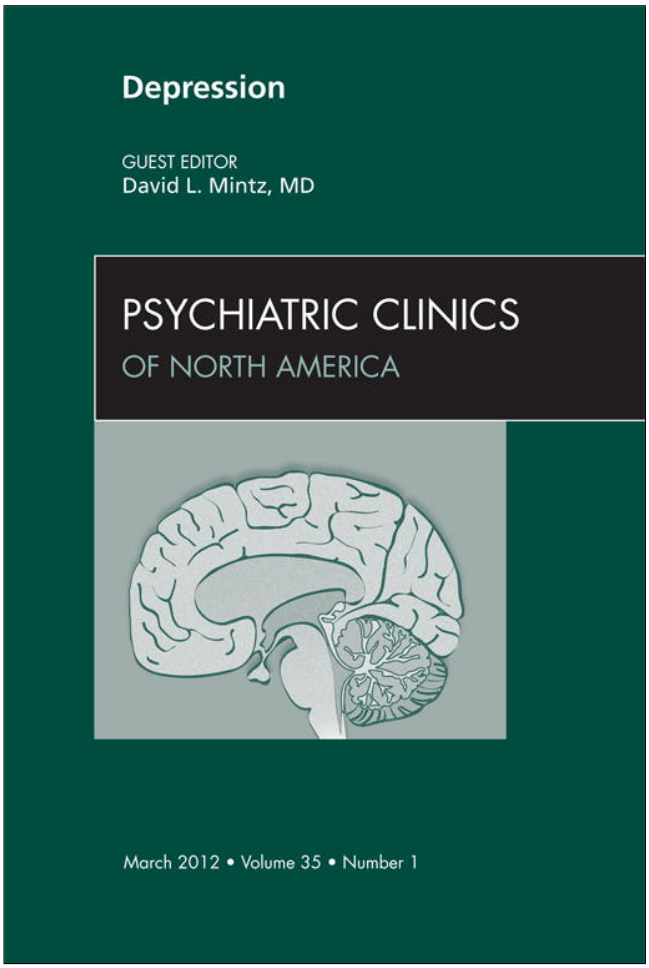

Psychodynamic Treatment of Depression

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KEYWORDS

• Depression • Mood disorder • Psychoanalytic
• Psychodynamic • Treatment • Efficacy • Effectiveness

Key Points: Summary of Key Findings Concerning Psychodynamic Treatment of Depression

- Psychodynamic treatments for depression are readily accepted by many depressed patients as a viable treatment
- Brief psychodynamic treatment
  - Is superior to control conditions, is equally effective as other active psychological treatments, and treatment effects are often maintained in the long run
  - Is as effective as pharmacotherapy in the acute treatment of mild to moderate depression, and either alone or in combination with medication is associated with better long-term outcome compared with pharmacotherapy alone
- Longer-term psychoanalytic treatment and psychoanalysis
  - May be indicated in patients with complex, chronic psychological disorders characterized by mood problems, often with comorbid anxiety and personality problems.
  - May be more effective in the long run compared with brief treatment for depression, although more research is needed in this context.
- Evidence suggests that psychoanalytic treatment is also effective in children and adolescents

Over the last 2 decades, there has been a remarkable increase in research into psychodynamic treatments (PT) for depression.[1–4] This article reviews the key theoretical assumptions of PT for depression and summarizes findings concerning

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the efficacy and effectiveness of these interventions alone and in combination with pharmacotherapy in adults, children, and adolescents. Issues of suitability and acceptability are also discussed as well insights into the mutative factors in these treatments. We close this article with a summary and implications for future research and treatment guidelines.

SPECIFICITY OF THE PSYCHODYNAMIC APPROACH: COMMON AND SPECIFIC FACTORS IN PSYCHODYNAMIC TREATMENTS OF DEPRESSION

Meta-analyses have identified very few, if any, differences in the efficacy of bona fide psychotherapies for a number of conditions, including depression.[5,6] This may be because the effects of these treatments are only in part related to specific techniques. Other factors may account for a larger portion of the variance in treatment outcome; it has been estimated that only 15% is predicted by specific techniques, 30% by common factors (eg, providing support), 15% by expectancy and placebo effects, and 35% to 40% by extratherapeutic effects (eg, spontaneous remission, positive events or changes).[7] Moreover, it has been difficult to find differences among treatments because most studies have focused on symptom remission in brief, highly structured, and manualized interventions. Furthermore, most randomized, controlled trials (RCTs) have only had power to investigate noninferiority compared with other active treatments and thus may be unable to detect meaningful differences between treatments. Research focusing on outcomes broader than symptom remission, as well as long-term effects, may be more promising as discussed below.

Psychodynamic Specific Features

Notwithstanding the many common features of treatments for depression (such as provision of hope, support, and a theoretical framework concerning the origins of and potential cure for the disorder), studies do show important differences between psychodynamic and other treatments. For instance, relative to cognitive–behavioral therapists, psychodynamic therapists tend to have a stronger emphasis on[8]:

1. Affect and emotional expression
2. Exploration of patients' tendency to avoid topics (ie, defenses)
3. Identification of recurring patterns in behavior, feelings, experiences, and relationships
4. The past and its influence on the present
5. Interpersonal experiences
6. The therapeutic relationship
7. Exploration of wishes, dreams, and fantasies.

These findings are largely congruent with work done in the United Kingdom in the context of the Improving Access to Psychological Therapies initiative. This demonstrates that although psychodynamic competencies overlap to some extent with those of other treatments (such as the ability to engage the client and establish a positive therapeutic alliance), there are a number of competencies specific to psychodynamic therapy (such as the ability to work with transference and countertransference and to recognize and work with defenses).[9] The focus on competencies has also led to the development of dynamic interpersonal therapy, a promising novel psychodynamic treatment for depression that integrates features of a number of current empirically supported PT of depression. Dynamic interpersonal therapy is currently being evaluated in an RCT.[2]

Aside from these specific techniques and competencies, a number of general assumptions, rooted in psychodynamic theory,[10] further define the specificity of the psychodynamic approach to the treatment of depression.

Psychodynamic Approaches Focus on the Patient's Internal World

First, perhaps more so than any other treatment, PT focus on the patient's internal world, that is, representations or cognitive affective schemas of self and others that influence our perceptions, thoughts, feelings and actions, including an emphasis on the role of unconscious motivation and intentionality. The emphasis in psychodynamic approaches to depression is on how (unconscious) motivational factors lead the patient to (mis)perceive and (mis)interpret external reality and experiences and to create, unwillingly, problems that maintain depressive symptoms, particularly in interpersonal relationships. For instance, highly dependent individuals may unconsciously avoid any manifest expression of aggression in close relationships for fear of abandonment, although they may feel very frustrated and dissatisfied. Likewise, because of their high standards and competitiveness, highly self-critical individuals may unconsciously and unwittingly elicit criticism and dislike by others, reinforcing their belief that that nobody really likes or loves them.[11] Of course, these tendencies are likely to be influenced by social–environmental factors (eg, growing up in a family characterized by low parental warmth or working in a competitive work environment) and by biological factors, some of which are discussed below.

Yet, psychoanalytic approaches to depression emphasize the need to understand the subjective experience of the disorder. As we discuss in more detail below, a focus on the phenomenology of depression has not only allowed researchers from different theoretical strands to delineate different types of depressive experiences. This has also facilitated research into neurobiological and social factors related to depression[12–14] and led to an awareness of the role of distortions in mentalization, that is, the ability to reflect on the self and others in terms of mental states, both as a cause and a consequence of depression. These distortions may not only influence the course but also the treatment of this disorder.[2,13]

Psychodynamic Approaches Take a Developmental Perspective

Second, psychodynamic approaches have always emphasized the importance of a developmental perspective in conceptualizing and treating depression, and recent research has provided dramatic support for these assumptions. For instance, the emphasis in contemporary models of depression concerning the impact of early adversity on the programming of the main human stress system and the existence of critical time windows in development, when biological/psychological systems are especially sensitive to environmental experiences, are congruent with assumptions about the role of early developmental factors in the causation of depression.[15–17] Psychoanalytic treatment approaches more specifically emphasize the role of insight into the past in changing attitudes and feelings in the present, offering the possibility of a "new beginning."[18] Moreover, even in brief PT of depression that focus less on the past, developmental antecedents of behavior, thoughts, feelings, and attitudes are always taken into account.[2]

Psychodynamic Approaches are Person Centered

Finally, psychodynamic approaches of depression are more *person* than *disorder* centered. The view, supported by empirical research,[19,20] is that depression is not categorically distinct from subclinical depression and from normality and that

depression is not a discrete disorder, distinct from other Axis I and Axis II disorders. Depression is first and foremost considered to be a basic affect that signals a discrepancy between a wished-for state and an actual state of the self; it is not necessarily considered something pathologic. It is seen as a primordial, probably for evolutionary reasons prewired, signal affect or a basic "building block" of the individual's internal affective world. From a psychoanalytic perspective, both normal and disrupted development involve ongoing attempts by the individual, throughout the life span, to find an optimal balance between biological givens and the demands of the environment.[11] Depression is, thus, not conceptualized in terms of a static end state, but as reflecting continuing attempts of the individual, however maladaptive, to find a (better) balance between endowment and experience.[21] Together with anxiety and aggression, depression is seen as a basic emotional response of the individual, in particular to feelings of loss of a wished-for state. Depression, anxiety, and aggression are, thus, inextricably linked. This also explains the high comorbidity of depression and anxiety and the largely artificial distinction between these 2 disorders in psychiatric classification.[22] Viewing depression as a basic affect suggests there is no qualitative but only quantitative distinction between normal and "pathological" mood, with depression situated on a continuum ranging from mild dysphoria to clinical depression, a view supported by taxometric studies.[23]

Person- and disorder-centered approaches should be seen as complementary. Studies clearly show that most patients seek help from psychoanalytically trained therapists primarily for (chronic) mood problems, often in combination with anxiety and personality problems.[24,25] In response, a substantial empirical tradition focusing on depression and its treatment has emerged within the psychoanalytic tradition.

THEORETICAL PERSPECTIVES

Historical Developments

Freud aptly described depression as a psychic wound or hemorrhage ("innere Verblutung"), a kind of "hole in the psyche" ("ein Loch im psychischen") that drains all energy of the individual.[26] From a psychoanalytic perspective, the core features of depression indeed refer to a problem related to desire, that is, the relationship of the individual to his wishes, ideals, and ambitions[27,28] or "wished-for state."[29] The depressed patient's complaints can be seen as indicative of a continuous and often very painful confrontation resulting from the gap between his ideals and ambitions, his wished-for state of the self and the actual state of the self. This may lead to feelings of helpless or hopelessness,[30] possibly explaining the typical feelings of anhormia (lack of drive) and anhedonia observed in depressed individuals. Yet, this state is also often accompanied by anxiety (anxious or agitated depression), and aggression toward the self or others. In Kleinian[31] and attachment-based[32] approaches, aggression toward the self and others (eg, because of self-criticism or disappointment) is seen as playing a prominent role in depression. Moreover, feelings of pain and exhaustion also typically color the clinical picture, as is also expressed in the high co-occurrence and comorbidity between depression, pain, and fatigue syndromes.[33] By contrast, in (hypo)manic states, which are almost the opposite of depression in terms of symptoms, the individual appears to be at one with his ego ideal.[34] Although these observations are still relevant clinically, traditional psychoanalytic theories of depression were often overspecified, lacked theoretical precision, and were too broad to be empirically tested.

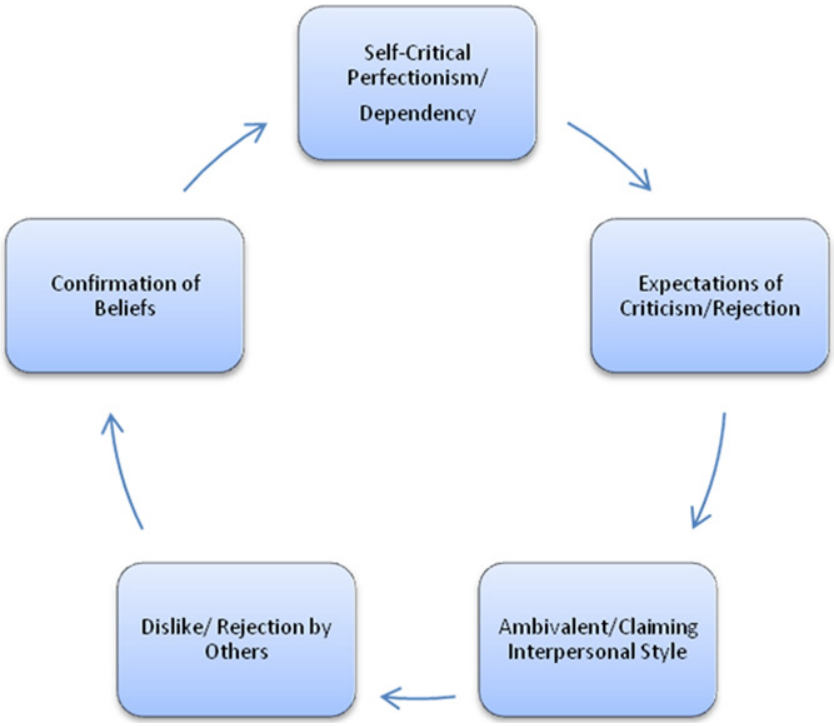

Fig. 1. Treatment focus: dysfunctional transactional styles associated with personality-related vulnerability for depression.

Personality and the Dynamics of Depression

In the early 1970s, Blatt[35] provided a view of depression that has been the basis for almost 40 years of empirical research and most contemporary psychodynamic approaches to depression.[11,14,20,36,37] Congruent with earlier psychoanalytic theorizing, he argued that in the phenomenologic experience of depression, 2 central issues can be identified: one relating to loneliness, feelings of neglect, and abandonment, the other to self-worth, responsibility, and guilt. As a result of this distinction, investigators from both the psychodynamic and cognitive–behavioral tradition have focused on 2 independent personality dimensions in depression,[35,38,39] an interpersonal dimension, reflecting high levels of dependency, and a self-critical dimension that involves extensive preoccupation with self-definition and autonomy. Beck,[38] from a cognitive-behavioral perspective, similarly distinguished sociotropy and autonomy, personality dimensions that, in the extreme, confer vulnerability for depression.

Considerable evidence indicates that the dependency and self-critical personality dimensions are associated with differences in the onset, course, and clinical expression of depression,[14,20,35] basic personality style,[11] relational and attachment style,[21,40] and current and early life experiences.[41,42] Perhaps most importantly, as discussed in the final section of this article, these 2 dimensions are also related to treatment response across different therapeutic modalities.[43]

Evidence also indicates that high levels of dependency and self-criticism are associated both with increased stress sensitivity and the generation of stress, particularly through so-called dysfunctional interpersonal transactional styles,[20,44,45] which often are the central focus in PT of depression (**Fig. 1**). These findings are particularly relevant given that stress and adversity play a major role in the causation of depression.[46,47]

Individuals with high levels of dependency or self-criticism tend to behave in ways that elicit particular responses from others. These reactions often confirm the

individual's fear of rejection and abandonment or of disapproval, thereby creating a vicious cycle. For example, high levels of dependency have been associated with annoyance and resentment in others, eventually leading to rejection and abandonment, thereby confirming fears associated with high levels of dependency. Similarly, high levels of self-criticism are associated with ambivalence toward others because of fear of criticism and disapproval. Accordingly, others perceive these individuals as cold, competitive, and distant, confirming the highly self-critical individual's belief that others do not like and disapprove of them.

Attachment, Mentalization, and the Neurobiology of Depression

Attachment

Blatt's and Beck's models are conceptually and empirically linked to attachment theory,[20] fostering dialogue between psychoanalytic, developmental psychopathology, and neuroscience approaches to depression.[13,48] Contemporary research suggests that 2 dimensions, avoidance and anxiety, underlie attachment styles[49,50] and that these are conceptually related to Blatt's concepts of self-definition and relatedness, respectively. The attachment avoidance dimension refers to "discomfort with closeness and with discomfort depending on others"[49] and is typically associated with the use of attachment deactivation strategies. In times of distress, automatic unconscious strategies are activated that involve denying attachment needs and asserting one's own autonomy, independence, and strength. The attachment anxiety dimension, in contrast, involves "fear of rejection and abandonment."[49] In times of stress, the attachment system becomes hyperactivated leading to frantic attempts to find security, support, and relief, often expressed in demanding or clingy behavior.

Evidence from various strands of research support the key role of attachment in depression.[13] Vulnerability to depression is related to both attachment hyperactivation and deactivation strategies.[51,52] Insecure attachment has been shown to be prospectively related to recurrent depression and is associated with more depressive episodes and residual symptoms, longer use of antidepressants, greater impairments in social functioning,[53] and suicide.[54] As noted, early adversity, and disruptive attachment experiences in particular, play a central role in the causation of depression.[46] This may explain, at least in part, the role of increased responsivity to both daily and major life stressors in the causation and course of depression.[46,55] Furthermore, both animal[56–58] and human[59–61] research suggests that the neuropeptide oxytocin (and potentially also vasopressin), which is involved in neural systems underlying attachment,[56,62] plays a key role in stress regulation. This hormone is involved in affiliative behavior (eg, pair bonding, maternal care, and sexual behavior), social memory, and social support[63] and has stress-reducing and anxiolytic effects,[56] again indicating the close relationship between attachment history, depression, and anxiety.[48]

The emphasis on attachment in depression is further reinforced by findings on the role of impairments in social cognition, and mentalizing in particular, in depression.[2,64]

Mentalization

Mentalizing refers to the imaginative mental activity involving interpretation of the self and others in terms of mental states, such as feelings, desires, wishes, and goals. It enables us to navigate the social world and is typically acquired in the context of (early) attachment relationships. Impairments in mentalizing have been associated with depression, and they may, in part, underlie the interpersonal problems typically associated with this disorder (for a detailed review, see Luyten and coworkers[13]).

As well as having a causative role, it is likely that impairments in mentalizing also result from depression. Depressed mood impairs the capacity of an individual to reflect on both the self and others, and when he or she does mentalize, it is likely to be distorted. As a result, modes of thinking that antedate full mentalizing re-emerge that help understand the phenomenologic experience of depression. For example, in the psychic equivalence mode, psychological and physical pain and emotional and physical exhaustion are equated, possibly explaining the high comorbidity of pain, fatigue, and depression.[65,66] Psychological experiences are felt as too real; psychological pain means bodily pain, and criticism by others is felt as a physical attack on the integrity of the self. Findings on the common neural circuits underlying psychological and physical pain show that these experiences are closely intertwined; rejection literally hurts.[67] In the pretend mode, thoughts and feelings are severed from reality, which is typically expressed in overly detailed, highly cognitive, or affectively overwhelming narratives, often characterized by rumination, self-blame, or the relentless blaming of others. In the teleological mode, only observable behavior or material causes can be real. The patient can only feel loved if there is also a physical expression of love, which may lead to frantic attempts to elicit care and love from attachment figures, including the therapist (eg, demanding longer or more sessions or asking to be hugged or touched, which may lead to boundary violations). In this mode, suicidal thoughts and gestures often lead others, including professionals, to similarly revert to a teleological mode in an attempt to demonstrate love, care, and concern.

EFFICACY AND EFFECTIVENESS OF PSYCHODYNAMIC THERAPY FOR DEPRESSION

Over the last decades, a range of brief and long-term psychodynamically based treatments for depression have been empirically evaluated in children, adolescents, and adults. Although some of these treatments have been based on generic psychodynamic treatment principles,[68–73] others have been more explicitly rooted in extant psychodynamic findings concerning depression.[2,74] These treatments differ to the extent that they emphasize supportive and expressive techniques (although they all include elements of both) and whether their primary focus is interpersonal or intrapsychic. Despite these differences, as noted, these treatments have in common a focus on recurring patterns in feelings and relationships with the aim to increase the patient's insight into these patterns, so that he or she can change them.[8] Several recent reviews and meta-analyses have addressed their efficacy and effectiveness.[4,75,76] Below we critically review the findings.

Efficacy and Effectiveness of Psychodynamic Treatment Alone

A recent meta-analysis of 23 studies with a total of 1365 patients found that brief psychoanalytic therapy (BPT) for depression was associated with large symptom reductions (Cohen's $d = 1.34$) that were maintained at 1-year follow-up.[4] BPT was found superior to control conditions ($d = 0.69$). After treatment, BPT was slightly less effective than other psychotherapies ($d = 0.30$), yet these differences disappeared at 3- and 12-month follow-up ($d = 0.05$ and $d = 0.29$, respectively). Moreover, individual BPT ($d = 1.43$) was more effective compared with group BPT ($d = 0.83$) and was as effective as other individual psychotherapies after treatment ($d = 0.19$) and at 3- and 12-month follow-up ($d = 0.05$ and $d = 0.31$, respectively; all nonsignificant). These results are surprisingly good, given that in early trials, BPT was often included as a control condition.

The use of BPT as a control may also explain, in part, why some previous reviews found BPT to be inferior to other therapies, including cognitive behavioral treatment (CBT). In the meta-analysis by Gloaguen and colleagues,[77] for example, Wampold and coworkers[5] found that once non–bona fide therapies were removed, superiority

of CBT over other therapies could no longer be demonstrated. A recent meta-analysis of RCTs comparing the efficacy of BPT to CBT in major depressive disorder, similarly found no differences in changes in depressive and general psychiatric symptoms nor social functioning.[78]

Specific types of depression and BPT

Reviews and meta-analyses focusing on specific types of depression and related conditions similarly support the efficacy and effectiveness of BPT. Abbass and colleagues[79] recently presented a meta-analysis of BPT in patients with depression and comorbid personality disorder, showing moderate to large effect sizes that were maintained at treatment follow-up. These findings are important, as estimates of comorbidity between major depression and personality disorder typically range between 35% and 65%.[80] Maina and colleagues[81] compared the efficacy of BPT, brief supportive therapy (ST), and a wait-list condition (WL) in the treatment of minor depressive disorder. Both BPT and ST were superior to the WL at treatment termination, and BPT was superior to ST at 6-month follow-up. In one RCT focusing on pathologic grief, it was found that group BPT was superior to a WL control group.[82] In a second RCT of this group, there was a patient–treatment interaction; patients with high quality of object relationships showed greater improvement with regard to grief symptoms in insight-oriented BPT, whereas those with low-level object relations showed greater gains in supportive BPT.[83] These findings are congruent with those from studies showing that patients with lower levels of personality organization may benefit more from treatments with a greater emphasis on supportive interventions.[84] Yet, for general symptoms, insight-oriented BPT was superior regardless of level of object relations.

Although BPT is highly effective for a considerable subgroup of patients suffering from depressive disorders, a substantial proportion do not improve, as is the case with other brief treatment.[85] Recent studies suggest that only about 50% of depressed patients show a response to brief treatment and that relapse figures can be as high as 75%.[19,20,85,86] A recent follow-up study found that 42% of patients treated with BPT for depression had a recurrence within a 5-year time span, which is similar to findings in follow-up studies of other brief psychological treatments, such as CBT.[87]

Long-term perspective in depression treatment

Current treatment guidelines, therefore, emphasize the role of a long-term perspective in the management of depression, stressing continuation and maintenance treatment, with a focus on relapse prevention.[85] In this context, studies concerning longer-term psychoanalytic treatment (LTPT) are highly relevant, as LTPT focuses on patients suffering from chronic mood problems, which often result from a combination of depression, anxiety, and significant personality and relational problems. Studies by Knekt and colleagues[88,89] are particularly pertinent in this context. They conducted an RCT comparing BPT, LTPT, and solution-focused therapy in 326 patients with depressive and anxiety disorders. During the first year, BPT was superior to LTPT, during the second year there were no differences between these treatments, and at 3-year follow-up LTPT outperformed both BPT and solution-focused therapy, with no differences between the latter 2 treatments. These findings are consistent with the assumption that LTPT is characterized by a slower rate of change compared with brief treatment (probably because it focuses less on symptomatic improvement), but is associated with more lasting, and perhaps broader, changes. In the

next section, we discuss evidence suggesting that LTPT may be associated with greater changes in underlying vulnerabilities than BPT.

More generally, recent meta-analyses have found evidence for the efficacy and effectiveness of LTPT for patients with so-called "complex" disorders, often including previously unsuccessfully treated (chronic) depressed patients with considerable personality comorbidity.[25,90] Similarly, there is some evidence for the effectiveness of psychoanalysis in the treatment of this group.[89] (de Maat S, De Jonghe F, de Kraker R, et al. The effectiveness of psychoanalysis: a comparison between psychoanalysis (PA) and long-term psychoanalytic psychotherapy (LTPP). Manuscript submitted for publication, 2010.) Importantly, both LTPT and psychoanalysis have been associated with continuing improvement after treatment termination, suggesting that they are associated with changes in vulnerability to depression.[91]

Summary: BPT and LTPT for depression treatment

Overall, findings suggest that BPT should be included in guidelines as a first-line treatment for patients suffering from depressive disorders.[75] LTPT and perhaps psychoanalysis should be considered for patients suffering from complex conditions characterized by (chronic) mood and personality problems. None of the meta-analyses reviewed found differences in effect sizes between controlled trials and naturalistic studies, suggesting that PT for depression can be translated to routine clinical practice without loss of its effects. Future research should concentrate on the cost effectiveness of both BPT and LTPT. A recent review of 8 studies showed that BPT was consistently associated with a significant decrease compared with control conditions in health care costs as expressed in lower physician and hospital costs, reduced medication usage and disability claims, and increases in the proportion of patients returning to work. (Abbass A, Driessen E, Town J. Cost-effectiveness of intensive short-term dynamic psychotherapy. Manuscript submitted for publication, 2011.) More studies focusing on the cost effectiveness of BPT and LTPT in the treatment of depression are needed.

Psychodynamic Psychotherapy and Pharmacotherapy

The evidence base of research comparing the efficacy and effectiveness of PT, pharmacotherapy, and their combination is still relatively limited. Yet, studies in this area seem to be consistent with meta-analyses suggesting few differences in the effects of bona fide psychotherapeutic treatments and pharmacotherapy in the acute treatment of depression and that psychotherapy and combined treatment are associated with better (long-term) outcome.[6,92]

A mega-analysis of 3 RCTs found that BPT was as effective as pharmacotherapy in terms of symptom reduction based on the Hamilton Rating Scale, but patients and therapists considered the effects of BPT to be superior compared with pharmacotherapy.[74] Because this conclusion is based on studies investigating psychodynamic-supportive psychotherapy, results may not generalize to other brief PT. Salminen and colleagues[93] compared a more expressive variant of BPT and fluoxetine in a trial of 51 patients with major depression and found no differences in terms of symptoms and functional ability. BPT was not manualized in this study, so it is possible that therapists differed considerably in their adherence to the therapeutic model. Moreover, follow-up analyses showed that patients with high levels of immature defense styles benefited more from BPT than fluoxetine, suggesting that BPT may be superior to pharmacotherapy when addressing depression in patients with fewer psychologic resources and more severe character pathology.[94] One study found that pharmacotherapy was associated

with a more rapid response compared with BPT, but this difference largely disappeared after 8 weeks.[95]

In a small trial (n = 35), Maina and colleagues[96] found that the combination of BPT with pharmacotherapy was superior to the combination of pharmacotherapy with ST. In another study, Maina and collaborators[97] followed up patients that had remission after a trial with either a combination of BPT and medication or medication alone. Remission rates in both conditions were identical (64.1% vs 61.4%, respectively). All patients subsequently received a 6-month continuation treatment with medication alone. At the 48-month follow-up, patients who received the combined treatment, however, showed significantly lower recurrence rates than patients in the medication-alone condition (27.5% vs 46.9%, respectively).

A mega-analysis of 3 RCTs of brief psychodynamic-supportive treatment found that combined treatment was more efficacious than pharmacotherapy alone.[74] Interestingly, again, rates of change were somewhat slower in BPT compared with pharmacotherapy. Finally, Burnand and colleagues[98] found that combined treatment was associated with fewer treatment failures, better work adjustment, better global functioning, and lower hospitalization rates. The costs of psychotherapy were offset by fewer hospitalizations and lost work days in patients receiving the combined treatment.

Although more research is needed, current evidence suggests that BPT is as effective as pharmacotherapy for mild to moderate depression and that combined treatment is more effective and cost effective. Studies show similar findings in patients with comorbid anxiety and depression.[99,100] Moreover, there are also indications that combined treatment is more acceptable to patients than monotherapy.[101] More long-term follow-up studies are needed. A recent follow-up study, for instance, found no differences in recurrence of depression at 5-year follow-up between BPT alone and combined treatment.[87]

Psychodynamic Therapy in Children and Adolescents

There has been less research on the effectiveness of psychodynamic therapy for children and adolescents than there has been for adults. A recent review, however, provides evidence for both BPT and LTPT in the treatment of young people suffering from various emotional disorders, including depression.[102] Yet, only 2 naturalistic studies[73,103] and 1 randomized trial[104] have specifically targeted children and adolescents with depression as the primary problem. Although this is in line with the more person-centered rather than disorder-focused approach, and children and adolescents do tend to present with a variety of emotional and behavioral problems, more studies of PT that specifically focus on depression are needed. In a study by Trowell and coworkers,[104] depressed adolescents improved more slowly with BPT but made more sustained changes compared with those receiving family therapy. This finding parallels the research focusing on adults with depression who had been treated with PT; results showed slower rates of change but maintenance of effects and even posttreatment improvement. More research in this area is needed. Several ongoing trials, including a trial comparing BPT and CBT in the treatment of adolescent depression,[3] promise to fill this critical gap in our knowledge.

PROCESS AND OUTCOME OF PSYCHODYNAMIC TREATMENT

Little is known about the mutative factors in the range of evidence-based treatments for depression, including PT. Several studies, however, have begun to elucidate those ingredients that promote change. Hilsenroth and colleagues,[105] for instance, using the Comparative Psychotherapy Rating Scale, found a strong association between psychodynamic–interpersonal technique and change in depressive

symptoms (r=.57, P<.01) in patients treated with BPT. Conversely, studies have found that the extent to which psychodynamic techniques were used in other treatments was correlated with good outcome (for an overview, see Shedler[106]). Yet, much more research is needed in this context, particularly as patient, therapist, and alliance factors (and their interactions) may explain more variance in outcome than specific techniques, particularly in brief treatments.

Self-Critical Perfectionism

Blatt and colleagues,[43] for instance, found that self-critical perfectionism, a personality dimension that, as noted, is related to the onset and course of depression, negatively predicted treatment outcome in CBT, Interpersonal Psychotherapy (IPT), and pharmacotherapy in the National Institute of Mental Health Treatment of Depression Collaborative Research Program (TDCRP). Pretreatment levels of self-critical perfectionism were also associated with lower enhanced adaptive capacities, that is, the capacity to manage life stress, at 18-month follow-up, which may explain in part the negative effect of self-critical perfectionism on long-term outcome in this study. Importantly, further analyses showed that pretreatment self-critical perfectionism significantly interfered with therapeutic outcome in the TDCRP by disrupting the development of the therapeutic alliance as well as patients' general social relationships, which left them more vulnerable to stressful life events. Decreases in self-critical perfectionism were significantly associated with a decline in symptoms of depression, which provides further evidence for the role of patient factors in the treatment of depression. More specifically, in the TDCRP, the strength of the therapeutic alliance was significantly associated with changes in self-critical perfectionism, which, in turn, significantly influenced the reduction of depressive symptoms.[107] These findings suggest that the lack of sustained therapeutic gain in the TDCRP may have been the consequence of the failure to address the personality factors involved in vulnerability for depression in all treatment conditions, which then, in turn, negatively affected the therapeutic alliance and, ultimately, treatment outcome. Yet, compared with medication, the 2 psychotherapies (ie, CBT and IPT) led to significantly greater enhanced adaptive capacities and a significantly greater reduction of stress reactivity,[108] which may provide a partial explanation for the superiority of psychotherapy compared with medication in the prevention of relapse of depression.

The negative impact of self-critical perfectionism on outcome in brief treatments has now been replicated in a number of studies.[13,43] The typically externally imposed time-limited treatment may interfere with the strong need for autonomy and control associated with self-critical perfectionism.[109] Patients with these features may also have more difficulty accepting an interpersonal focus,[110] and they may be unable to form a positive therapeutic alliance in such a short timeframe.[43] More generally, in some patients, brief treatments (including BPT), may be associated with relatively high relapse rates because they do not lead to changes in vulnerability factors for depression but only result in a deactivation of maladaptive representations of self and others that are relatively easily re-activated when confronted with stress and adversity.[91] By contrast, LTPT and PA are typically associated with more profound changes as expressed in[106,111]:

1. Increased capacity for self-analysis
2. Ability to experiment with new behaviors, particularly in interpersonal relationships
3. Finding pleasure in new challenges
4. Greater tolerance for negative affect
5. Greater insight into how the past may determine the present

6. Use of self-calming and self-supportive strategies, among which is the use of the representation of the therapist as a supportive good internal object.

Yet, more research that specifically focuses on depression is needed, and studies are needed that investigate whether such changes are causally related to sustained symptom reduction in both brief and long-term treatments.

ACCEPTABILITY AND SUITABILITY OF PSYCHODYNAMIC TREATMENT

BPT is readily accepted by many depressed patients.[2] Patients often prefer combination treatment over medication alone[101] and BPT over pharmacotherapy.[112] Similarly, a study in Germany suggests that LTPT and PA are well accepted by many (chronic) depressed patients and even preferred by at least a substantial subgroup of depressed patients over cognitive behavioral treatment.[113] Yet, cultural factors are likely to determine patient preference.

As for suitability for PT, clinical decision making is seriously hampered by our lack of understanding of therapeutic mechanisms. Clinical lore emphasizes the importance of psychological mindedness, a wish to target the treatment beyond symptom reduction and an openness to consider the antecedents and particularly the relational contexts of current problems.[114] Yet, whether these features are associated with better treatment outcome remains to be investigated, particularly given the broadening scope of PT to more characterologically disturbed patients. Interestingly, in a study by Van and colleagues,[112] there were no differences in outcome after BPT for depression between randomized and by-preference patients. These findings contrast somewhat with findings by Watzke and colleagues[115] that provides some validation for clinical judgment in relation to suitability for psychodynamic psychotherapy. This study also highlights the potential negative effects of unselected assignment to PT and possible iatrogenic factors, at least of PT as practiced in routine clinical care.[114] Basically, Watzke and colleagues[115] found that patients whom clinicians considered suited for PT had better outcome compared with patients who were randomly assigned to PT. No such effect was found for CBT, with patients whom clinicians originally considered to be suited for PT showing similar improvement when they were randomly assigned to CBT compared with patients that initially were considered more suited for CBT. These findings suggest potential limitations in terms of suitability of patients for PT. Yet, they may also suggest limitations of the particular psychoanalytic treatment model that was investigated in this study. More systematic treatment delivery and the ongoing monitoring of intermediate treatment outcomes may lead to improved outcome also in patients that are often considered to be less suited for PT. Moreover, whether these results generalize to depressed patients and all types of PT is unknown. A recent trial in Germany is currently exploring whether randomization versus preference for PT is related to outcome in the long-term psychodynamic treatment of depression.[113]

SUMMARY

Findings reviewed in this article show that PT should be included in treatment guidelines for depression. BPT in particular has been found to be superior to control conditions, equally effective as other active psychological treatments, with treatment effects that are often maintained in the long run, conferring resistance to relapse. Moreover, BPT is as effective as pharmacotherapy in the acute treatment of mild to moderate depression, and, either as monotherapy or combined with medication, BPT is associated with better long-term outcome compared with pharmacotherapy alone. PT is accepted by many depressed patients as a viable and preferred treatment. Furthermore, LTPT and PA have shown promise in treating patients with complex

psychological disorders characterized by mood problems, often with comorbid personality problems. Finally, although studies suggest that effects of PT may be achieved somewhat slower compared with other forms of psychotherapy[116] as well as medication[95] in the acute treatment of depression, LTPT appears to be more clinically effective and perhaps more cost effective in the long run, particularly for chronically depressed patients.

As noted, these conclusions need to be interpreted within the context of important limitations. Compared with other treatments, the evidence base for PT in depression remains relatively small, despite a respectable research tradition supporting psychodynamic assumptions with regard to the causation of depression.[64] Moreover, and perhaps most importantly, although more studies now include longer follow-up assessments, our knowledge about the long-term effects of so-called evidence-based treatments of depression remains sketchy at best. In this context, the growing evidence for the efficacy and effectiveness of LTPT is promising.

Overall, it is clear that the future of the treatment of depression may lie in a combined disorder- and person-centered, tailored-made approach, which takes into account, particularly in chronic depression, the broader interpersonal context and life history of the individual. It is clear that psychodynamic therapies have an important role to play in this respect.

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