
3bP2	Experience of the therapist as a person	0.43

DISCUSSION

The aim of the present study was to identify and conceptualize the factors at work in the process of psychodynamic psychotherapy for depression based on the views of both the patients and therapists. We applied factor analysis to investigate the experiences and perceptions of the patients and therapists of the commonly targeted core elements of the treatment. Below, we separately discuss our findings in relation to the outcomes of the primary and secondary factor analysis.

PRIMARY FACTOR ANALYSIS

More than 2/3 of all the process variables were loaded in factor analysis with communality higher than 0.30. Of the 15 clusters designed to characterize the psychotherapy process of depressive patients, 13 formed at least one factor for both the therapist and patient variables. The good loading of the variables and the formation of the factors suggest that selected variables and their clustering had clinical validity. Moreover, the joint behaviour of the patient and therapist clusters suggests that the patients and the therapists were reciprocally tuned to the therapeutic work with the depression of the patient.

In the early stage of the treatment, both the patient and the therapist variables formed no more than a single factor from each cluster, whereas at the end of the first year of treatment, five clusters of the patients and two clusters of the therapists divided into two or more factors. A long enough period of therapeutic work seems to be required before a more detailed evaluation of the different dimensions of the clusters becomes meaningful.

The formation of the factors revealed several differences between the patients and therapists in their way of experiencing and perception of the therapy process and the manifestation of depression. The variables of the cluster "Emergence of a rational treatment alliance" only formed a factor for the therapists, which probably indicates that in the early stage of the treatment the patients' expectations are more concentrated on the experience of therapeutic help in the midst of their difficulties, while the therapists also pay specific attention to the functioning of the working relationship and the wider life situation of the patient (30).

The variables of the cluster "Capacity for insight" did not form a factor for either the therapists or the patients in the early stage of treatment, but loaded after 11 months of therapy and formed two factors for both of them. It is likely that the experience of insight only occurs as the therapy process gradually develops and not in the initial stage of the treatment. The formation of insight at the end of the first year as a factor in both patients and therapists indicates that the meaning of gaining understanding was recognized at this stage. This is in line with Høglend (31) and Kallestad et al. (32), who have suggested that insight is a specific mechanism of change in dynamic psychotherapy that requires a long enough time to produce change. Insight has been suggested to be a relevant mechanism of change even across different psychotherapeutic treatment modalities in a recent meta-analysis by Jennisen et al. (36). Moreover, increased insight may also have had relevance in the findings from the Helsinki Psychotherapy Project (33,34,35) of the sustained benefits of long-term psychodynamic psychotherapy in comparison with short term therapies.

In the early stage of the therapy, the variables of the cluster "Affective relationship between the patient and the therapist" formed one factor for both the patients and the therapists. After 11 months, however, they formed three factors for the patients and two factors for the therapists, suggesting a different evolution of understanding between the patients and therapists over the second period. The factors of the patients emphasized confidence in the therapist's assistance, experience of the therapist as a person and experience of one's own significance to the therapist, whereas the therapist factors brought up the importance of confidence in the method and the quality of the affective relationship.

The difference between the patients and the therapists in this respect highlights the significance of the evaluator's perspective. The perspective of the patients concerning the affective relationship reflects self-uncertainty and the need for help, whereas the viewpoints of the therapists have a more professional basis. Patient factors appear to reflect the activation of narcissistic vulnerability and dealing with low self-esteem in relation to the therapist. These two themes have been suggested to reflect core features in depression (4). Their activation, and working through within the transference, is presumably essential in bringing about positive changes. Increasing awareness of the repetitive and fantasy-driven nature of depressive thinking and behaviour is commonly assumed to enable change to occur, particularly in patients with long-standing problems in interpersonal relationships (37,38,31)

The therapists appeared to aim at a comprehensive understanding of the overall situation of the patient, including the various underlying causes of the symptoms of depression, such as developmental, interpersonal and psychosocial

factors, whereas the patients seemed to experience the factors affecting their condition and the process of therapy as more divided into separate issues. This difference may relate to the difficulty of the patients in experiencing, communicating and gaining insight into aggressive and other affectively loaded mental contents, especially within the treatment relationship. This would be in agreement with the commonly found difficulties of depressed subjects in experiencing and expressing affect, on a conscious level, especially negative affect and inhibited anger (39,5). The promotion of affective experience and expression has been found to be associated with improvement over the course of psychodynamic psychotherapy (40,41). The apparent ambiguity among the patients in conceptualizing these themes probably also made their activation during the first year of the therapy process difficult. The distribution of the variables of the patients into several factors relative to the therapists may additionally indicate a more subjective evaluation of the process by the patients, due to their need for help and support during the depressive episode, which would be in line with the finding that hospitalized patients with major depression prefer supportive psychotherapy (42).

The factors of the patients "Confidence in the therapist's assistance" and "Functionality of the object relationships", and respectively the factors of the therapists "Confidence in the method in relation to the patient" and "Object relationships", explained the largest proportion of common variance. These findings emphasize the significance of the value of the working out of the therapeutic relationship (5).

SECOND-ORDER FACTOR ANALYSIS

In the second-order factor analysis, all primary factors of the patients and therapists were pooled together, resulting in three second-order factors. The first factor, which we labelled as "Coping with depression", appeared to represent at the content level more broadly the state of a depressed patient. The second factor, labelled as "Coping with present and past reality", represented more the difficulties and the obstacles related to the depression. The third factor, labelled as "Understanding self-experience", contained elements which represented emotional insight into the underlying factors of depression.

Most of the primary factors loaded into the same second-order factor, labelled as "Coping with depression". The good concordance of loadings between patients and therapists suggests that the work within the therapeutic couple was satisfactorily tuned for coping with depression and not driven by the preconceptions of the therapist. In therapists only, possibly depression-related contributing factors of mental activity and themes related to the therapeutic relationship and method also loaded into this factor.

These differences in the loadings of the themes between the patients and the therapists are in line with the results of the primary factor analysis and provide methodological support to the generalizability of its results (43). From both analyses, the same trend becomes evident: the therapists perceived the situation of the patient and the therapy process more comprehensively, while the experience of the patients was more heterogeneous.

The primary factors that loaded into the second factor named as "Coping with present and past reality" were different in the therapists and the patients. In the therapists, this second-order factor appeared to reflect the underlying developmental factors of depression as they were revealed within the therapeutic relationship. The patients' factors appeared to mainly reflect difficulties with aggression in respect of occupational problems, thus probably representing more the obstacles to than the factors promoting the therapy.

Only primary factors of the patients concerning the underlying factors of depression and experience of the self in relation to others loaded into the third factor, "Understanding of self-experience". The primary factors "Understanding of one's own mental functioning" and "Recognition of depression and hopelessness within the treatment setting" had the highest communalities for this second-order factor. The emphasis of these themes in the patients plausibly associates with the progress of treatment. According to Gabbard (44), for example, central to the psychodynamic approach with depressed patients is the establishment of the interpersonal meaning and context of their depression. The formation of a separate second-order factor only in patients regarding these subjects also further suggests that the patients perceive the symptoms of depression and its determinants as less integrated than the therapists.

STRENGTHS AND LIMITATIONS

The strengths of the study are the inclusion of drug-naïve subjects, the absence of significant previous treatment, the homogeneity of the training of the therapists, and the ethnically and culturally homogeneous patient sample. The small number of subjects is an obvious limitation. On the other hand, De Winter et.al. (28) have suggested that for loadings higher than 0.8 and one factor, even sample sizes smaller than 10 are sufficient for factor recovery, and when

loadings are as high as 0.9, even with a high number of factors (f=4) and a limited number of variables (p=12), a sample size of 12 may suffice. Also, the simulation study by Hogarty et al. (29) suggested that high communalities and a small number of highly overdetermined factors can provide good recovery of factors even in the case of small sample size. Moreover, assessment of the validity of the used variable clusters remained incomplete in this study and requires further work. Finally, all except two patients continued their psychotherapy after the first year, which might have caused heterogeneity in the therapeutic relationships and in the phase of their therapeutic process in our sample, and thus limits the generalization of our finding to the long-term psychodynamic psychotherapy process.

CONCLUSIONS

The analysis yielded factors that appear to be clinically relevant and in concordance with the nature of depression and its treatment with psychotherapy. The formation of the factors was largely consistent between the patients and the therapists, reflecting a good mutual tuning to the therapeutic work with depression. The main finding was the significant difference between the patients and the therapists in perceiving the overall situation of the patients, including the symptoms and their underlying factors, such as developmental, interpersonal and psychosocial issues. The variables representing these themes were dispersed to a greater extent into separate factors in the patients compared to the therapists. The depressive patients seemed to be less able to perceive in an integrative way the background factors of depressive symptoms and to detect a connection between these and depression.

The results of the present study are in accordance with our previous more qualitative analysis (22) and indicate that the perceptions and experiences of patients and their therapists differ, especially with respect to affective and negatively loaded themes and object relationships. We hypothesize that the working through of these themes is important for achieving understanding of the underlying factors of the symptoms and for creating a meaningful connection between the past and present in patients with depression.

Conflict of Interest statement

All authors declare that there is no conflict of interest

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