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SPECIAL ARTICLE

Depression and psychodynamic psychotherapy

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Depression is a complex condition, and its classical biological/psychosocial distinction is fading. Current guidelines are increasingly advocating psychotherapy as a treatment option. Psychodynamic psychotherapy models encompass a heterogeneous group of interventions derived from early psychoanalytic conceptualizations. Growing literature is raising awareness in the scientific community about the importance of these treatment options, as well as their favorable impact on post-treatment outcomes and relapse prevention. Considering the shifting paradigm regarding treatment of depressive disorder, the authors aim to provide a brief overview of the definition and theoretical basis of psychodynamic psychotherapy, as well as evaluate current evidence for its effectiveness.

Keywords: Depressive disorder; mood disorders, unipolar; psychotherapy; psychoanalysis and psychodynamic therapies

Introduction

Depression is considered a frequent and complex condition. According to the World Health Organization, it is expected to be the third leading cause of disability worldwide by 2020.[1] The lifetime prevalence of major depressive disorder (MDD) is estimated at around 2-20%. The Global Burden of Disease Study 2010[2] revealed it as the second most prevalent cause of illness-induced disability, affecting people of all ages and social status, and a major impact factor in social, professional, and interpersonal functioning. Mathers et al.[3] predicted MDD as the leading worldwide cause of disease burden in high-income countries by the year 2030. The decrement in health associated with depression is described as significantly greater than that associated with other chronic diseases.[4] More than 60% of patients with MDD have a clinically significant impairment in their quality of life.[5]

Common features of all depressive disorders include the presence of sad or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function.[6] Overall, depression is characterized by a general feeling of sadness, anhedonia, avolition, worthlessness, and hopelessness. Cognitive and neurovegetative symptoms, such as difficulty in concentrating, memory alterations, anorexia, and sleep disturbances, are also present.

Various known risk factors for depression have been recorded in the literature: female gender, older age, poorer coping abilities, physical morbidity, impaired level of functioning, reduced cognition, and bereavement. Depression has been associated with an increased risk of mortality and poorer treatment outcomes in physical disorders.[7]

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Although not fully understood, psychological, social and biological processes are thought to overdetermine the etiology of depression; comorbid psychiatric diagnoses (e.g., anxiety and various personality disorders) are common in depressed people.[8]

The classical biological/psychosocial distinction, which separates psychotherapy from pharmacotherapy as treatment options for depression, is fading out. Growing evidence from the neuroscientific literature supports similar (and different) changes in brain functioning with these approaches, concluding that both psychotherapy and pharmacotherapy are biological treatments, and that there is no legitimate ideological justification for the decline of the former.[9]

Understandably, current treatment guidelines[10,11] for depressive disorders are increasingly advocating psychotherapy as a treatment option, alone or in combination with antidepressant medications.

Considering this shifting paradigm regarding treatment of depressive disorder, the authors aim to evaluate current evidence for the effectiveness of psychodynamic psychotherapy (PDP) in depression. A brief clarification of the definition of PDP and its theoretical basis for understanding depression are also presented.

Methods

A narrative review was performed, including recent and current published papers on PDP and its role as a treatment modality in depressive disorders. Recent empirical studies were also included in order to integrate authors' critical perspectives, supported by classical and contemporary literature.

Results

Defining psychodynamic psychotherapy

PDP models are derived from early psychoanalytic conceptualizations, including ego psychology, object-relations

theory, self-psychology, and attachment theory. Treatment goals or focus and setting changes have been reconsidered by contemporary authors. Gabbard[12] described PDP's basic principles as: much of mental life is unconscious; childhood experiences, in concert with genetic factors, shape the adult; the patient's transference to the therapist is a primary source of understanding; the therapist's countertransference provides valuable understanding about what the patient induces in others; the patient's resistance to the therapeutic process is a major focus of therapy; symptoms and behaviors serve multiple functions, and are determined by complex and often unconscious forces; finally, the psychodynamic therapist assists the patient in achieving a sense of authenticity and uniqueness.

PDP operates on an interpretive-supportive continuum. Interpretive interventions enhance the patient's insight about repetitive conflicts sustaining his or her problems. The prototypic insight-enhancing intervention is an interpretation by which unconscious wishes, impulses, or defense mechanisms are made conscious. Supportive interventions aim to strengthen abilities ("ego functions") that are temporarily not accessible to a patient due to acute stress or that have not been sufficiently developed. Thus, supportive interventions maintain or build ego functions. Supportive interventions include, for example, fostering a therapeutic alliance, setting goals, or strengthening ego functions such as reality testing or impulse control. The use of more supportive or more interpretive (insight-enhancing) interventions depends on the patient's needs.[13]

Common factors of psychotherapy and specific features of the psychodynamic approach

Common factors are currently understood as a set of common elements that collectively shape a theoretical model about the mechanisms of change during psychotherapy. A recent meta-analysis[14] has shed light on strong evidence regarding factors such as therapeutic alliance, empathy, expectations, cultural adaptation, and therapist differences in terms of their importance for psychotherapeutic treatments in theory, research, and practice.

Overall, the influence of common factors in psychotherapies has been estimated at 30% when consider ing the variation in depression outcomes. Nonetheless, other factors, including specific techniques, expectancy, the placebo effect, and extratherapeutic effects, have also been studied.[15]

Zuroff & Blatt[16] have concluded that the nature of the psychotherapeutic relationship, reflecting interconnected aspects of mind and brain operating together in an interpersonal context, predicts outcome more robustly than any specific treatment approach *per se*.

Regarding common factors in PDP, Luyten et al.[15] mentioned the important differences between psychodynamic and other treatments. Comparatively to cognitive-behavioral therapists, psychodynamic therapists tend to place stronger emphasis on certain aspects, namely: affect and emotional expression; exploration of patients' tendency to avoid topics; identification of recurring behavioral patterns, feelings, experiences, and relationships; the past and its influence on the present; interpersonal experiences; the therapeutic relationship; and exploration of wishes, dreams, and fantasies. Along with these features, specific characteristics of a psychodynamic-oriented treatment have been described: a focus on the patient's internal world; a developmental perspective; and a person-centered approach.

Depression from the psychodynamic perspective

Psychodynamic understandings of depressive disorders were first described by Freud, Abraham, and Klein. Freud explored the individual's reactions to an actual loss or disappointment associated to a loved person, or to a loss of an ideal. Plainly, he tried to explain why some people react with a mourning affect (surpassed after a period of time) and others succumb into melancholy (depression, as we now call it). Mourning is the reaction to the loss of a loved one or the loss of an abstraction, which has taken the place of something (a country, freedom, or an ideal, for example), and although it involves significant disruptions from one's normal attitude towards life, it should not be regarded as pathological. Thus, mourning occurs following loss of an external object. Melancholy, on the other hand, arises from the loss of the object's love and is an unconscious process where a remarkable decrease in self-esteem is observed. Culpability is also a feature clearly present in melancholic processes, as the loss of the object comes with feelings of guilt, stressing the ambivalent feelings towards the lost object; not only because the individual knows that he or she attacked (in fantasy or in reality) the lost object, but mostly because he or she desired that very loss (due to the object's unsatisfactory presence and love). Freud clearly outlined the symptoms of melancholy: "... a profoundly painful dejection, cessation of interest in the outside world, loss of capacity to love, inhibition of all activity, and lowering of the self-regarding feelings to a degree that finds utterance in self-reproaches and self-revilings and culminates in delusional expectations of punishment."[17] These features seem to resemble the current DSM definition of depression.

Abraham proposed a specific model for the melancholic process,[18] consisting of a series of explanatory events: after an initial frustration (loss of an object), the subject reacts with externalization of the introjected object and its destruction, thus to an early anal-sadistic stage. Identification with the object - (primary) narcissism - results in its introjection, thus explaining the sadistic vengeance against the object as part of the subject's ego; one's self-destruction often manifested as suicidal thoughts. Ambivalence plays a key role, as the subject struggles with his own survival and destruction.

Klein later elucidated the importance of the establishment of an internal world in which the lost external object is "reinstated." Thus, in melancholy, there is a regression to an earlier failure to integrate good and bad partial objects into whole objects in the inner world. The depressive individual believes himself omnipotently responsible for the loss, due to his inherent destructiveness, which has not been integrated with loving feelings. Klein argues that pining, mourning, guilt, reparation, possibly delusional

thinking, omnipotence, denial, and idealization characterize depression.[19]

More recently, Luyten & Blatt[15] commented on these works as "still clinically relevant" but "often over specified, lacking theoretical precision, and too broad to be empirically tested." However, these authors stated that unconscious motives and processes still play an important role in recent psychodynamic theories of depression.

Evidence for psychotherapy as a treatment for depressive disorders

A meta-analysis of direct comparisons found psychotherapy about as effective as pharmacotherapies for depressive disorders.[20] In another meta-analysis, Cuijpers et al.[21] included 92 different randomized controlled trials (RCTs) and demonstrated the efficacy of psychotherapy in comparison with pharmacotherapy – equal in the short-term and superior in the long-term, regarding relapse prevention. Different forms of psychotherapy have been compared, with no clear differences observed or, when so, with certain methodological specificities pointed out.[22] Nevertheless, the effectiveness of many well-recognized interventions has been regarded as possibly overestimated, considering that most evidence is based on symptom reduction.[23] A comprehensive meta-analysis[24] has highlighted the effectiveness of Interpersonal Psychotherapy (which has its structure and theoretical roots in PDP) in depression, as compared to other psychotherapies and vs. combined treatment, as well its role in preventing onset or relapse after successful treatment.

Extensive literature supports the efficacy of psychotherapy as an established treatment for MDD, stating its effectiveness and comparableness to that of antidepressant medications. The significance of these findings and possibility of publication bias have also been object of attention from the scientific community. A recent analysis stated an excess of significant findings relative to what would be expected for studies of psychotherapy's effectiveness for MDD.[25]

On this subject, Driessen et al.[26] found clear indications of study publication bias among U.S. National Institute of Health-funded clinical trials that examined the efficacy of psychological treatment for MDD, ascertained through direct empirical assessment. Through these data, the authors concluded that psychological treatment, like pharmacologic treatment, may not be as efficacious as the published literature would indicate.

Cuijpers et al.[27] published a meta-analysis on the effects of psychotherapies on remission, recovery, and improvement of MDD in adults. The response rate for the analyzed psychotherapies was 48% (vs. 19% in control conditions), and there was no significant difference between types of psychotherapy.

Evidence for psychodynamic psychotherapy as a treatment for depressive disorders

Shedler[28] presented five independent meta-analyses showing that the benefits of PDP not only endure, but also increase with time (including after treatment end). Patients reported significant symptom reductions, which held up over time, and increased mental capacities, which allowed them to continue maturing over the years. Additionally, Shedler presented several studies demonstrating that it is the psychodynamic process that predicts successful outcome in cognitive therapy, rather than the pure cognitive aspects of treatment – i.e., non-psychodynamic psychotherapies may be effective because the more skilled practitioners utilize techniques that have long been central to psychodynamic theory and practice.

Leichsenring et al.[22] conducted an empiric review of supported methods of PDP in depression and suggesting a unified protocol for the psychodynamic treatment of depressive disorders. The authors found a twofold risk for poor outcome in depression when patients were diagnosed with a comorbid personality disorder. However, several studies were found to have methodological limitations, such as taking a personality disorder diagnosis in account as a primary object of treatment, sample size differences, and divergent results, largely depending on the personality cluster identified. The findings of these authors contradict repeated claims that PDP is not empirically supported.

A subsequent systematic review by Leichsenring[29] identified and included a total of 47 RCTs providing evidence for PDP in specific mental disorders; it stated the efficacy of PDP compared to cognitive-behavioral therapy (CBT) (but not to other forms of psychotherapy) in MDD, and concluded that several RCTs provide evidence for the efficacy of PDP in depressive disorders (including comparisons with control groups, waiting-list condition at the end of treatment, group therapy, pharmacotherapy, and brief supportive therapy).

Varying results have also been observed according to treatment duration – specifically, short-term (STPDP) vs. long-term psychodynamic psychotherapy (LTPDP) as applied in patients with depressive disorders. One recent meta-analysis[30] evaluated the efficacy of a specific STPDP (experiential dynamic therapy) within multiple psychiatric disorders, and found the largest effect on depressive symptoms. A meta-analysis from the Cochrane Collaboration[31] studied the effects of STPDP for common mental disorders across several studies, including 23 RCTs. It showed significantly greater improvement in the treatment groups as compared to controls, with most improvement maintained on medium- and long-term follow up.

Another meta-analysis by Leichsenring et al.[32] examined the comparative efficacy of LTPDP in complex mental disorders in RCTs fulfilling specific inclusion criteria (therapy lasting for at least a year or 50 sessions; active comparison conditions; prospective design; reliable and valid outcome measures; treatments terminated). It concluded that LTPDP is superior to less intensive forms of psychotherapy in complex mental disorders.

More recently, Driessen et al.[33] published a meta-analysis of 54 studies highlighting STPDP outcomes in symptom reduction and function improvement during treatment. They found either maintained or further improved gains at follow-up, and stated that the efficacy of STPDP compared to control conditions and outcomes on depression did not differ from that of other psychotherapies.

A recent review[34] provided evidence towards maintained effects with both modalities as a treatment option for depression, emphasizing their moderate (rather than large) effects. PDP is noted as a preferred alternative to pharmacotherapy in depressive disorders; nevertheless, the authors highlight the high frequency of studies involving psychotherapy in combination with medication – or adding to the effectiveness of medication. In comparison with CBT, PDP is described as neither largely nor reliably different. No single type of PDP was found particularly efficacious within its different forms. Regarding LTPDP, its cost-effectiveness and early stage are mentioned when describing its value, especially in more complex and chronic cases of depression.

Discussion

An extensive, growing body of literature confirms that the classical divergence in treatment approaches for depressive disorders is fading. Psychotherapy has been found as efficacious as pharmacotherapy, with different results regarding its superiority in short-term and long-term relapse prevention.[20,23] Moreover, a systematic review has elucidated the potential benefits of a change in intervention design in depression, switching the paradigm from a symptom-oriented one to more rehabilitation- and functioning-oriented therapies.[23] These results are in agreement with Westen et al,[35] who presented evidence that treatments focusing on isolated symptoms or behaviors (rather than personality, emotional, and interpersonal patterns) are not effective in sustaining even narrowly defined changes.

The large number of publications in this topic has drawn the attention of the scientific community, prompting systematic analyses with increasing complexity and the creation of specific protocols for psychotherapeutic intervention, bearing in mind the importance of structured interventions by qualified clinical staff.

Although it would stray from the primary scope of this review, it is worth highlighting the growing number and relevance of published neuroscientific literature that reports neuroimaging and neurochemical changes exerted by psychotherapeutic interventions,[9] specifically PDP.[36]

The effectiveness of PDP has been found difficult to isolate due to its limitations as a measurable intervention, which has led to the proposition of unified protocols both to facilitate training and to improve the status of evidence.[22] The quality of PDP trials published from 1974 to 2010 was assessed in a review paper[37] which concluded that the existing RCTs of PDP mostly show superiority of PDP to an inactive comparator. Studies concerning longer-term treatments are scarce but highly relevant, as they focus on important individual aspects like chronic mood problems, which often result from a combination of depression, anxiety, and significant personality and relational problems.[15]

While these aspects are simple to clarify, few studies have taken them into account. Further RCTs could provide new evidence on the effectiveness of PDP, as well as facilitate its clear integration among the range of standard treatment options to consider for depressive disorders. One important related aspect refers to the training of future therapists in PDPs: institutes are mostly small and independent, and lack the necessary resources to conduct expensive or large-scale studies.

This narrative review presents certain limitations. Only recent published studies or systematic reviews were included. Due to practical reasons, only English-language publications were included, which may have left out important published findings. Publication bias may also be a factor, perhaps resulting in studies or systematic reviews that only showed positive or equal results for PDP treatments. However, we emphasize the importance of gathering and comparing recent findings and systematic reviews with classical published works in the field of PDP.

In conclusion, despite its controversial history, PDP's influence in the psychiatric panorama is definitely increasing. The effectiveness of PDP has been demonstrated in various studies which have compared it with other treatment modalities. In recent years, the body of empirical evidence supporting said effectiveness has grown, and, more recently, meta-analyses have confirmed the role of PDP in the treatment of depressive disorders.

Many advances have been made in to enable high-quality scientific research in this complex, layered field. Nonetheless, contemporary authors continue to claim the importance of early conceptualizations of the psychodynamic perspective toward depression and depressive disorders.

Disclosure

The authors report no conflicts of interest.

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