Short-Term Psychodynamic Psychotherapy in Major Depression

Subjects: Psychology, Psychoanalysis

Contributor: Gabriele Di Salvo, Matteo Bianco, Elena Teobaldi, Giuseppe Maina, Gianluca Rosso

The term Short-term psychodynamic psychotherapy (STPP) identifies a set of psychotherapeutic techniques-rooted in the Freudian theoretical model that developed over time newer and specific methodological approaches, progressively departing from classical long-term models.

Keywords: short term psychodynamic therapy ; STPP ; major depressive disorders

1. Short-Term Psychodynamic Psychotherapy (STPP): Origins and Theoretical Foundation

The term Short-term psychodynamic psychotherapy (STPP) identifies a set of psychotherapeutic techniques-rooted in the Freudian theoretical model [1] that developed over time newer and specific methodological approaches, progressively departing from classical long-term models. STPPs largely refer to basic principles of psychoanalysis: clinical symptoms are considered as expression of conflicts between unconscious psychic instances and the occurrence of pathologies is linked with relational dysfunction in early development and object relations. Furthermore, therapeutic work is carried out through the analysis of verbal and non-verbal communication and transferential/countertransferential dynamics [2].

At the same time, STPPs embody the need for change of traditional models in response to historical and social progresses, which demanded for adjustments in psychotherapeutic interventions: expanding the fields of application, identifying areas of intervention by determining indications and contraindications, verifying results and evaluating costs/benefits [2][3].

The first reason for differentiation from classical models was certainly represented by the request for a limitation in the number of sessions and the overall duration, which at present constitutes one of the founding features of STPPs. The need for brevity of treatment, in opposition to the tendency to increase the duration of analysis, was firstly postulated by Ferenczi and Rank [4], who questioned the centrality of the elaboration of infantile neurosis and the consequent development of personality as fundamental paths for therapeutic change. The researchers argued that the analyst's attention should be focused on the emotional elements reproduced by the patient through the relationship with the therapist (i.e., present transfert), since relational dynamics of the past tend to repeat in the present. Alexander and French [5] proceeded in challenging the belief that short-term therapies could not lead to lasting transformation, emphasizing the concept of recovery occurring outside the therapy session rather than during the analysis.

The second reason for evolving beyond classical models can be identified in the request for more versatility towards different types of patients: frequently, subjects with severe psychic disorders could not tolerate a classical psychoanalytic treatment. The overcoming of the theoretical and clinical Freudian psychoanalytic orientation was especially carried out through the interpretative-applicative models proposed by the American literature. In particular, Luborsky performed comparative studies on psychotherapies which underlined the role of transference as an essential working tool for the management of emotional conflicts. By identifying a core conflictual relationship theme (CCRT) as foundation of supportive-expressive therapies, Luborsky suggested current relational issues of the individual as the target of short-term psychodynamic interventions, focusing the gain of insight towards recurring conflicts (both intrapsychic and interpersonal) rather than to more classical psychoanalytic elements [6]. This model led to a problem-centered psychotherapeutic approach, therefore particularly suitable to a time-limited therapeutic setting such as the public health care system. In this regard, the introduction of a manual of psychoanalytic psychotherapy proved to be a valuable asset, both for the training of practitioners and for research development: therapists were provided a basic framework to measure elements associated to the internal coherence and the outcome of psychotherapeutic practice [7]. In fact, the same researcher emphasized the need to obtain clearer parameters to determine a patient's therapeutic improvement. Three areas were identified:

- changes in the patient (better understanding of symptoms and conflicts, internalization of the alliance and ability to consciously manage the problem);
- modalities of change in the patient (active engagement, elaboration of relevant problems, ability to establish a therapeutic alliance);
- means used by the therapist (facilitation of expression, comprehension and reworking, ability to provide useful elements to integrate the patient's information).

Beyond the historical path of the various schools of thought (**Table 1**), it is necessary to highlight some common aspects shared by the different STPP techniques. The concept of time has now become an integral part of the interpersonal relationship, since the brevity of treatment holds major importance in accelerating the psychotherapeutic process. In this regard, anxiety and pain for separation-in contrast with the desire for continuity and repetition-can increase the emotional tension experienced in the context of therapy itself [8]. Such distress can be exploited in a brief psychodynamic intervention to provide the tools to help patients showing anxiety, depression and interpersonal difficulties, which are considered the product of chronic maladjustments [9]. In this field, the main techniques are represented by interpretation and clarification: the therapist has thus the task of highlighting connections with significant interactions from the past, comparing them to the present relationship.

Table 1. Comparison of Short term psychodynamic therapy schools.

	Malan	Sifneos	Davanloo	Mann
Selection criteria	**Yes**	**Strict**	**Yes**	**Broad**
Number of meetings	**20–40**	**12–20**	**5–40**	**12**
Predetermined endpoint	**Yes**	**No**	**No**	**Yes**
Active therapist	**Yes**	**Very active**	**Very active**	**Yes**
Neutrality	**Yes**	**No**	**No**	**No**
Focus	**Yes**	**Yes**	**Yes**	**Yes**
Transference interpretation	**Yes**	**No**	**Yes**	**Yes**
Targeting defence mechanisms	**No**	**Yes**	**Yes**	**No**
Confrontational approach	**No**	**No**	**Yes**	**No**
Suggestive approach	**No**	**No**	**No**	**Yes**
Pedagogical approach	**No**	**Yes**	**No**	**Yes**
Relaxation techniques	**No**	**No**	**No**	**No**
Pharmacological treatment	**No**	**No**	**No**	**No**

These models are therefore based on techniques that favor a significant reduction in the time of intervention, foregoing the complete restructuring of personality in favor of limited but not negligible objectives, such as clinical improvement and social-relational functioning, contact with emotional experiences and cognitive acquisition of conflicts and limitations [10].

Another crucial feature of STPP is the setting negotiation: it is necessary to define both the area in which the therapy will be developed and the frequency and duration of meetings (more frequently weekly, 45 min each). The total number of sessions generally varies from 10 to 30 (12 according to Mann's school), ranging from 7 to 40; in some circumstances ultra-short techniques (less than 6 meetings) may be applied. Particular attention is paid to the definition of the focus, which must address a precise therapeutic theme towards which the intervention is targeted. The content of the focus can be equally represented by a symptom, conflicts, maladaptive or critical preconscious situations or to grief and separation-related issues [8].

Lastly, the therapist has to seek an effective management of the therapeutic alliance, with moderately active and empathic involvement or, according to the model of the American schools, with an aggressive and deliberately provocative attitude to induce an intense motivational reaction in the patient [11][12].

In addition to the technical and ideological motivations that brought to the development of different techniques, the debate around psychotherapy has been centered on public assistance and hospitals as pivots of psychiatric care [13][14][15]. Interest towards more detailed treatment modalities was motivated by various factors: growing need for applicability of treatments in the public health care system, demands for cost containment, and lack of scientific studies documenting efficacy, safety, appropriateness, and cost-effectiveness of therapies [9].

In response to the need for evaluation of effectiveness, validity and reproducible and scientifically comparable models, in the last decades psychotherapy has been object of systematic research. A number of studies have evaluated the clinical efficacy in treating major psychiatric disorders [16][17][18][19][20] and verified the superiority of these therapies in sample groups compared to controls or placebo [21]. Other studies have evaluated the psychodynamic approach by examining possible predictive factors of outcome and selecting the most suitable techniques according to the characteristics of the patients [22][23]. Despite such caution, the relationship between this type of therapeutic intervention and its effects on psychiatric disorders still requires further evaluation [24].

The choice of psychotherapeutic intervention undergoes rigorous patient selection criteria. The indications for treatment are not only limited to the clinical characteristics of the disorder: other variables such as patient's insight, level of education, motivation for change, relational skills and available economic resources are also taken into account.

Currently, STPP find application in Depressive disorders, Anxiety Disorders, Eating Disorders (especially in Bulimia Nervosa), stress-related disorders and occasionally in Somatoform Disorders and substance use disorders [25][26]. The efficacy of the treatment in Personality Disorders has not yet provided definitive data. Absolute contraindications to treatment are current psychotic symptoms, drug addiction and personal traits that may interfere with the therapeutic relationship.

2. STPP in the Treatment of Major Depressive Disorder (MDD)

In recent years, the therapeutic approach to MDD has increasingly embraced the use of psychotherapeutic treatment, both in association with pharmacotherapy and in monotherapy. The growing need for more flexible models arised alongside the first results of controlled studies that showed high rates of non-response and relapse in patients treated with antidepressant monotherapy [27], as confirmed by more recent research [28]. Moreover, such necessity for versatility is also strengthened by the modern conception of depression as a spectrum of disorders, whose clinical presentation depends on multiple emotional, psychomotor, cognitive, personality and somatic aspects [29]. In particular, depression can lead to somatic changes as well as psychic symptoms: it is widely acknowledged that somatic symptoms predict worse prognosis in MDD independently of psychiatric characteristics, medical comorbidities, lifestyle and disability, especially if cardiopulmonary and gastrointestinal systems are involved [30]. Somatic symptoms are also related to biological structural changes of the brain, feature which furtherly contributes to the complexity of depression [31].

Given these premises, the brief psychodynamic approach targets a substantial modification of the substrate of the depressive disorder, focusing on the therapeutical relationship and on a series of consecutive, timeframe-related goals:

- decreasing intensity of symptoms through expression of suppressed negative feelings;
- modulation of Super-Egoic standards of perfection, in order to reduce feelings of inappropriateness and guilt and to strengthen self-esteem;
- increasing awareness on the patient's current interpersonal relationships [32].

Concerning MDD, guidelines recommend psychotherapy in monotherapy as a first line in case of mild to moderate depressive symptoms, while a combination of medication plus psychotherapy is suggested in case of moderate to severe symptomatology [33][34]. Therefore, most of the studies on STPP in patients with MDD are focused on combined approach [35][36][37][38][39] and only few evaluated STPP monotherapy [40][41]. Regarding 'minor' depressive disorders, there are few evidence concerning STPP monotherapy as well [42].

Furthermore, according to the APA guidelines [43] psychodynamic psychotherapy is particularly indicated in patients with MDD with specific characteristics such as the presence of chronic feeling of emptiness, rigid self-expectations and lack of self-worth, history of childhood abuse, loss or separation or chronic conflict in interpersonal relationship. Moreover STPP, as other psychotherapeutic strategies, has to be preferred as a first line in case of MDD during pregnancy, post-partum, childhood and adolescence [33].

Given the above, STPP in monotherapy has less evidence than cognitive-behavioural therapy (CBT) or interpersonal therapy (ITP), which are thus the first two psychotherapy approaches recommended by the most recent guidelines [34][44][45][46]. However, the time-limited and problem-focused approach of STPP can make it more suitable in the public health context compared to other psychotherapeutic techniques.

References

1. Sripada, B. Toward a re-appraisal of the relationship between psychoanalysis and dynamic psychotherapy. Psychodyn. Psychiatry 2015, 43, 396–422.
2. Gabbard, G.O. Psychodynamic Psychiatry in Clinical Practice; American Psychiatric Publishing: Washington, DC, USA, 2014.
3. Baée, J.; Jeyasingam, N. Short-term psychodynamic psychotherapy: A brief history. Aust. Psychiatry 2019, 27, 581–583.
4. Ferenczi, S.; Rank, O. Entwicklungsziele der Psychoanalys. Zur Wechselbeziehung von Thorie und Praxis, Italian Translation: Prospettive di Sviluppo della Psicoanalisi. Sull'interdipendenza tra Teoria e Pratica. In Opere; Cortina: Milano, Italy, 1924; Volume III.
5. Alexander, F.; French, T. Psychoanalytic Therapy: Principles and Applications; Ronald Press: New York, NY, USA, 1946.
6. Luborsky, L. Principles of Psychoanalytic Psychotherapy; Basic Books: New York, NY, USA, 1984.
7. Luborsky, L.; DeRubeis, R. The use of psychotherapy manuals: A small revolution in psychotherapy research style. Clin. Psychol. Rev. 1984, 4, 5–14.
8. Messer, S.B. What makes brief psychodynamic therapy time effect. Clin. Psychol. Sci. Pract. 2001, 8, 5–22.
9. Strupp, H.H.; Binder, J.L. Psychotherapy in a New Key; Basic Books: New York, NY, USA, 1984.
10. Pavan, L.; Mangini, E.; Bogetto, F.; Bellino, S.; Banon, D. Psicoterapie brevi. In Trattato Italiano di Psichiatria; Masson: Padova, Italy, 1999.
11. Sifneos, P.E. Short Term Psychotherapy and Emotional Crisis. Italian translation: Psicoterapia Breve e Crisi Emotiva; Martinelli: Firenze, Italy, 1982.
12. Davanloo, H. La Psicoterapia Dinamica Breve; Armando: Roma, Italy, 1987.
13. Barten, H.H. The Coming of Age of the Brief Psychotherapies. In Progress in Community Mental Health; Grune and Stratton: New York, NY, USA, 1969.
14. Small, L. The Briefer Psychotherapies; Brunner/Mazel: New York, NY, USA, 1979.
15. Budman, S.H.; Gurman, A.S. The practice of brief therapy. Prof. Psychol. Res. Pract. 1983, 14, 277–292.
16. Svartberg, M.; Stiles, T.C. Comparative effects of short-term psychodynamic psychotherapy: A meta-analysis. J. Consult. Clin. Psychol. 1991, 59, 704–714.
17. Crits-Christoph, P. The efficacy of brief dynamic psychotherapy: A meta-analysis. Am. J. Psychiatry 1992, 149, 151–158.
18. Grawe, K.; Donati, R.; Bernauer, F. Psychotherapie im Wandel: Von der Konfession zur Profession Gottingeny; Hogrefe: Berlin, Germany, 1994.
19. Anderson, E.M.; Lambert, M.J. Short-term dynamically oriented psychotherapy: A review and meta-analysis. Clin. Psychol. Rev. 1995, 15, 503–514.
20. Wampold, B.E.; Mondin, G.W.; Moody, M.; Stich, F.; Benson, K.; Ahn, H. Meta-analysis of outcome studies comparing brief psychotherapies: Empirically, "all must have prizes". Psychol. Bull. 1997, 122, 203–215.
21. Grissom, R.J. The magical number. 7+/−2, 2: A meta-analysis of the probability of superior outcome in comparisons involving therapy, placebo, and control. JCCP 1996, 64, 973–982.
22. Ogrodniczuck, J.S.; Piper, W.E.; Joyce, A.S.; Mccallum, M. Transference interpretations in short-term dynamic psychotherapies. J. Nerv. Ment. Dis. 1999, 187, 571–578.
23. Piper, W.E.; McCallum, M.; Joyce, A.S.; Azim, H.F.; Ogrodniczuk, J.S. Follow up findings for interpretative and supportive forms of psychotherapy and patient personality variables. JCCP 1999, 67, 267–273.
24. Leichsenring, F.; Rabung, S.; Leibing, E. The efficacy of short-term psychodynamic psychotherapy in specific psychiatric disorders: A meta-analysis. Arch. Gen. Psychiatry 2004, 61, 1208–1216.

25. Steinert, C.; Munder, T.; Rabung, S.; Hoyer, J.; Leichsenring, F. Psychodynamic therapy: As efficacious as other empirically supported tretments? A meta-analysis testing equivalence of outcomes. Am. J. Psychiatry 2017, 174, 943–953.
26. Abbass, A.; Lumley, M.A.; Town, J.; Holmes, H.; Luyten, P.; Cooper, A.; Russel, L.; Schubiner, H.; De Meulemeester, C.; Kisely, S. Short-term psychodynamic psychotherapy for functional somatic disorders: A systematic review and meta-analysis of within-treatment effects. J. Psychosom. Res. 2021, 145, 110473.
27. Prien, R.F. Somatic Treatment of Unipolar Depressive Disorder. In American Psychiatric Press Review of Psychiatry; American Psychiatric Press: Washington, DC, USA, 1988.
28. Akil, H.; Gordon, J.; Hen, R.; Javitch, J.; Mayberg, H.; McEwen, B.; Meaney, M.J.; Nestler, E.J. Treatment resistant depression: A multi-scale, systems biology approach. Neurosci. Biobehav. Rev. 2018, 84, 272–288.
29. Akiskal, H.S. Diagnosis and classification of affective disorders: New insights from clinical and laboratory approaches. Psychiatry Dev. 1983, 2, 123–160.
30. Bekhuis, E.; Boschloo, L.; Rosmalen, J.G.M.; de Boer, M.K.; Schoetvers, R.A. The impact of somatic symptoms on the course of major depressive disorder. J. Affect. Disord. 2016, 205, 112–118.
31. Lui, P.; Tu, H.; Zhang, A.; Yang, C.; Liu, Z.; Lei, L.; Wu, P.; Sun, N.; Zhang, K. Brain functional alterations in MDD patients with somatic symptoms: A resting-state fMRI study. J. Affect. Disord. 2021, 295, 788–796.
32. Pavan, L.; Conforti, D. La Psicoterapia della Depressione; Minerva Psichiatrica: Rome, Italy, 1999; Volume 40, pp. 263–269.
33. Malhi, G.S.; Bassett, D.; Boyce, P.; Bryant, R.; Fitzgerald, P.B.; Fritz, K.; Hopwood, M.; Lyndon, B.; Mulder, R.; Murray, G.; et al. Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders. Aust. N. Z. J. Psychiatry 2015, 49, 1087–1206.
34. National Institute for Health and Care Excellence (NICE). Depression in Adults: Treatment and Management. 2022. Available online: www.nice.org.uk/guidance/ng222 (accessed on 1 July 2022).
35. Driessen, E.; Dekker, J.J.M.; Peen, J.; Van, H.L.; Maina, G.; Rosso, G.; Rigardetto, S.; Cuniberti, F.; Vitriol, V.G.; Florenzano, R.U.; et al. The efficacy of adding short-term psychodynamic psychotherapy to antidepressants in the treatment of depression: A systematic review and meta-analysis of individual participant data. Clin. Psychol. Rev. 2020, 80, 101886.
36. Maina, G.; Rosso, G.; Crespi, C.; Bogetto, F. Combined brief dynamic therapy and pharmacotherapy in the treatment of major depressive disorder: A pilot study. Psychother. Psychosom. 2007, 76, 298–305.
37. Maina, G.; Rosso, G.; Bogetto, F. Brief dynamic therapy combined with pharmacotherapy in the treatment of major depressive disorder: Long-term results. J. Affect. Disord. 2009, 114, 200–207.
38. Maina, G.; Rosso, G.; Rigardetto, S.; Piat, S.C.; Bogetto, F. No effect of adding brief dynamic therapy to pharmacotherapy in the treatment of obsessive-compulsive disorder with concurrent major depression. Psychother. Psychosom. 2010, 79, 295–302.
39. Martini, B.; Rosso, G.; Chiodelli, D.F.; De Cori, D.; Maina, G. Brief dynamic therapy combined with pharmacotherapy in the treatment of panic disorder with concurrent depressive symptoms. Clin. Neuropsychiatr. 2011, 8, 204–211.
40. Salminen, J.K.; Karlsson, H.; Hietala, J.; Kajander, J.; Aalto, S.; Markkula, J.; Rasi-Hakala, H.; Toikka, T. Short-term psychodynamic psychotherapy and fluoxetine in major depressive disorder: A randomized comparative study. Psychother. Psychosom. 2008, 77, 351–357.
41. Rosso, G.; Martini, B.; Maina, G. Brief dynamic therapy and depression severity: A single-blind, randomized study. J. Affect. Disord. 2013, 147, 101–106.
42. Maina, G.; Forner, F.; Bogetto, F. Randomized controlled trial comparing brief dynamic and supportive therapy with waiting list condition in minor depressive disorders. Psychother. Psychosom. 2005, 74, 43–50.
43. American Psychiatry Association. Practice Guideline for the Treatment of Patients with Major Depressive Disorder; APA: Washington, DC, USA, 2004.
44. Parikh, S.V.; Quilty, L.C.; Ravitz, P.; Rosenbluth, M.; Pavlova, B.; Grigoriadis, S.; Velyvis, V.; Kennedy, S.H.; Lam, R.W.; MacQueen, G.M.; et al. Canadian network for mood and anxiety treatments (CANMAT) 2016 clinical guidelines for the management of adults with major depressive disorder: Section 2. Psychological treatments. Can. J. Psychiatry 2016, 61, 524–539.
45. American Psychological Association. Clinical Practice Guideline for the Treatment of Depression across Three Age Cohorts; APA: Washington, DC, USA, 2019.

46. Malhi, G.S.; Bell, E.; Bassett, D.; Boyce, P.; Bryant, R.; Hazell, P.; Hopwood, M.; Lyndon, B.; Mulder, R.; Porter, R.; et al. The 2020 Royal Australian and New Zealand College of Psychiatrist clinical practice guidelines for mood disorders. Aust. N. Z. J. Psychiatry 2021, 55, 7–117.