Unipolar depression in adults: Psychodynamic psychotherapy

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INTRODUCTION

There are many types of psychotherapy indicated for the treatment of depression, including psychodynamic psychotherapy. (See "Unipolar major depression in adults: Choosing initial treatment".)

Psychodynamic psychotherapy is based upon the idea that childhood experiences, past unresolved conflicts, and previous relationships significantly influence an individual's current situation in life [1]. Thus, adult relationships are understood to be a byproduct of unconscious patterns that begin in childhood [2]. Psychodynamic psychotherapy uncovers the unconscious patterns of object relations (interpersonal relationships), conflicts, and desires that cause depression.

This topic reviews psychodynamic psychotherapy for treating mild to moderate depression in adults. The initial treatment of depression; treatment of resistant depression; diagnosis of depression, prognosis of depression; treatment of late-life depression; and epidemiology, pathogenesis, and neurobiology of depression are discussed elsewhere.

- (See "Unipolar major depression in adults: Choosing initial treatment".)
- (See "Unipolar depression in adults: Choosing treatment for resistant depression".)
- (See "Unipolar depression in adults: Assessment and diagnosis".)
- (See "Unipolar depression in adults: Course of illness".)

- (See "Diagnosis and management of late-life unipolar depression".)
- (See "Unipolar depression in adults: Epidemiology".)

INDICATIONS

Treating patients with psychodynamic psychotherapy is based upon the nature of the patient's depression and psychological characteristics:

- Patients with mild to moderate depression can be treated with psychodynamic therapy alone. Treatment studies evaluating the efficacy of psychodynamic psychotherapy for treating depression have largely been conducted with mild to moderately depressed patients. (See 'Evidence of efficacy' below.)

- Patients with moderate to severe depression, especially moderate to severe suicidal ideation or moderate to severe neurovegetative symptoms (decreased sleep, appetite, and energy), require pharmacotherapy in addition to psychodynamic therapy [3]. (See "Unipolar major depression in adults: Choosing initial treatment".) The patient's personality, motivation, and level of social and occupational functioning determine whether a depressed patient is a good candidate for psychodynamic psychotherapy (table 1).

A randomized trial found that better outcomes occurred when patients were systematically selected for psychodynamic therapy on the basis of specific criteria that included diagnosis, the patient's therapeutic goals (eg, integrating unconscious aspects of behavior), and patient preference, compared with not using these criteria prior to treatment with psychodynamic therapy [4].

THEORETICAL FOUNDATION

Psychodynamic psychotherapy requires an understanding that the past repeats itself in the present in ways that are painful for the patient. Therapy is based upon the theory that adult relationships are governed by unconscious conflicts, desires, thoughts, feelings, and patterns of relating to others, which are ingrained from childhood.

The goal of treatment is to make these unconscious, repetitive patterns more conscious by studying how they emerge in the relationship between the patient and the clinician. The clinician identifies and interprets the patient's transference and resistance. In addition, the

clinician's countertransference is also used to understand the unconscious conflicts that occur in the patient's life outside of therapy. (See 'Fundamental concepts and processes' below.)

Etiology of depression — Different psychodynamic theorists have conceptualized the origin of depression in various ways [5-8]. Depression may be due to psychosocial issues, stressors, or internal feelings and needs. These various causal factors are not mutually exclusive, and there are other possible etiologies.

Social issues may lead to depression. One hypothesis is that depression arises from anxiety and guilt related to having harmed loved ones. Another hypothesis is that the patient is living her life for others instead of herself, a concept referred to as the "dominant other." For these patients, success in life is closely connected to eliciting the desired response from the dominant other.

Stressors and what they mean to the patient may be involved in the onset of depressive syndromes. As an example, stressors involving both loss and humiliation are more likely to cause depression than events involving loss alone [9].

One psychodynamic model identifies two types of depression based upon internal feelings and needs [10]. The "anaclitic" type is characterized by feelings of helplessness, weakness, and loneliness that are linked to chronic fears of being unprotected, alone, and abandoned. Patients with this type of depression want to be loved, protected, and nurtured. They use the defense mechanisms of disavowal, displacement, and denial. The "introjective" type of depression occurs in patients who are primarily focused on their own self-development. Relationships with others are regarded as secondary. These patients tend to be perfectionistic, competitive, and driven to achievement. Depression may be due to disparity (conflict) between a patient's ideals and reality, ie, the patient believes that he has not held himself up to a high standard. These patients use the defense mechanisms of reaction formation, rationalization, and intellectualization (table 2).

FUNDAMENTAL CONCEPTS AND PROCESSES

Psychodynamic therapy is based upon the idea that there are unconscious mental states and processes, including transference, countertransference, defense mechanisms, and resistance.

Unconscious — A large part of mental functioning is driven by the unconscious [4]. The unconscious is a reservoir of repressed content that is kept out of awareness because it creates conflict. According to topographic model, mental functioning consists of three domains: conscious, preconscious, and unconscious. It is difficult to become aware of unconscious

material. However, preconscious content can be retrieved by simply shifting one's attention. The aim of psychodynamic therapy is to bring unconscious material to the surface so it can be examined and understood.

Transference — Transference is the unconscious displacement onto the clinician of feelings, thoughts, wishes, and qualities associated with an important individual from the patient's past [2]. As an example, the patient may unconsciously respond to the clinician in the same manner that the patient responded to an authority figure from the past, such as a parent. Transference thus represents the unconscious re-creation of a past relationship in the present. In addition, transference may involve multiple prior relationships, or ongoing relationships that began prior to the relationship between the patient and clinician.

Whereas the original definition assumed that the feelings and thoughts were transferred and superimposed upon the clinician without much change, it is now believed that the clinician's behavior influences how the patient responds to the clinician [2]. Transference to the clinician is thus based partly upon individuals from the patient's past and partly upon the real characteristics of the clinician.

Countertransference — Countertransference is the clinician's conscious and unconscious feelings and thoughts about the patient [2,11]. It consists of:

- The clinician's feelings and thoughts about an individual from a previous relationship that are displaced onto the patient
- Feelings and thoughts induced in the clinician by the patient's behavior

Recognizing countertransference provides data that help the clinician to discern problems that the patient encounters in relationships outside the therapy [12]. Other people probably respond to the patient in a manner similar to the clinician.

Defense mechanisms — Patients unconsciously use defense mechanisms to cope with anxiety and conflict, preserve self-esteem, and maintain a sense of control in interactions with people who are important to the patient [2]. Defense mechanisms are usually divided into two classes, those that are primitive or immature, and those that are higher-level. It is worth noting that everyone uses primitive defenses, such as denial and splitting, when under stress (table 2).

Resistance — Another principle of psychodynamic psychotherapy is that patients may be ambivalent about getting better and resist the clinician's effort to help. The unconscious process of resistance may take many forms, such as the patient refusing to speak about a painful issue, or periodically showing late for appointments, or not at all. Resistance may indicate that the

patient feels guilty about something, the depression is deserved, and that the patient should not get better.

ASSESSMENT

Clinicians should assess patients to determine whether psychodynamic psychotherapy is indicated. In addition, the clinician should examine past and ongoing stressors, the patient's behavioral patterns in relationships, and defense mechanisms that the patient uses to reduce anxiety and control conflict. Clinicians continue to assess patients throughout the entire treatment process. A skillful assessment requires psychiatric training and experience.

The first step in the assessment is to determine whether the patient can benefit from psychodynamic psychotherapy. Clinicians should assess the patient's personality characteristics, motivation, judgment, capacities and psychological mindedness, psychosocial functioning, and insight (table 1).

The clinician should identify stressors in the patient's life and what each stressor means to the patient. The clinician will later examine if the stressors fit into a particular pattern. Stressors involving trauma may reawaken earlier losses or trauma that had been forgotten.

Information is gathered on developmental deficits, which may have occurred in the form of early losses, abuse, neglect, or parental failure to respond empathically to the patient's childhood needs [2]. The clinician analyzes how these losses or trauma impact the patient's relational style and overall behavior.

Behavioral patterns are observed and familiar themes in relationships are explored. As an example, a 59 year-old woman discussed with her clinician that she repeatedly finds herself resenting her friends and family members when they do not help her in time of need. The clinician pointed out that the patient overextends herself in relationships to the point of self-sacrifice, and encouraged her to explore if the sacrifices she makes contribute to her pervasive resentment.

Biological predispositions as well as intergenerational reenactment patterns are considered.

The patient's personality characteristics are also assessed to see if they contribute to the depressive syndrome. As an example, perfectionism may make patients feel it is impossible to reach their goals, leading to hopelessness and worthlessness.

The patient's typical defense mechanisms are assessed to understand how the patient copes with anxiety and conflict [2] (table 2). (See 'Defense mechanisms' above.)

TREATMENT

Clinicians should follow certain general principles in providing psychodynamic therapy. In addition, a number of specific interventions are used. However, treatment depends less upon any specific maneuver and more upon the therapeutic alliance (relationship) between the patient and clinician.

The relationship between the clinician and patient starts at the beginning of the first interview or session. Thus, treatment begins with the first session, even though the first few sessions are focused primarily upon assessing the patient.

General treatment principles — Psychodynamic psychotherapy is based upon the following principles:

- Clinicians should elicit a narrative of the patient's life during the history-taking and listen to how the patient formulates the experience of depression. In addition, the clinician should ask about stressors that have occurred and are ongoing, and explore the underlying meaning that a stressor may have to the patient.

- The clinician and patient need to negotiate the goals of treatment. While resolution of the depressive syndrome is an explicit goal, the broader goal is change in personality characteristics that leave the patient vulnerable to depression. The focus is upon developing awareness of unconscious feelings, thoughts, and behaviors that cause depression and relationship problems [13].

- The clinician looks for stressors that generally precede depression (eg, breakup of a relationship) and characterological tendencies (eg, perfectionistic expectations for oneself) that can lead to depression.

- As psychotherapy proceeds, the clinician helps the patient understand the origins of the depressive syndrome, by interpreting and explaining repetitive patterns and unconscious conflicts that occur within relationships outside the therapy and in the relationship with the clinician. In addition, the clinician points out the patient’s use of defense mechanisms, and explores how these defenses may be helpful (eg, prevent overwhelming anxiety), as well as detrimental (eg, prevent self-examination on the part of the patient). The patient's improvement is directly linked to gaining insight into these patterns, conflicts, and defenses.

- The clinician observes how the patient relates to the clinician. As an example, the patient may ask questions about the clinician, as part of the patient's desire or fantasy of creating a social relationship with the clinician that extends beyond their professional relationship.

- Clinicians should minimize disclosing information about themselves in order to maintain the focus of treatment upon the patient. In addition, the unconscious process of transference is more likely to occur if the patient has less tangible information about the clinician. Thus, questions posed by a patient should be explored for their underlying meaning, rather than directly answered. However, revealing a current feeling or discussing a common interest with the patient as part of spontaneous conversation may enhance the therapeutic relationship. (See 'Transference' above and 'Therapeutic alliance' below.)

- The clinician determines how the patient unconsciously resists the clinician's efforts to help. In addition, the clinician monitors countertransference that occurs in response to the patient's resistance and to other aspects of the patient's behavior. (See 'Resistance' above and 'Countertransference' above.)

Treatment is usually provided in an individual, face-to-face format. However, psychodynamic therapy has been adapted for use in groups [13] as well as internet administration [14].

Psychodynamic therapy can be either time-limited or open-ended. Time-limited therapy generally ranges from 12 to 24 sessions that are provided once per week over three to six months [15,16]. Open-ended, long-term therapy is provided at a frequency of one or two sessions per week. Longer-term therapy is indicated when brief therapy is not effective and the presence of longstanding personality traits complicates recovery from the depressive syndrome. The duration of each session is approximately 50 minutes.

If one clinician is providing psychodynamic psychotherapy and another clinician is prescribing antidepressant medication, they need to work together as members of the same treatment team. The clinicians must have an agreement with each other and with the patient that there are no secrets between the two clinicians, and that the clinicians will regularly communicate about any concerns they have.

Clinicians who lack experience with psychodynamic psychotherapy should receive supervision from a clinician who has expertise with this treatment.

Psychodynamic psychotherapy developed from psychoanalysis, but the two treatments differ in some ways. Whereas in psychoanalysis patients lie on a couch, psychodynamic therapy calls for patients to be seated and facing the therapist. In addition, psychodynamic therapy does not

emphasize using dreams to study the patient's unconscious processes, as is done in psychoanalysis.

Therapeutic alliance — The therapeutic relationship between the patient and clinician is more important than any specific technique in producing a positive outcome. Extensive research shows that a strong therapeutic alliance is associated with good outcomes [2,17,18]. A strong therapeutic alliance is defined by the following:

- The patient feels attached to the clinician
- The patient feels the therapist is helpful
- The patient and clinician feel a sense of mutual collaboration

The clinician should work to develop the therapeutic alliance from the first session by [2]:

- Listening closely and sensitively to the patient
- Conveying warmth, trust, and understanding
- Addressing both emotional and cognitive material
- Conducting treatment in a nonjudgmental manner
- Identifying and pursuing new clinical issues

Ruptures in the alliance can occur, marked by deterioration in the relationship between the patient and clinician, diminished collaboration, and poor communication [2]. Clinicians should identify and explore these problems. Successful resolution is more likely to occur if clinicians can acknowledge their contribution to the rupture, rather than simply blaming it entirely upon the patient.

Repairing a rupture in the therapeutic alliance can provide the patient with a corrective emotional experience, in which the patient is exposed to and tolerates an emotional situation that was previously intolerable. Thus, the rupture and repair provide the patient with an opportunity to confront previously difficult situations, within the more favorable circumstance of the therapeutic relationship [19].

Therapeutic interventions — Therapeutic change and resolution of the depressive syndrome occur through use of techniques that form a continuum [2,15]. At one end are interventions that increase the patient's insight through exploration and interpretation of the patient's defenses and behavior. The other end consists of interventions that directly support the patient and maintain adaptive defense mechanisms. Assessment of the patient reveals how to balance the need for both interpretive and supportive comments. As therapy progresses, the clinician should emphasize interpretation and other interventions intended to increase insight into unconscious processes (table 2).

The specific interventions listed below begin with those that are intended to promote insight, and end with interventions aimed at directly supporting the patient [2].

Interpretation — An explanatory statement that links a feeling, thought, behavior, or symptom to its unconscious meaning or origin. Thus, interpretations involve underlying motivations. As an example, the clinician may state: You seem to hold yourself back from succeeding because you worry that your mother will be envious and retaliate against you.

Patients are more likely to seriously consider an interpretation if it is presented as a possibility or hypothesis, rather than a definitive conclusion. In addition, interpretations should be made judiciously and sparingly, after the clinician has gathered enough evidence to substantiate them.

Observation — A comment that calls attention to something that the patient is not aware of, such as nonverbal behavior, a pattern in the therapeutic process, or a sequence of moving away from certain topics of discussion. However, an observation does not attempt to provide an explanation, as does an interpretation. As an example, a clinician may make the observation, “Have you noticed that when we begin speaking about your mother, you change the topic?”

Confrontation — Calls attention to something that the patient does not want to accept or think about. It differs from observation in that confrontation addresses conscious material that the patient is avoiding. Confrontation may also involve setting limits with a patient who may attempt to cross the boundaries of the relationship between the clinician and patient.

Clarification — Reformulates or pulls together what the patient is saying into a more coherent view of what the patient is communicating in a vague and uncertain manner. The clinician summarizes or repackages what the patient has spoken about, so that both the patient and clinician are clear about the patient’s feelings and thoughts. A clarification is often posed as a question, such as, “I wonder if what you really are saying is that you’re not sure if you want to remain in your current job?”

Encouragement to elaborate — An open-ended comment asking for more information. As an example, “You just mentioned your father’s family. Please tell me more about them.” Ideally, patients trust the clinician and will not censor or filter what they are saying.

Empathic validation — This intervention demonstrates a clinician's empathic understanding of the patient's internal state by validating the patient's subjective experience. Many patients, while growing up, have had parents or other adults invalidate or deny their internal experience, being told, for example, “You have no right to feel that way.” Empathic validation assures a patient that their feelings and responses are legitimate, given what the patient has

experienced. As an example, a clinician may state, “It’s understandable that you’re reluctant to get close to people after being hurt in previous relationships.”

Psychoeducation — The clinician teaches the patient about the nature of depression, goals of therapy, and limits of therapy. In a broader sense, the clinician uses psychodynamic therapy to teach the patient about him or herself, and how to examine one’s own behavior.

Advice and praise — These reinforce and prescribe certain activities through explicit suggestions or compliments. Advice may be necessary for patients who are in crisis and unsure of how to proceed. Praise may be offered for the patient coming up with original insights that the clinician had not considered, and for changing their behavior in ways that are consistent with the patient’s goals.

Therapeutic strategy — There are different strategies that clinicians can use to help the depressed patient become more self-aware and work through repetitive, painful patterns and problems [2]. One useful model is the Core Conflictual Relationship Theme [20]. It consists of three related phenomena:

- The patient's wishes, expectations, and fantasies about other people.
- The perceived reaction of other people to these wishes, expectations, and fantasies.
- The patient's response to the imagined reaction of the other.

The clinician identifies the core theme in the patient's stories about childhood and adult life, and observes its emergence in the therapeutic relationship.

An example of an interpretation based upon this model is the following, which involves a patient who is stuck and unable to complete a major task, such as completing graduate school: “After getting to know you, I can see that you always imagined that you had to be perfect to please your dad, but you assumed that nothing you did would ever satisfy him, and he would be disappointed in you and always expect more. As a result, you gave up and decided not to try anymore.” The clinician might also help the patient see how that fantasy plays out in the therapeutic relationship, with the patient assuming that the clinician expects perfection from the patient.

TERMINATION

Treatment is terminated for several reasons [2]:

- The goals have been completed.
- Therapy is no longer feasible. As an example, the patient or clinician may relocate.
- An impasse occurs.

Clinicians need to temper their expectation for change upon the part of the patient and not impose goals upon the patient. Successful treatment helps patients internalize the process of inquiry that occurs in treatment, and enables patients to examine themselves and continue the work of therapy on their own.

Euthymic patients should be told that even though psychotherapy helped them, depression is often a recurring illness. Patients should understand that if they notice early, prodromal depressive symptoms, “the door is always open” to resume treatment.

CONTINUING CARE

Patients may need to continue pharmacotherapy to prevent relapse of the depressive syndrome, despite successful treatment with psychodynamic psychotherapy. If the same clinician who provided psychotherapy continues to provide pharmacotherapy, the clinician should schedule regular follow-up meetings to assess the patient for early signs and symptoms of relapse. Some psychodynamic interventions are also helpful at those regular follow-up appointments to maintain the insight gained through the therapy.

EVIDENCE OF EFFICACY

Research studies indicate that psychodynamic psychotherapy effectively treats depression in adults.

Psychotherapy trials, like pharmacotherapy trials, are methodologically variable. Some psychotherapy trials are rigorous and specify a priori hypotheses and analytic tests, use active psychotherapy comparators that control for the nonspecific aspects of psychotherapy, use standardized diagnostic criteria and outcome measures, carefully blind outcome ratings, develop manuals for the psychotherapies that are studied and measure adherence, and stratify patients on predetermined risk variables. Less meticulous studies use open-label designs, less rigorous comparators (eg, treatment as usual or waiting lists), or fail to adequately blind outcome ratings. Although it is commonly believed that blinding of patients in psychotherapy is less successful compared with pharmacotherapy trials, this has never been studied.

In addition, meta-analyses appear to overestimate the clinical effect for nearly all types of psychotherapy in treating depression because of publication bias and study quality [21-23].

Psychodynamic psychotherapy — Randomized trials suggest that psychodynamic therapy is effective for mild to moderate unipolar depression [24-26]. As an example, a meta-analysis of five trials (n = 435 patients with depressive disorders) compared short term psychodynamic psychotherapy (10 to 24 weekly sessions) with a control condition (eg, pharmacotherapy, supportive psychotherapy, or waiting list) [27]. Psychodynamic psychotherapy was superior to the control conditions, and the clinical benefit was moderate; however, heterogeneity across studies was moderate to large. A prior meta-analysis of four randomized trials also found that short term psychodynamic psychotherapy was superior to control conditions [13].

Compared with other psychotherapies — For treatment of mild to moderate depression, there is little or no difference between psychodynamic psychotherapy and other types of psychotherapy [1,13]. Specifically, the evidence suggests that the efficacy of psychodynamic psychotherapy is similar to:

- Behavioral activation therapy
- Cognitive-behavioral therapy
- Interpersonal therapy
- Problem-solving therapy
- Social skills training
- Supportive psychotherapy

Evidence regarding the comparable efficacy of psychodynamic psychotherapy and all other psychotherapies combined includes the following:

- A meta-analysis examined outcome in 23 studies with 1365 depressed patients treated with time-limited psychodynamic psychotherapy [13]. Patients who received other types of psychotherapy (usually a form of cognitive-behavioral psychotherapy) improved significantly more than patients treated with psychodynamic therapy. However, the clinical effect favoring the alternative therapies was small, and the differences disappeared at follow-up 3 months and 12 months post-treatment.

- A meta-analysis of 53 randomized trials (2757 patients with mild to moderate depression) compared psychodynamic psychotherapy with all other psychotherapies combined together, and found that outcomes were comparable [1]. Drop-out from psychodynamic therapy and from all other psychotherapies was also similar.

Multiple meta-analyses of randomized trials have specifically compared psychodynamic psychotherapy with cognitive-behavioral therapy, and found that improvement of depressive symptoms and social functioning was comparable [1,26,28]. Subsequently, a trial that compared psychodynamic psychotherapy with cognitive-behavioral therapy (16 sessions within 22 weeks) in 233 patients with unipolar major depression found that remission was comparable (approximately 23 percent in each group) [29]. In addition, another subsequent trial (n = 237 patients with unipolar major depression) found that the rate of response with psychodynamic psychotherapy or cognitive therapy, administered over 16 sessions across five months, was comparable (16 and 22 percent) [30].

Other randomized trials indicate that psychodynamic psychotherapy is superior to usual care psychotherapy. A 12-week trial compared brief psychodynamic psychotherapy with treatment as usual psychotherapy in 40 outpatients attending a community mental health center, and found that improvement of depression was greater with psychodynamic psychotherapy [31]. Also, a trial compared adjunctive, brief psychodynamic psychotherapy with psychosocial treatment as usual in patients who were hospitalized for unipolar major depression (n = 149); antidepressant medication was prescribed to 75 percent and the average length of stay was five weeks [32]. Improvement post-treatment was greater with adjunctive active treatment than usual care, and the benefit persisted at the follow-up assessment one year after discharge.

Additional information about the efficacy of supportive psychotherapy compared with other psychotherapies is discussed separately. (See "Unipolar major depression in adults: Choosing initial treatment", section on 'Selecting a specific psychotherapy'.)

Compared with pharmacotherapy — For patients with major depression, it is not clear if time-limited psychodynamic psychotherapy is as effective as pharmacotherapy. One randomized trial found that psychotherapy was comparable to pharmacotherapy, but the lack of a placebo control made it difficult to interpret the results; a second trial found that pharmacotherapy and psychotherapy were each comparable to placebo:

- A 16-week trial compared psychodynamic psychotherapy (one session per week) with fluoxetine (20 to 40 mg per day) in 51 patients, and found that remission occurred in a comparable number of patients (57 and 68 percent) [33].

- In another 16-week trial, 156 patients were randomly assigned to psychodynamic psychotherapy (20 sessions), sertraline (maximum dose 200 mg per day), or placebo plus clinical management [34]. After 8 weeks, patients unresponsive to sertraline were switched to venlafaxine (maximum dose 375 mg per day), and patients unresponsive placebo were

switched to another placebo. Remission was comparable for psychotherapy, pharmacotherapy, and placebo (22, 25, and 20 percent).

Psychodynamic psychotherapy plus pharmacotherapy — Few studies have tested the efficacy of combining psychodynamic therapy with an antidepressant, either for treating acute unipolar depression, or as maintenance treatment for preventing recurrence of depression.

Acute depression — For patients with acute depression, psychodynamic therapy plus pharmacotherapy may provide superior outcomes compared with pharmacotherapy alone. A randomized trial compared combination treatment (psychodynamic psychotherapy plus clomipramine) with clomipramine alone, in 74 patients with unipolar major depression [35]. Significantly fewer patients who received combination treatment met criteria for major depression at 10 weeks, compared with clomipramine alone (9 versus 28 percent). In addition, psychosocial functioning was significantly better in patients who received combination treatment.

Maintenance treatment — Combination treatment (psychodynamic therapy plus pharmacotherapy) may provide significantly better long-lasting effects compared to pharmacotherapy alone. A study enrolled patients with major depression who were successfully treated with six months of combination treatment (n = 41) or with pharmacotherapy alone (n = 51) [36]. All 92 remitted patients were then treated for an additional six months with pharmacotherapy alone, after which treatment was stopped and patients were prospectively followed for up to four years. Recurrence of major depression occurred in significantly fewer patients who had received combined treatment compared with patients who had received pharmacotherapy alone (27 versus 47 percent).

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Depressive disorders".)

SUMMARY

- Adult relationships are understood to be a byproduct of unconscious patterns that are ingrained from childhood. Psychodynamic psychotherapy involves identifying and making patients aware of these patterns in relationships, as well as unconscious meanings, conflicts, and desires that cause depression. (See 'Introduction' above.)

- Psychodynamic psychotherapy, without pharmacotherapy, can be used to treat patients with mild to moderate depression. The suitability of psychodynamic therapy is also based upon the patient's personality, motivation, and level of social and occupational functioning (table 1).(See 'Indications' above.)

- Psychodynamic psychotherapy emphasizes an understanding of unconscious conflict as it manifests itself in life outside the therapy as well as in the clinician-patient relationship through transference, countertransference, defense mechanisms, and resistance. The clinician interprets and helps the patient become aware of repetitive patterns and unconscious conflicts. Remission of the depressive syndrome is directly linked to the patient gaining insight into these patterns, conflicts, and defenses. (See 'Theoretical foundation' above and 'Fundamental concepts and processes' above.)

- Clinicians should assess patients to determine whether psychodynamic psychotherapy is suitable. In addition, the clinician should examine past and ongoing stressors and what they mean to the patient, the patient's behavioral patterns in relationships, and defense mechanisms that the patient uses to reduce anxiety and control conflict. (See 'Assessment' above.)

- General treatment principles for psychodynamic psychotherapy include asking about stressors and what they mean to the patient; observing how the patient relates to the clinician and unconsciously resists the clinician's efforts to help; helping the patient to become aware of unconscious feelings, thoughts, and behaviors that cause depression and relationship problems; and changing personality characteristics (eg, problematic defense mechanisms) that leave the patient vulnerable to depression (See 'General treatment principles' above.)

- The therapeutic relationship between the patient and clinician is more important than any specific technique in producing a positive outcome. A strong therapeutic alliance is defined by the following: the patient feels attached to the clinician, the patient feels the therapist is helpful, and the patient and clinician feel a sense of mutual collaboration. (See 'Therapeutic alliance' above.)

- Treatment involves the use of the following interventions: interpretation, observation, confrontation, clarification, encouragement to elaborate, empathic validation, psychoeducation, and advice and praise. (See 'Therapeutic interventions' above.)

- One therapeutic strategy to help patients work through their problems is based upon identifying the patient's wishes, expectations, and fantasies about other people; the perceived reaction of other people to these wishes, expectations and fantasies; and the

patient's response to the imagined reaction of the other. The clinician identifies these thoughts and feelings in the patient's stories about childhood and adult life, and observes their emergence in the therapeutic relationship. (See 'Therapeutic strategy' above.)

- Psychodynamic psychotherapy efficaciously treats mild to moderate depression. Controlled trials have found that psychodynamic therapy is significantly superior to control conditions (eg, waiting list or treatment as usual), and is comparable to other types of psychotherapy (eg, cognitive-behavioral therapy or interpersonal therapy). (See 'Evidence of efficacy' above.)

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