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Review

Empirically supported methods of short-term psychodynamic therapy in depression – Towards an evidence-based unified protocol

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ABSTRACT

Context: There is evidence that psychotherapy is helpful in depressive disorders, with no significant differences between psychotherapies. For psychodynamic therapy (PDT) various models prove to be efficacious. Thus, the evidence for PDT is "scattered" between different forms of PDT, also implying problems in training of psychotherapy and in transferring research to clinical practice. A unified protocol based on empirically-supported methods of PDT in depression may contribute to solve these problems

Methods: Systematic search for randomized controlled trials fulfilling the following criteria: (a) individual psychodynamic therapy (PDT) of depressive disorders, (b) treatment manuals or manual-like guidelines, (c) PDT proved to be efficacious compared to control conditions, (d) reliable measures for diagnosis and outcome, and (f) adult patients.

Findings: Fourteen RCTs fulfilled the inclusion criteria. By a systematic review of the applied methods of PDT seven treatment components were identified. A high consistency between components was found. The components were conceptualized in the form of seven interrelated treatment modules.

Conclusions: A unified psychodynamic protocol for depression may enhance the empirical status of PDT, facilitate both the training in psychotherapy and the transfer of research to clinical practice and may have an impact on the health care system.

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Contents

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1. Introduction

There is evidence from a large number of randomized controlled trials (RCTs) that psychotherapy is effective in depressive disorders (Barth et al., 2013). Psychotherapy was found to be as efficacious as pharmacotherapy in the short-term but superior in the long-term especially with regard to relapse prevention (Cuijpers P et al., 2013; Dobson et al., 2008; Forand et al., 2013; Hollon et al., 2005; Imel et al., 2008; Spielmans et al., 2011; Vittengl et al., 2007). In dysthymia, however, a small but significant advantage of pharmacotherapy was found (Cuijpers et al., 2013; Imel et al., 2008). Whereas the combination of psychotherapy and pharmacotherapy was reported to be superior to monotherapies by small to medium effect sizes in the short-term (Cuijpers, 2009; Cuijpers et al., 2009a, 2009b; Hollon and Beck, 2013), no superiority was found with regard to long-term effects (Cuijpers et al., 2009a, 2009b; Forand et al., 2013). With rates of relapse between 40% and 85%, the risk of relapse after pharmacotherapy is relatively high (Hughes and Cohen, 2009). Maintenance pharmacotherapy has shown moderate efficacy in preventing relapse (Forand et al., 2013; Geddes et al., 2003).

With regard to the different forms of psychotherapy, several meta-analyses found no significant differences in efficacy in depressive disorders including cognitive-behavioural therapy (CBT), psychodynamic therapy (PDT), interpersonal therapy and supportive therapy (Abbass and Driessen, 2010; Barth et al., 2013; Cuijpers et al., 2013a; Driessen et al., 2010; Leichsenring, 2001). These results were corroborated by a recent large-scale RCT finding PDT and CBT to be equally effective in the treatment of depression (Driessen et al., 2013). From these results, Thase (2013, p. 954) concluded: "On the basis of these findings, there is no reason to believe that psychodynamic psychotherapy is a less effective treatment of major depressive disorder than CBT."

However, in spite of the evidence for psychotherapy in depression, we cannot be satisfied with the current state for the following reasons. (1) The effects of psychotherapy in depression appear to be overestimated (Cuijpers et al., 2010); (2) with post-therapy rates for remission between 30% and 40% and for response between 40% and 60% a substantial proportion of patients do not benefit sufficiently from the available treatments (Blackburn and Moore, 1997; DeRubeis et al., 2005; Dimidjian S, 2006; Elkin et al., 1989; Keller MB, 2000; Rush et al., 2006; Shea et al., 1992). A recent meta-analysis found rates for remission and response of 43% and 54% respectively, again with no significant differences between the various methods of psychotherapy (Cuijpers et al., 2014). (3) Furthermore, results for long-term outcome are often disappointing and the likelihood of relapse is relatively high (Emmelkamp, 2013). There is evidence which suggests that about 50% of the patients who recovered by the end of treatment suffered a relapse two years later. Maintenance treatments have only shown moderate efficacy with regard to relapse prevention, especially in long-term follow-ups of up to two years, not only for pharmacotherapy, but also for psychotherapy (Blackburn and Moore., 1997; Fava et al., 2004; Forand et al., 2013; Hollon et al., 2005; Vittengl et al., 2007). Thus, there is a need to further improve the efficacy of psychotherapy in depression (Thase, 2013). As PDT is frequently used in clinical practice (Cook et al., 2010; Norcross et al., 2002), this applies to psychotherapy in general and to PDT in particular.

As another problem, evidence for PDT in depression comes from RCTs in which different concepts and methods of PDT were applied. Thus, the evidence for PDT is "scattered" between the different forms of PDT, not only for depressive disorders, but for other mental disorders as well (Leichsenring and Klein, 2014). It was for this very reason that PDT was judged as only "possibly efficacious" by Chambless and Hollon (1998). To be judged as "efficacious" at least two RCTs are required in which the same treatment was effectively applied in the same mental disorder (Chambless and Hollon, 1998). Furthermore, the existence of different methods of PDT (for any mental disorder) implies a problem for training in psychotherapy: should candidates in psychotherapy learn to apply all empirically supported methods of PDT in depression? Should the training focus on only a limited number of these approaches and if so, on which of the approaches? Furthermore, a clinician is confronted with a similar problem if he or she sees a patient suffering from a depressive disorder. In addition, it is not clear how "different" the various approaches really are.

During the last ten years, unified, transdiagnostic and modular treatments have emerged (Barlow et al., 2004; Wilamowska et al., 2010). Unified protocols aim at integrating the most effective disorder-specific treatment components targeting the core processes underlying the respective disorder. Barlow et al. (2004), for example, have developed a unified cognitive-behavioural protocol for "emotional disorders", including both depressive and anxiety disorders. For the psychodynamic treatment of depressive disorders, however, a unified protocol has not yet been developed.

Unified protocols for the psychodynamic treatment of mental disorders would have several advantages, that is (1) using unified protocols in efficacy studies will enhance the status of evidence of PDT by aggregating the evidence; (2) unified protocols will facilitate both training in PDT and transfer of research to clinical practice; (3) thus, they can be expected to have a significant impact on the health care system. Furthermore integrating the most effective treatment principles of empirically supported treatments, unified protocols can be hypothesized to further enhance the efficacy of PDT. Further RCTs to test the unified protocol are desirable.

For these reasons we made the effort to develop a unified protocol for the psychodynamic treatment of depressive disorders. For this purpose the available RCTs of PDT in depression were reviewed and the treatment components included in the efficacious approaches were identified and integrated within a unified protocol.

2. Methods

2.1. Definition of psychodynamic psychotherapy

Psychodynamic psychotherapy serves as an umbrella concept encompassing treatments that operate on a continuum of supportive–interpretive psychotherapeutic interventions (Fig. 1; Gunderson and Gabbard, 1999; Luborsky, 1984; Wallerstein, 2002). *Interpretive* interventions (e.g. interpretation) aim to

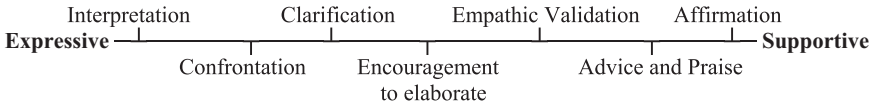

Fig. 1. The expressive–supportive continuum of psychodynamic interventions according to Gabbard (2000, p. 96).

Table 1
Depression: psychodynamic perspectives.

The understanding of depression from a psychodynamic perspective has a long history and can be summarized as follows.

- At the heart of an acute depressive decompensation lies a loss of an important and significant other or of an important outer or inner goal or hold. Coping and defence mechanisms, which are closely connected to precipitating more or less adaptive personality characteristics, are exhausted or did not exist primarily. Depression is therefore a ubiquitous human reaction of outer or inner helplessness. It presents itself with some core features of well-known psychological or bodily symptoms.
- Early psychodynamic works described the core features of depression as a painful gap between the ideal and the actual state of the self (Freud, 1914, 1915). The relations to important objects (persons) were described as ambivalent and characterized by unconscious or latent aggression (Freud, 1915). Being associated with the fear of being abandoned, defence mechanisms are (unconsciously) applied by turning aggression against the self – attacking oneself is experienced as less threatening than attacking an important person. Turning against the self was considered as the prototypic defence mechanism in depression (Freud, 1915). These (psycho-) dynamics show the close interrelation between anxiety, depression and aggression. However, the early psychodynamic works on depression suffer from several shortcomings. Luyten and Blatt (2012, p. 114), for example, recently commented on these works as follows: "Although these observations are still clinically relevant, traditional psychoanalytic theories of depression were often over specified, lacked theoretical precision, and were too broad to be empirically tested."
- Attachment theory focuses on early adverse and disruptive experiences in depression (Luyten and Blatt, 2012). Insecure (fearful) attachment was found to be associated with recurrent depression, longer use of antidepressants, greater impairments in social functioning, and increased risk of suicide attempt (Conradi and de Jonge, 2009; Grunebaum et al., 2010). Attachment styles were not only found to be related to clinical depression, but also to psychosocial depressive-vulnerability (Bifulco et al., 2002a, 2002b). In the context of modern attachment theory impairments in mentalization have also been associated with depression (Luyten and Blatt, 2012; Luyten et al., 2012). On the one hand impairments in the capacity to reflect on the self and others in terms of mental states (e.g. feelings or goals) may contribute to the development of depression, on the other hand depression may impair the capacity to reflect on others and the self (Luyten and Blatt, 2012; Luyten et al., 2012).
- An influential research tradition, with some connection to the concept of attachment insecurity, has described two interpersonal personality patterns in depression, which can be seen as maladaptive and insufficient ways of coping with the above mentioned vulnerability. They are centred around issues of dependency vs. autonomy (or relatedness vs. self definition) (Blatt and Zuroff, 1992). Whereas the former subjects tend to avoid aggression in close relationships in order to prevent from being abandoned, highly self-critical subjects may unconsciously (through devaluation) elicit criticism by others confirming their belief that nobody loves them (self-fulfilling prophecy) (Luyten and Blatt, 2012).
- In a modern emotion theory, depression, like anxiety and aggression, is regarded as a basic emotional response (Luyten and Blatt, 2012). Depression signals a discrepancy between a wished-for-state and the actual state of the self (Luyten and Blatt, 2012; Sandler, 1987). According to a recent psychodynamic theory of emotions, depression (and anxiety) function has the belief that one's wishes will not be satisfied (Dahl, 1995). Whereas anxiety signals a **likelihood** that wishes/needs (e.g. for security) will not be satisfied ($0 < p < 1$), depression signals the **certainty** for nonsatisfaction ($p = 1$, Dahl, 1995, p. 110). This view may explain both the above mentioned associations between depression (certainty of nonsatisfaction) and feelings of hopelessness and helplessness (Seligman, 1975) and the high comorbidity between anxiety and depressive disorders and the lack of distinction between distress and fear disorders (Kessler et al., 2005, 2011; Luyten and Blatt, 2012) – as both anxiety and depression refer to the belief of non-satisfaction. According to the information feedback theory of emotions and defences, both depression and anxiety tend to provoke defences against the wish and/or against anxiety or depression or may themselves function as defences (against a wish, e.g. aggression) (Dahl, 1995). In sum, unconscious motives and processes still play an important role in recent psychodynamic theories of depression (Luyten and Blatt, 2012).

enhance the patient's insight concerning repetitive conflicts sustaining his or her problems, e.g. depression (Gabbard, 2004). The establishment of a helping (or therapeutic) alliance is regarded as an important component of the *supportive* component of PDT (Luborsky, 1984). Specific supportive interventions aim to strengthen abilities (ego-functions, Bellak et al., 1973) that are temporarily not accessible to a patient due to acute stress (e.g. traumatic events) or that have not been sufficiently developed especially in patients with more severe impairment of personality functioning (e.g. regulation of self-esteem or assertiveness in depression). Modern variants of PDT are manual-guided and specifically tailored to the respective disorder (Leichsenring and Klein, 2014).

2.2. The understanding of depression from a psychodynamic perspective

The current understanding of depression from a psychodynamic perspective was recently reviewed by Luyten and Blatt (2012), taking research on attachment theory and neurobiology into account. Major issues are summarized in Table 1.

2.3. Inclusion criteria and selection of studies

Best evidence for efficacy is provided by RCTs examining manual-guided treatments in well-defined patient populations (Chambless and Hollon, 1998). Naturalistic studies and process research may provide additional evidence, but only if efficacy of the treatments examined has been proved in RCTs before (Leichsenring and Salzer, 2014). For this reason, we applied the following inclusion criteria for study selection: (a) RCT, (b) individual PDT meeting the above definition (Gabbard, 2004; Luborsky, 1984; Wallerstein, 2002), (c) use of treatment manuals or manual-like guidelines, (d) treatment of a depressive disorder, (e) use of standardized instruments in making diagnosis, (f) reliable and valid measures for outcome, (g) adult patients (≥ 18 years), (h) better outcomes for PDT than waiting list, treatment as usual, or alternative treatment or no differences in outcome in comparison with established treatment, and (i) combinations of PDT with pharmacotherapy were not included except for treatment arms examining PDT alone. As a recent meta-analysis reported lower effect sizes for group treatments, we did not include studies employing PDT in groups (Abbass and Driessen, 2010; Driessen et al., 2010).

We collected studies of PDT that were published between 1970 and January 2014 by use of a computerized search of MEDLINE and PsycINFO. The following search terms were used: (psychodynamic OR psychoanalytic* OR dynamic) and (therapy or psychotherapy or treatment) and (outcome or result or *effect or change*) and (RCT* or trial*) and ("mood disorder*" OR "affective disorder*" OR "depress*"). In addition, previous reviews and meta-analyses were reviewed (Abbass and Driessen, 2010; Barth et al., 2013; Cuijpers et al., 2014; Driessen et al., 2010; Leichsenring, 2001; Leichsenring and Klein, 2014). Manual searches in articles and textbooks were performed. In addition, we communicated with authors and experts in the field.

2.4. Data extraction

The authors independently extracted the following information from the articles: author names, publication year, mental disorder treated with PDT, duration of PDT, number of sessions, type of comparison group, sample size in each group, duration of follow-up period, applied treatment concepts and manuals, and included treatment components. Disagreements were resolved by consensus.

3. Results

3.1. Evidence-based psychodynamic treatments of depressive disorders

After completing literature searches, all hits ($n=351$) were saved in EndNote. After removal of duplicates ($n=45$), the authors independently screened titles and abstracts of the resulting 306 articles according to the selection criteria described above. All potentially relevant articles were then retrieved for full-text review which resulted in 14 RCTs that were finally included in the review for the UPP. Uncertainties regarding inclusion were discussed and resolved by consensus. In addition, recent meta-analyses and reviews were screened (Abbass et al., 2014; Cuijpers et al., 2013b, 2013c, 2013d, 2013e, 2014). Fourteen RCTs fulfilled the inclusion criteria (Barkham et al., 1996; Beutel et al., 2013; Connolly Gibbons et al., 2012; Cooper et al., 2003; de Jonghe et al., 2004; Driessen et al., 2013; Gallagher-Thompson and Steffen, 1994; Johansson et al., 2012, 2013; Knekt et al., 2008; Maina et al., 2005; Salminen et al., 2008; Shapiro et al., 1994; Thompson et al., 1987). The characteristics of these studies are given in Table 2, with a specific focus on the applied treatment concepts and the included treatment components. The review of the treatments was based on both the methods section of the included studies and on the original treatment manuals. The treatment components were extracted by the two authors. Disagreements were solved by consensus.

Several RCTs of PDT in depression did not fulfil the inclusion criteria (Barber et al., 2012; Bastos et al., 2013; Huber et al., 2013; Kornblith et al., 1983; Steuer et al., 1984; Thyme et al., 2007). The 14 RCTs included in this review provide evidence for the efficacy of the applied methods of manual-guided PDT alone (i.e. without medication) in depressive disorders (Barkham et al., 1996; Connolly Gibbons et al., 2012; Cooper et al., 2003; de Jonghe et al., 2004; Driessen et al., 2013; Gallagher-Thompson and Steffen, 1994; Heim et al., 2008; Johansson et al., 2012, 2013; Knekt et al., 2008; Maina et al., 2005; Salminen et al., 2008; Shapiro et al., 1994; Thompson et al., 1987). In these RCTs, manual-guided PDT of depression was either superior to waiting list (Maina, Forner and Bogetto, 2005), treatment as usual (Connolly Gibbons et al., 2012; Cooper et al., 2003), supportive therapy (Johansson et al., 2012, 2013; Maina et al., 2005), other treatments (Knekt et al., 2008)[1] or no differences in outcome were found in comparison with established treatments, that is either pharmacotherapy (Salminen et al., 2008), combined pharmacotherapy and psychotherapy (de Jonghe et al., 2004) or CBT (Barkham et al., 1996; Cooper et al., 2003; Driessen et al., 2013; Gallagher-Thompson et al., 1990; Gallagher-Thompson and Steffen, 1994; Shapiro et al., 1994, 1995; Thompson et al., 1987).

In the studies included between 8 and 20 sessions were performed. With the exception of two studies investigating subjects with minor depression, major depressive disorder (MDD) was treated (Table 2) (Gallagher-Thompson and Steffen, 1994; Maina et al., 2005). In the studies by Johansson et al. (2012, 2013) internet-based PDT was examined and proved to be superior to supportive treatments. Specific depressive populations were examined by Thompson et al. (1987) (elderly subjects with MDD), Gallagher-Thompson and Steffen (1994) (depressive caregivers), Cooper et al. (2003) (maternal depression, MDD) and Beutel et al. (2013) (major and minor depressive disorders in patients with breast cancer)Due to the highly specific nature of the patient population and the interventions, we decided to not include the treatment concept used by Cooper et al. (2003) in the following considerations regarding a unified protocol. As we focused on face-to-face treatments, we also did not include modules of the internet-based self-help studies in the unified protocol.

3.2. Towards a unified psychodynamic protocol for depressive disorders

In the 14 RCTs, various psychodynamic treatment concepts were applied. They are listed in Table 2. The concepts by Malan (1973, 1979), Luborsky (1984), de Jonghe (1994), and Shapiro and Firth (1985), were most frequently used (Table 2). The treatment components of the empirically supported methods of PDT in depression are listed in Table 2. As can be taken from the table, they have several components in common, that is

- a focus on the (unconscious) conflicts or deficits in ego-functions underlying the symptoms of depression,
- the use of interpretive interventions in order to address (unconscious) conflicts (e.g. interpretation),
- fostering a supportive alliance,
- the use of specific supportive elements in the case of impaired ego-functions (e.g. encouraging, affirming, advising, reassuring, calming, respect of vital defences), and
- a focus on termination.

This does not imply that these methods share all treatment components, but rather that some components are used by several approaches, with some components being more prominent than others. On the other hand, some components were included only by specific approaches (Table 2). The supportive–expressive approach by Connolly Gibbons et al. (2012), for example, includes a socialization component, an education-focused component and a cultural sensitivity component. As a specific form of psychodynamic intervention, transference interpretations (an explicit interpretation of the patient's ongoing relationship with the therapist) are not included by all of the approaches listed in Table 2. They were explicitly included, for example, by Salminen et al. (2008), whereas transference is considered, but not interpreted by de Jonghe (1994).

Like psychodynamic interventions in general, also the evidence-based treatments listed in Table 2 can be situated on a supportive–expressive continuum (Fig. 1). The differences between the psychodynamic approaches in this regard are rather gradual in nature with some treatment concepts putting more emphasis on supportive techniques whereas others putting a stronger focus on expressive (insight-oriented) aspects. In this context, it is of note that a recent meta-analysis found supportive and expressive modes of PDT in depression to be equally effective (Driessen et al., 2010).

Thus, despite some specific differences, there is a high overlap and consistency between the treatment components of the empirically-supported psychodynamic treatments for depression. For this reason, we propose the integration of these components

[1] That is long-term psychodynamic therapy in the study by Knekt et al. at 7-month follow-up.

Table 2
Randomized controlled studies providing evidence for psychodynamic psychotherapy (PDT) in depressive disorders.

Study	Disorder	Sample size (*N*)	Concept of PP/Treatment elements	Treatment duration (sessions)	Success rates (%)
Barkham et al. (1996)	Major depression	PDT: 18 CBT: 18	Shapiro and Firth (1985) (a) focus on interpersonal relationships, (b) focus on relationship to therapist to understand interpersonal problems (link), (c) conversational model (negotiation, language of mutuality, use of metaphor, focus on here and now, offering hypotheses).	8 vs. 16	(No information)
Beutel et al. (2013)	MDD or minor depressive disorder	PDT: 78 TAU: 79	Luborsky (1984) (a) focus on CCRT, (b) interpretive and supportive interventions, (c) specific interventions dealing with life-threatening disease.	20–25	Remission (no depressive disorder and reliable change in HADS-D): SET: 44% TAU: 23%
Connolly Gibbons et al. (2012)	MDD or minor depressive disorder HAMD ≥ 14	PDT: 21 TAU: 19	Luborsky (1984) and Connolly Gibbons et al. (2012) (a) focus on CCRT, (b) supportive alliance building component, (c) socialization-focused component, (d) education focused component, (e) cultural sensitivity component.	12	HAMD-reliable change SET: 50% TAU: 21% HAMD-clin. sig. change SET: 44% TAU: 36%
Cooper et al. (2003)	Maternal depression (MDD)	PDT: 50 Counselling: 48 CBT: 43 Primary Care: 52	Cramer et al. (1990) exploring the mother's representation of and relationship to her infant taking her own attachment history into account	10	Remission (no MDD) Post/9MFU: PDT: 71/79 Counselling: 54/66 CBT: 57/75 Primary Care: 69/81
de Jonghe et al. (2004)	MDD	PDT: 106 PDT+Pharmacotherapy: 85	de Jonghe (1994) (a) focus on actual relationships, (b) supportive attitude (e.g. empathic, accepting, affirmative, active), (c) systematic use of supportive interventions (e.g. reducing anxiety, reassuring, encouraging, advising, modelling, confronting, clarifying, reframing symptoms as problem-solving attempts), (d) defences are respected, (e) interpretation is used cautiously, (f) transference is used, but not interpreted.	16	per protocol: Remission (HAMD ≤ 7): STPP: 31 STPP+Medication: 42 Response (CGI-I=1,2) STPP: 67 STPP+Medication: 75
Driessen et al., 2013	Major depression HAMD ≥ 14	PDT: 177 CBT: 164	de Jonghe (1994)	16	Post (completers) Remission (HAMD ≤ 7) PDT: 21% CBT: 24% Response (≥ 50% reduction in HAMD): PDT: 37% CBT: 39% 1YFU: Remission (HAMD ≤ 7)

Table 2 (*continued*)

Study	Disorder	Sample size (*N*)	Concept of PP/Treatment elements	Treatment duration (sessions)	Success rates (%)
					PDT: 27%. CBT: 35%
Gallagher-Thompson and Steffen (1994)	Major, minor or intermittent depression in caregivers	PDT: 30 CBT: 36	Mann (1973) and Rose and DelMaestro (1990) (a) conflicts over dependence and independence reactivated by caregiving situation, (b) focus on this conflict.	16–20	SADS: Post (improved/ remitted): PDT: 5/62 CBT: 10/77 3MFU: PDT: 10/55 CBT: 18/68
Johansson et al. (2012)	Major depression	PDT: 46 structured support: 46	Internet-guided self-help; Silverberg (2005); 9 modules (1) introduction to the treatment and the concept by Silverberg, (2) techniques how to discover unconscious patterns, (3) understanding the pattern, (4) techniques to break unhelpful patterns, (5) preventing relapse to old patterns, (6) applying obtained knowledge in working life, (7) applying obtained knowledge in personal relationships, (8) relationship between unconscious patterns and depression, (9) summary and advice for future.	10 weeks	Remission (BDI-II $\leq$ 10): Post: I-PDT: 35 Structured Support: 9 10MFU: IPDT: 54 Structured support: (no data reported)
Johansson et al. (2013)[a]	Depressive and anxiety disorders	PDT: 50 support: 50	McCullough et al. (2003) and Frederick (2009) Internet-guided self-help, 8 modules (1) introduction to affect phobia model, (2) explanation of the problem, (3) mindfulness practice, (4) defence restructuring, (5) anxiety regulation, (6) affect experiencing, (7) affect expression and self/ other restructuring, (8) summary and advice for continued work.	10 weeks	Remission (no MDD): PDT: Post: 86% 7MFU: 83% Support (post): 57%
Knekt et al. (2008)[a]	Depressive and anxiety disorders	LTPP: 128 (Mood disorder: 113) STPP: 101 (Mood disorder: 79) Solution-focused therapy, 97 (Mood disorder: 84)	STPP: Malan (1979) and Sifneos (1978) (a) focus on intra-psychic and interpersonal conflicts, (b) transference-based, (c) actively creating alliance, (d) use of confrontation, clarification, interpretation.	LTPP: 232 STPP: 18.5 SFT: 9.8	Recovery from depression (no more MDD): Post (7 months): STPP:30; LTPP[b]: 13 SFT: 32 12MFU: STPP: 34; LTPP: 23 SFT: 41 36MFU: STPP: 50: LTPP: 51 SFT: 43
Maina et al. (2005)	Dysthymic, disorder, depressive disorder NOS, adjustment disorder with depressed mood	PDT: 10 Supportive therapy:10 Waiting List: 10	Malan (1979) (a) early phase: definition of a focus (symptoms, conflicts, or crisis), (b) middle phase: addressing the focus, (c) terminal phase: discussion of termination, review of progress, consolidation of gains.	15–30 M=19.6	Remission (HAMD $\leq$ 7+50% reduction) Post:

Table 2 (*continued*)

Study	Disorder	Sample size (*N*)	Concept of PP/Treatment elements	Treatment duration (sessions)	Success rates (%)
			Goal: insight into repetitive conflicts and trauma underlying and sustaining the patient´s problems; Techniques: interpretation, clarification		PDT: 50 Supportive: 40 Waiting List: 0 6MFU: PDT: 70 Supportive: 40
Salminen et al. (2008)	Major depression	PDT: 26 Fluoexetine: 25	Malan (1979) and Mann (1973) (a) formulation of psychodynamic focus, (b) active therapist, (c) early transference interpretation, (d) working through termination. Use of confrontation, clarification, interpretation	16	3MFU: Remission (HAMD ≤ 7) PDT: 57 Fluoxetine: 63
Shapiro et al. (1994), Shapiro et al. (1995)[c]	Major depression	PDT: 58 CBT: 59	Shapiro and Firth (1985) (a) focus on interpersonal relationships (b) focus on relationship to therapist to understand interpersonal problems (link), (c) conversational model (negotiation, language of mutuality, use of metaphor, focus on here and now, offering hypotheses)	8 vs. 16	Remission (BDI ≤ 8); 1YFU: 8-session-PDT: 39 8-session-CBT: 54 16-session-PDT: 54 16-session-CBT: 60
Thompson et al. (1987) Gallagher-Thompson et al. (1990)	Major Depression in elders (60 or above)	PDT: 24 BT: 25; CBT: 27; waiting list: 19	Horowitz and Kaltreider (1979) (a) establishing a working alliance (b) focus on central conflicts, developmental problems, defensive styles making subjects vulnerable to this particular stress experience (c) use of clarification and interpretation (d) reappraisal of serious life event (e) revisions of the inner model of self and world (f) supportive interventions (g) termination: working through approaching loss of therapist, relating it to stress event (e.g. loss).	16–20	SADS (improved/remitted): Post: PDT: 23/47 BT: 23/57 CBT: 10/52 1YFU: PDT: 24/52 BT: 11/54 CBT: 11/68 2YFU: PDT: 4/79 BT: 8/63 CBT: 12/69

Note: BDI: Beck Depression Inventory; CGI-I: Clinical Global Improvement Scale; BT: Behaviour Therapy; HADS-D: Hospital Anxiety and Depression Scale; HAMD: Hamilton Rating Scale for Depression; LTPP: long-term psychodynamic therapy; PDT: psychodynamic therapy; SADS: Schedule for Affective Disorders and Schizophrenia; STPP: short-term psychodynamic therapy.

[a] The results were separately evaluated for patients with depressive and anxiety disorders.

[b] Only in the short-term condition by Knekt et al. a manual-like guideline was used. Thus, the long-term psychodynamic did not fulfil the inclusion criteria.

[c] In the study by Shapiro et al. (1994) dose–effect relationship was observed with PDT of 8 sessions showing less improvement than CBT and PDT of 16 sessions being equivalent to 16-session CBT (Table 2). In a replication study carried out in an applied setting, the 16 session conditions of both CBT and PDT were superior to the 8 session-conditions of CBT and PDT on some measures at some assessments.

within a unified psychodynamic protocol (UPP-Depression). Within the framework of UPP-Depression, e.g. in a study, the author-specific concepts of STPP for example by Malan (1979) or Luborsky (1984), may be used as a base, but should be supplemented by the other components described in the modules.

3.3. General principles of a Unified Psychodynamic Protocol for depressive disorders

Consistent with the treatments listed in Table 2, UPP-Depression has a modular format allowing flexible application

and enabling the sequence and "dosage" of each treatment element to be adapted to the individual patient's needs. By the modular format, both the course of treatment and individual differences between patients can be taken into account, e.g. patient motivation or severity of pathology. However some modules are regarded as core modules and should be used in every treatment though possibly with varying emphasis. In order to apply UPP-Depression, therapists should be trained in psychodynamic therapy.

Some general principles of UPP-Depression can be summarized as follows:

- consistent with the RCTs fulfilling the inclusion criteria (Table 2), UPP-Depression constitutes a method of short-term psychodynamic therapy (STPP);
- the treatment is conducted in a face-to face position;
- regression (i.e. intense affect mobilisation) is generally restricted (e.g. by setting goals, avoiding longer periods of silence (Luborsky, 1984; Luborsky et al., 1995);
- both in identifying and working through the focus of treatment and in the application of supportive elements, the therapist adopts a more active stance than in classical psychoanalysis or long-term psychodynamic psychotherapy (Luborsky, 1984; Luborsky et al., 1995);
- in order to foster the transfer to everyday situations, the therapist is recommended tp put a strong emphasis on working through (i.e. reflecting on newly gained insight and testing new behaviours) not only *within* sessions but also *between* the sessions (Leichsenring and Leibing, 2007; Leichsenring and Salzer, 2014; Stricker, 2006);
- the use of more interpretive or supportive interventions depends on the patient's capacity and needs (Connolly Gibbons et al., 2012; Luborsky, 1984; Luborsky et al., 1995);
- research on transference interpretations has shown that in STPP high levels of transference interpretations were negatively associated with outcome in more severely disturbed patients (Ogrodniczuk et al., 1999; Piper et al., 1991). Thus, UPP-Depression puts the emphasis on the patient's maladaptive interpersonal patterns as experienced in current relationships outside therapy. If transference interpretations including the therapeutic relationship are made, they should be carefully applied taking the quality of the patient's object relations into account (Connolly et al., 1999; Gabbard, 2006; Levy and Scala, 2012). In more severely disturbed patients, they should be avoided.
- No treatment component is unique to the unified protocol. However, the whole is more than the sum of its constituent parts.

3.4. The seven modules of a Unified Psychodynamic Protocol for depressive disorders[2]

The treatment elements used in the empirically supported methods of psychodynamic therapy in depression are listed in detail in Table 2. The treatment elements common to these treatments were briefly summarized above (i.e. focus on conflicts or impaired ego-functions, interpretive and supportive interventions, supportive alliance, focus on termination). From the detailed listing in Table 2, seven treatment components can be distilled. They will be described in the following as treatment modules. Further details and examples for interventions to help clinicians to apply the treatment elements are given in Table 3. Core principles that are regarded as essential for every treatment using the UPP-Depression are marked by [C].

Caveat: if we list treatment principles in the following, this does not imply that the UPP-Depression is a puzzle of treatment modules. Being more than the sum of its parts, the UPP-Depression represents an integrated psychodynamic treatment, a whole, based on the supportive–expressive continuum of psychodynamic interventions (Luborsky, 1984). In Fig. 2, the modules are presented as cycles illustrating the cyclic process of psychotherapy and the interrelation of the modules within the unified protocol for depression.

3.4.1. Module 1: preparing the patient for psychotherapy – the socialization interview

A introductory meeting is conducted at the beginning of the treatment to make the patient familiar with the principles of the approach (Connolly Gibbons et al., 2012; Luborsky et al., 1995). It follows the principles outlined by Orne and Wender (1968), Luborsky et al. (1995), Book (1997) and Connolly Gibbons et al. (2012) The patient is given a rationale allowing for a first orientation with regard to the disorder and the planned treatment (Connolly Gibbons et al., 2012). A more detailed description is given in Table 3.

3.4.2. Module 2: motivating, addressing ambivalence and setting treatment goals

Addressing the patients motivation and setting treatment goals are regarded as important for patients with mental disorders in general (Leichsenring and Salzer, 2014; Luborsky, 1984) and for depressed patients in particular (Connolly Gibbons et al., 2012). Further evidence for addressing possible ambivalence early in treatment comes from studies of motivational interviewing (Westra et al., 2009). So the UPP-Depression puts a specific emphasis on the ambivalence and resistance to change. In the context of the introductory meeting, the therapist clarifies the patients' motivation for treatment (Connolly Gibbons et al., 2012). A description of the techniques and an example for an intervention are given in Table 3.

If possible initial ambivalence has been sufficiently worked through, treatment goals are discussed. In case that the patient seeks only relief from depressive symptoms, the therapist may also need to enhance his or her motivation for insight (Crits-Christoph et al., 1995a; Leichsenring et al., 2007). Realistic treatment goals are discussed and set that do not only refer to symptom reduction, but also to gaining insight in the motivations and fears underlying the symptoms and the difficulties in interpersonal relationships (Table 3; Crits-Christoph et al., 1995a; Leichsenring et al., 2007).

3.4.3. Module 3: educating and empowering the depressive patient

Based on psychoeducational approaches, Connolly Gibbons et al. (2012) implemented an "education-focused component" in their treatment approach. A major aim is to empower the patient to become an active participant in the treatment. In order to achieve this, the therapist pays attention to legal, medical and family crises. A more detailed description is given in Table 3 (Connolly Gibbons et al., 2012).

3.4.4. Module 4: supportive interventions: secure alliance and further specific supportive Interventions [C]

The establishment of a secure helping alliance is a very important treatment element (Luborsky, 1984) and was shown to be significantly associated with favourable treatment outcome

[2] It is important to note that the proposed protocol is not a treatment manual. UPP-Depression is a description and integration of empirically supported treatment components. For a manual based on the unified protocol, more detailed descriptions of treatment procedures are required.

Table 3
Modules of a unified psychodynamic protocol for depressive disorders (UPP-Depression).

Modules	**Content**
1	**Socializing the depressed patient for psychotherapy – the socialization interview** • The therapist informs the patient about the depressive disorder and the planned treatment. • The treatment process is explained to the patient emphasizing his or her active role which will be necessary if the treatment is to be successful. The therapist's role is explained as well (Luborsky et al., 1995, p. 20), e.g. by saying: "You are about to start psychotherapy for your depression and other problems. I want to help you to know how psychotherapy works. The basic plan is that you tell what you have to tell about yourself, about events, and about how you feel in the treatment. I will listen and respond whenever it is likely to be helpful." • Following Connolly Gibbons et al. (2012) any doubts about the usefulness of the treatment are discussed and the patient is motivated to expect that change is possible. • Practical arrangements for the treatment are made (e.g. duration of treatment and sessions, arrangements for vacations and cancelled sessions). Thus, the patient is given a rationale allowing for a first orientation regarding the disorder and the treatment. Further helpful examples for interventions were given by Luborsky et al. (1995, p. 20)
2	**Motivating, addressing ambivalence and setting treatment goals** • The UPP-Depression puts a specific emphasis on the ambivalence and resistance to change, classical concepts of the psychodynamic approach (for a review of the different forms of resistance from a psychodynamic view see, for example, Sandler et al. (2002, pp. 99–119). To address ambivalence, the psychodynamic techniques for working with and understanding resistance are applied (Gabbard, 2000; Greenson, 1967). • Taking an empathic position, the therapist confronts, clarifies and interprets the patients' ambivalence between changing and remaining, and resistance to change as well as any doubts about the usefulness of the treatment (Connolly Gibbons et al., 2012). Conveying to the patient that he/she understands the patient's motives, the therapist positions him- or herself on the side of anxiety and resistance, e.g. by saying: "If you avoid showing your mother (or X) that you are angry with her, you protect your relationship with her. That's helpful to you" (or: What's wrong with that?"). Ambivalence may also be addressed by open questions: "What's good about staying in bed all day?" or "What problem do you solve by staying in bed all day?" Doing so will lead to a discussion of benefits and costs of depression and of remaining the same or changing. The therapist may conclude: "I see that staying in bed (at home) has some benefit to you (i.e…). But there are also some costs to you (i.e…)." As neither ambivalence nor resistance will ever disappear completely, they will have to be addressed empathically again and again during the course of treatment. • If the initial ambivalence has been sufficiently worked through, treatment goals are discussed, that is the changes the patient wants to achieve. Realistic treatment goals are discussed and set that do not only refer to symptom reduction, but also to interpersonal relationships, e.g. "You told me that you would like to get rid of your depression. I can see that this is important to you. However, you also told me that there are some problems in your interpersonal relations. Maybe we can examine whether they related to your depression?" • During the course of treatment goals provide a marker for both the therapist and the patient of whether or not the patient has made some progress (Luborsky, 1984; Schlesinger, 1977). Furthermore, setting goals serves as a modulator or brake on regression (Luborsky, 1984).
3	**Educating and empowering the depressive patient** A major aim is to empower the patient to be an active participant in the treatment (Connolly Gibbons et al., 2012). The therapist is instructed to pay immediate attention to legal, medical and family crises and to provide the patient with information to avoid further life crises without detracting from the discussion of relationship conflicts. Once the current stressors are stabilized, the therapist returns to addressing the relationship patterns associated with the crisis (Connolly Gibbons et al., 2012).
4 [C]	**Supportive alliance and specific supportive interventions** • Luborsky and Crits-Christoph described several principles that foster the establishment of a supportive alliance, i.e. expressing empathy, using a conversational style, explaining the treatment process, setting treatment goals, supporting the patient in achieving the goals, monitoring the process by reference to goals, communicating a realistic hope to achieve the treatment goals, recognition that the patient has made some progress toward the goals, regularly examining the patient's motivation for treatment, encouraging a "we bond (e.g. "When you started treatment, you made your goal to reduce your depression. It seems to have decreased. You see, in fact, we are working together to achieve this."), conveying recognition of the patient's growing ability to use the tools of treatment as the therapist does, and monitoring and discussing ruptures of the bond in an accepting climate (Crits-Christoph et al., 2006; Luborsky, 1984, pp. 82–88). • In addition to the elements described within the context of establishing a supportive alliance, specific interventions may be required in some patients and/or in some therapeutic situations**,** e.g. reducing anxiety (e.g. "Your doctor has told you that you do not suffer from cancer, so let's see why you are not convinced by this."), reassuring, encouraging, advising, or modelling, The therapist may also reframe symptoms as problem-solving attempts, help the patient to maintain vital defences and activities or foster the patient's ability to reflect on their own and others' thoughts and feelings (mentalization).
5 [C]	**Identifying, interpreting and working through underlying core conflicts: wishes (affects), object relations and defences associated with depression** Consistent with the evidence-based psychodynamic treatments of depression listed in Table 1, UPP-Depression focuses on unresolved (unconscious) conflicts related to depression. By use of patient narratives, the core conflict associated with the symptoms of depression is identified. To facilitate the identification of the core conflict, a **relationship episode interview** (REP) as described by Luborsky is recommended. The following instruction may be used (Luborsky, 1990, p. 103): "Please tell me some events involving you and another person. Each one should be a specific event. Some should be old and some current incidents. For each one, please tell me (1) who the other person was, (2) what he/she did and what you did, (3) and what happened in the end. Tell me at least ten of these events." The core conflict is that pattern that occurs most often. Telling stories including relationship episodes were shown to significantly predict outcome in depressive patients (Connolly Gibbons et al., 2012). In the unified protocol, we recommend that the therapist discusses the CCRT as his/her "**depression formula**" that explains his/her symptoms of depression. For a patient with depression, the CCRT may be described, for example, in the following way (Luborsky et al., 1995, p. 26, 27): • "I want to be respected (or understood) (**W**). • However, the others do not respect (understand) me (**RO**). • I feel unloved and depressed (**RS**, symptoms of depression)." The symptoms of depression (RS) are interpreted and discussed with the patient as a problem-solution or coping attempt (Luborsky, 1984, p. 114). The therapist may say, for example: "Withdrawing from others protects you from further disappointments." The therapist may refer to the discussion of the benefits and costs of the patient's depression and anxiety during application of module 2. –It is important to note that not only Luborsky's CCRT method may be used here, but other conceptualizations of conflicts as well, e.g. the concepts by Malan or Lemma et al. (Lemma, Target and Fonagy, 2011; Malan, 1979) or the relationship axis of the Operationalized Psychodynamic Diagnostics system (OPD) (Schauenburg and Grande, 2011). As noted above, however, the concept by Luborsky has two advantages: it is empirically best supported and the associated treatment concept has been specifically adapted to the treatment of depression (Connolly Gibbons et al., 2012; Luborsky et al., 1995). Once the conflict associated with depression is identified, it serves as the focus of treatment. The therapist relates the components of the conflict to the patient's symptoms of depression. Interpreting and working through the core conflict constitutes the expressive (insight-oriented) element of the

Table 3 (*continued*)

Modules	**Content**
	UPP-Depression. This form of gaining insight has not only a cognitive, but also an emotional component – working through the core conflict includes the dynamics, that is the defences and the warded-off affects (Crits-Christoph et al., 1995a, pp. 56–57; Luborsky, 1984). The following intervention may serve as an example for an (expressive) intervention referring to interactions with some people the patient just described (Luborsky et al., 1995, p. 27): "In these interactions, you clearly felt you couldn't get the respect and understanding you needed and so you ended up feeling unloved and began to feel depressed." The therapist repeatedly works through the core conflict with a focus on current relationships (Luborsky, 1984; Menninger and Holzman, 1973). The UPP-Depression specifically emphasizes the process of **working through** including both the therapist and patient activity. Not only within **but also between sessions** (Stricker, 2006), patients are asked to work on their core conflict, that is to monitor their emotions including their bodily components and to identify the components of the core conflict that lead to depression. We have described this procedure in detail for the treatment of social anxiety disorder (Leichsenring et al., 2007). The concept by McCullough et al. (2003) used in the study by Johansson et al. (2013) puts a specific focus on experiencing the warded-off affect. Here, the UPP-Depression follows the principles outlined by McCullough et al. Having established a secure therapeutic alliance, patients are encouraged to repeatedly experience the avoided affect, first in sensu, than in real relationships (McCullough and Osborn, 2004). It is important that also the bodily components of the affect are included here (McCullough and Osborn, 2004). In the UPP-Depression the therapist is recommended to put a specific focus on **each** component of the core conflict (Leichsenring and Salzer, 2014): • Focusing on the wish component of the core conflict, that is on the warded-off affect aims at increasing the patient's tolerance of the warded-off affect or impulse, improving awareness and perception of this affect and to better integrate the avoided impulse into the patient's conscious experience (McCullough and Osborn, 2004). • Focusing on the RO component of the CCRT or the anxiety (A) component of Malan's (1979) triangle of conflicts aims to improve the patient's reality testing ability, but also to allow for corrective emotional experiences with others including the therapist: others do not necessarily respond as expected (changing transference expectations). • The self response component of the core conflict includes both maladaptive and adaptive responses from the self. Working through the self-defeating aspects of the self response (e.g. maladaptive defences such as turning against the self) lays the groundwork for developing new self responses and new behaviours (Crits-Christoph et al., 1995b). In the UPP-Depression the therapist is recommended to actively foster the development of more adaptive responses from the self. For this purpose, he or she takes a more active stance than in classical psychoanalysis . Support comes from research showing that acquiring new skills to curtail the effects of negative thoughts predict outcome in depression (Connolly et al., 2009).
6	**Cultural sensitivity component** Cultural influences may have an impact on the therapeutic work. Connolly Gibbons et al. (2012) included an explicit cultural sensitivity component in their treatment approach for depression. They emphasized four concepts that can aid therapists to specifically address the role of culture in the therapeutic process: • being aware of both one's own cultural background; • being familiar with the patient's cultural background; • acknowledging and exploring the existing cultural differences, and • distinguishing between what is normal versus impaired within the patient's ethnocultural context.
7	**Termination and relapse prevention** The patient's needs at the beginning and at the end of treatment may differ (Fava and Tomba, 2010). Whereas the patients initially seek relief from acute distress, they benefit in the residual phase by interventions to improve functioning and relapse prevention (Fava and Tomba, 2010). Termination of therapy is regarded as a particularly important step in UPP-Depression, especially with regard to relapse prevention (Luborsky, 1984; Mann, 1973). Luborsky (1984) stressed both patient and therapist activities. He formulated several principles with regard to termination: • Therapists are recommended, for example, to remind the patient when termination will take place. He or she should also mark treatment phases (arrival at a goal) so that they can serve as milestones (e.g. "It was a kind of breakthrough when you told your mother that you will not be home for Christmas."). • Furthermore, when termination is being considered, therapist and patient will review what they have done. • When symptoms recur during the termination phase, the core conflict is often activated by both the anticipated loss of the therapist and by the anticipation that the wishes inherent in the conflict will not be fulfilled. • To patients who fear to lose the gains without the continued presence of the therapist, he or she may say (Luborsky, 1984, p. 28, 155): "You believe that the gains you have made are not part of you but depend on my presence. … You seem to forget that the gains you have made are based on your own work. You used the same tools to solve your problems that I used during our sessions. And you can go on doing so after the end of treatment." Thus, the therapist stresses that the reduction of depression was based on the patient's own activities. These procedures foster incorporating the gains. As Luborsky (1984, p. 26) put it: "The patient must be able to say to himself or herself, at least by the end phase of the treatment, that what has been learned during its course will remain, even though the schedule of face-to-face psychotherapy sessions will come to an end. However, what has been learned and the impression of the helping relationship will stay alive." By internalization, the patient incorporates the therapist as a helpful person and learns to use the tools applied by the therapist independently and in the absence of the therapist. • In addition, the final three sessions are carried out as booster sessions at two-week intervals to monitor and support the patient's improvements with regard to his or her depressive disorder. If symptoms recur, the patient is informed that this does not imply relapse. The therapist relates recurrence of symptoms to the core conflict and to the loss of the therapist (Luborsky, 1984). The therapist encourages and supports the patient's own activities in working on his or her problems. He or she stresses the patient's own contribution to progress. The plan of the booster sessions should be presented at the start of the treatment so that they will be understood as a part of the planned arrangements (Luborsky et al., 1995).
Future modules	
1	**Focus on mentalization:** enable the patient to reflect on his/her interpersonal problem related to depression. The treatment approach by Lemma et al. (Dynamic Interpersonal Therapy, DIT) helps the patient to (1) understand the relationship between depression and (current) interpersonal problems (interpersonal-affective focus, IPAF) and (2) encourage the patients' ability to reflect on their own and others' thoughts and feelings (mentalization) (Lemma et al., 2010, 2011). The focus is on the here-and-now. The primary goal of DIT is not to work through unconscious conflicts, **but to enable the patient to reflect on his or her interpersonal problem** (Lemma et al., 2010). DIT follows five treatment steps, i.e. (1) identify an attachment related problem that makes the patient feel depressed; (2) create a mentalized picture of the related interpersonal issues; (3) encourage the patient to explore alternative ways of feeling and thinking; (4) ensure the change in self is reflected on; (5) present the patient with a written summary of the collaboratively created view of the person and the selected unconscious conflict to hold onto, to reduce the risk of relapse. DIT is consistent with both the empirically supported methods of PDT in depression listed in Table 1 and with the seven modules described above (Lemma et al., 2010). Specifically, the focus on mentalization, i.e. the steps 2 ("create a mentalized picture of the related interpersonal issues") and 4 ("ensure the change in self is reflected on") may contribute to enhancing the treatment of depression in general and the unified psychodynamic protocol for depression in particular. For DIT first evidence from an open trial is available (Lemma et al, 2011). Results are promising. Further evidence from an ongoing RCT is awaited.

Table 3 (*continued*)

Modules	**Content**
2	**Focusing on risk of non-response by giving feedback on patient progress** The data on rates of response and remission reported above suggest placing a specific focus on patients at risk of non-response. There is evidence that giving feedback on patient progress and offering problem-solving tools improve the outcome of patients at risk of treatment failure (Lambert et al., 2002; Shimokawa et al., 2010). For this reason, we tentatively propose a further module for patients at risk of non-response that (a) systematically addresses obstacles to response and (b) makes use of feedback on patient progress. In order to assess whether a patient is "on- track" (Lambert et al., 2002, p. 95), patient progress is systematically assessed by use of observer-rated or self-report measures of depression (e.g. Hamilton Rating Scale for Depression, or the Beck Depression Inventory, BDI II)[a]. These data serve as a feedback to both the patient and the therapist. For assessing and giving feedback, we propose to follow the procedures outlined by Lambert et al. (2002). In patients found to be at risk of non-responding or worsening, we propose to specifically focus on the obstacles to response. From a psychodynamic perspective, this procedure is conceptualized as a specific form of working through including analysis of resistance. We have already developed such a module for the treatment of patients with social anxiety disorder at risk of non-response (Leichsenring et al., in press). The procedures can be summarized as follows: it is helpful to identify possible risks for non-response as early as possible. The first opportunity to do so is given in the socialization interview (module 1). If, for example, there is a strong ambivalence towards the treatment, it needs to be addressed in the way described in module 2. If the patient does not benefit sufficiently during the treatment, both the therapist and the patient need to take this seriously. Addressing non-response is giving priority. The focus is immediately put on the obstacles to response. These may be, for example, (1) a strong ambivalence towards the treatment, (2) psychosocial conditions preventing the patient from benefiting, e.g. specific interpersonal relationships, (3) the conflict associated with depression has not yet been precisely enough assessed. If so, it needs to be reformulated, (4) the relationship between the core conflict and the symptoms has not yet been sufficiently worked through, (5) the patient does not transfer the gains made during sessions to everyday situations, (6) a lack of psychosocial skills (e.g. expressing his or her anger or making contact), and (7) a strong secondary gain. In addition the therapist should question whether or not something important has been missed. The therapist clarifies these issues. These procedures may also be applied if patient progress is not formally assessed according to the procedures by Lambert et al. (2002) In this case risk of non-response is indicated, for example, by the patient not achieving predefined goals. It is of note, however, that at present evidence for this approach specifically in depression does not yet exist, neither for psychotherapy in general nor for psychodynamic therapy in particular.
3	**Focus on treatment-resistant depression and comorbid personality disorders** There is first evidence from an open study on Intensive Short-term Dynamic Psychotherapy (ISTDP) for the treatment of treatment-resistant depression (Abbass, 2006). All patients were diagnosed with treatment-resistant depression, comorbid personality disorder and histories of childhood abuse (Abbass, 2006). ISTDP is based on Davanloo´s model (Davanloo, 1990) and focuses specifically on resistance in the traditional psychodynamic sense of the word (Solbakken and Abbass, 2014). Among the contra-indications of his method, Davanloo (1990) listed psychotic decompensations, severe borderline personality disorders, substance dependence, severe psychopathic tendencies, and life-threatening psychosomatic conditions (e.g. colitis ulcerosa). Thus, the focus seems to be on patients with higher levels of personality organization. Abbass (2006), however, included patients with borderline personality disorder. We propose to test this approach for the treatment of depression in a RCT. Another approach to treat treatment-resistant/treatment refractory depression was presented by Taylor (2010). It is presently being tested in a RCT (Tavistock Adult Depression Study, TADS, Taylor et al., 2012). The approach by Taylor is permissive rather than prescriptive allowing the experienced psychoanalytic therapist to apply his or her usual way of working with the patient. The treatment is a medium-term treatment encompassing up to 60 sessions within 18 months (Taylor et al., 2012). Evidence for this approach is being awaited. From the presently available description of the treatment (Taylor, 2010), it is not clear whether specific treatment modules can be identified. In another ongoing RCT, this approach is presently being applied to the treatment of chronic depression (Beutel et al., 2012). Treatment duration was extended to up to 240–300 sessions. After the first year of treatment, psychoanalytic therapy will be carried out in a naturalistic manner.
4	**Maintenance treatment** Maintenance psychotherapy may reduce relapse in prior treatment responders by 21–29% (Vittengl et al., 2007). However, these results refer to CBT and interpersonal therapy. For PDT, no data on maintenance treatment are presently available. RCTs on generalized anxiety disorder, social phobia and depression have used booster sessions in the termination phase of treatment, but their effect on outcome was not evaluated separately (Connolly Gibbons et al., 2012; Leichsenring et al., 2009, 2013). Thus, further RCTs on STPP maintenance treatment are required. In the case that further evidence is provided by future research, STPP maintenance treatment may be a further treatment option to improve the long-term outcome of STPP. The therapist works in a similar way as in the termination phase and in the booster sessions as described above (module 7) stressing and supporting the patient's ability to maintain the gains.
5	**Treatment options for non-responders** For patients who have not sufficiently benefited at the end of treatment several options are available, e.g. continuing the treatment (Vos et al., 2004) with a specific emphasis on obstacles to response as recently shown for social phobia (Leichsenring et al., in press), switching to another treatment, including pharmacotherapy or combining psychodynamic therapy with pharmacotherapy using a sequential approach (Burnand et al., 2002; de Jonghe et al., 2001, 2004; Forand et al., 2013; Rush et al., 2006). If all treatment options have been exhausted, the therapist may put the focus on supporting the patient in accepting the residual symptoms and impairments.

Note: [C]: Core principle.

[a] Following Lambert et al. (2002) patient status may be compared with the score for reliable change or clinically significant improvement. A reliable improvement, for example on the BDI II (Beck et al., 1996) is indicated by a reduction in BDI ≥ 8 ("on track", "green feedback" analogous to Lambert), risk of non-response by a reduction < 8 ("yellow feedback"), reliable worsening by an increase in BDI ≥ 8 ("red feedback": risk of negative outcome or dropping-out). Clinically significant improvement is indicated by BDI ≤ 13 ("white feedback": ´consider termination´). In case of yellow or red feedback, the therapist turns to the non-responder module described above. In case of reliable or clinically significant improvement (green or white feedback), treatment may be terminated.

(Horvath et al., 2011). Luborsky described several principles that foster the establishment of the helping alliance (Table 3). Crits-Christoph et al. (2006) presented several additional helpful techniques to this effect, e.g. regularly examining the patients motivation for and involvement in the psychotherapeutic process, monitoring and discussing ruptures of the therapeutic bond in an accepting climate, and the use of a conversational style. Therapists can be trained in these techniques (Crits-Christoph et al., 2006; Connolly Gibbons et al., 2012). As many patients with depressive disorders suffer from insecure attachment representations (Bifulco et al., 2002a), a secure supportive alliance also may provide a corrective emotional experience.

The supportive–expressive continuum of psychodynamic interventions allows for additional supportive interventions in the case of more severe psychopathology or acute crisis (Luborsky, 1984). For patients with more severe depression, supportive

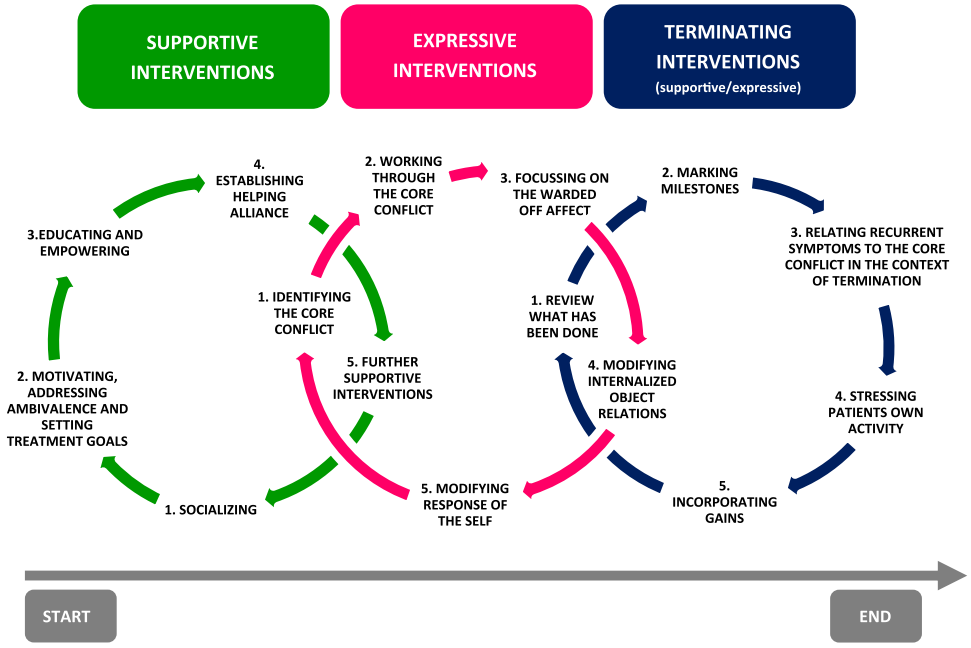

Fig. 2. The modules and processes of UPP-Depression illustrated as therapeutic cycles.

interventions may be required, like reassuring or encouraging (de Jonghe, 1994; Driessen et al., 2013). Further examples for interventions are given in Table 3. Depending on the patient's capacities and needs, the therapist oscillates between supportive and expressive interventions that are between working on structural deficits (e.g. in regulation of self-esteem, see e.g. Blanck and Blanck (1974), Kohut (1971) or Leichsenring et al. (2010) and on unconscious conflicts (see e.g. McCullough Vaillant (1997, p. 44–45) (see module 5)).

3.4.5. *Module 5: expressive interventions: identifying and working through the core conflict underlying depression: wishes, object relations and defences [C]*

The evidence-based psychodynamic treatments of depression listed in Table 1 assume that depression is related to unresolved conflicts (and/or deficits in ego-functions, Table 1). Luborsky operationalized the concept of conflict by the Core Conflictual Relationship Theme (CCRT) method (Freud, 1926; Luborsky, 1984). A CCRT consists of three components: a wish (W), a response from the others (RO) and a response of the self (RS). The RS component is complex, encompassing both defence mechanisms and the patient's symptoms (Luborsky, 1984). Including the patient's wishes and anticipated responses from the object, the CCRT also represents the patient's transference potential (Luborsky, 1984). The concept of the CCRT is among the best studied concepts of psychodynamic therapy (Leichsenring and Leibing, 2007). Another model to conceptualize the relationship between impulses, anxiety and defences is the "triangle of conflict" developed by Malan (1979). It is compatible with Luborsky's CCRT approach (Leichsenring and Salzer, 2014). This is also true for the concept of the interpersonal-affective focus (IPAF) recently presented by Lemma et al. (2011) and for the relationship axis of the Operationalized Psychodynamic Diagnostics system (OPD, Schauenburg and Grande, 2011). As these concepts are compatible with each other, clinicians may choose the concept they are most familiar with. The concept by Luborsky has the advantage that the associated treatment concept has been specifically adapted to the treatment of depression (Connolly Gibbons et al., 2012; Luborsky et al., 1995).

Consistent with empirical data (Vanheule et al., 2006) we do not assume that there is just one core conflict specific to all patients with depression (Crits-Christoph et al., 1995a; Leichsenring et al., 2007). The following core conflict, however, was identified as most representative for depression: a strong wish to feel close to others, the perception of rejection and possible dislike, and feelings of helplessness and disappointment (Vanheule et al., 2006).

Once the conflict associated with depression is identified, it serves as the focus of treatment. The therapist relates the components of the conflict to the patient's affective experience and to the symptoms of depression (Table 3). Interpreting and working through the (often unconscious) core conflict constitute the insight-oriented component of the UPP-Depression. There is evidence that modifications in the core conflict (especially the "response of the self" component) are significantly associated with treatment outcome (Crits-Christoph and Luborsky, 1990). Furthermore, expressive techniques addressing the core conflicts were shown to significantly predict outcome, both in mental disorders in general and in depression in particular (Barber et al., 1996; Connolly Gibbons et al., 2012; Crits-Christoph et al., 1988).

3.4.6. *Module 6: cultural sensitivity component*

Cultural influences may have an impact on the therapeutic work. Connolly Gibbons et al. (2012) included an explicit cultural sensitivity component in their treatment approach for depression. They emphasized four concepts that can aid therapists to specifically address the role of culture in the therapeutic process (Table 3).

3.4.7. *Module 7: termination and relapse prevention*

Termination of therapy is regarded as a particularly important step in STPP (Luborsky, 1984; Mann, 1973). Luborsky in this regard put emphasis on both patient and therapist activities. He formulated several principles pertaining to termination (Luborsky, 1984, pp. 142–158) These principles were used in an RCT by Connolly Gibbons et al. (2012). For the UPP-Depression we follow the recommendations by Luborsky et al. (1995) and Connolly Gibbons et al. (2012). Examples for interventions are given in

Table 3. In addition, we recommend carrying out the final sessions as booster sessions e.g. at two-week intervals. In these last sessions, a specific focus is put on the maintenance of gains (Table 3; Crits-Christoph et al., 1995a; Luborsky et al., 1995; Leichsenring et al., 2009, 2013).

3.5. Future modules

The efficacy of UPP-Depression may be enhanced by including further modules, provided that they are consistent with the procedures of the UPP-Depression and that they will be supported by evidence from RCTs. Some promising candidates are listed in Table 3: (1) focusing on mentalization (Lemma et al., 2010), (2) focusing on patients at risk for non-response by giving feedback on patient progress (Lambert et al., 2002; Leichsenring et al., in press; Shimokawa et al., 2010). Other issues are (3) treatment resistant depression (Abbass, 2006; Solbakken and Abbass, 2014; Taylor et al., 2012), (4) maintenance treatment, and (5) treatment options for non-responders.

4. Discussion

In this article we have reviewed the empirically supported methods of PDT in depression and extracted their successful treatment components. We suggest the integration of these components within a unified protocol for the psychodynamic treatment of depressive disorders. The UPP-Depression as proposed here includes seven interrelated modules that can be flexibly applied. It is open to the addition of further evidence-based psychodynamic methods, for example the treatment protocol by Lemma et al. (2011), if efficacy is proven by a RCT. These components are supposed to constitute the specific factors of the UPP-Depression adding to the "common factors" active in all kinds of psychotherapy.

Deriving the UPP-Depression from the available RCTs on major depressive disorders has several implications and possible limitations that should be noted: UPP is a short-term psychodynamic treatment for patients with major depressive disorder. From a psychodynamic perspective, however, patients with a major depression may vary considerably with regard to necessary treatment length according e.g. to the severity of the disorder and the level of personality organization. The presence of a comorbid personality disorder was found to be associated with a doubling risk for poor outcome in depression compared with no personality disorder (Newton-Howes et al., 2006). Concerning the evidence of PDT in depression combined with personality disorder a meta-analysis reported short-term psychodynamic therapy to be efficacious in major depression with personality disorder (Abbass et al., 2011). In some of the studies included, however, the primary diagnosis and the focus of treatment were on personality disorder and not on depression (e.g. Svartberg et al., 2004; Vinnars et al., 2005). Thus, by treating the personality disorder, apparently improvements in comorbid depression were achieved. This is consistent with results on the treatment of severe personality disorders: in the context of severe personality disorders such as borderline personality disorder, evidence suggests to first treat the borderline personality disorder, since improvement in borderline personality disorder often leads to subsequent resolution of major depressive disorder (Gunderson et al., 2004). In contrast, improvements in major depressive disorder were found to be not predictive of improvements in borderline personality disorder (Gunderson et al., 2004).

Taking the research on depression and personality disorder into account, it is of interest to see to what extent patients with comorbid personality disorders were included in the studies on which this review is based. Personality disorders were generally excluded only by Salminen et al. (2008). In the study by Knekt et al. (2008) only Cluster A personality disorders and patients with low level borderline personality organization were excluded. Maina et al. (2005) excluded Cluster A, borderline and antisocial personality disorders. On the other hand, only Hardy et al. (1995) and Knekt et al. (2008) reported data on the presence of personality disorders (24% and 18%, respectively). Thus, although not explicitly excluded by the other studies, it is not clear to what degree patients with personality disorders were represented in the other studies included here. This is of some importance since patients with major depression and a comorbid personality disorder may need modifications of the treatment. Interestingly, Hardy et al. (1995) did not find an effect of treatment duration (8 vs. 16 sessions) on therapy outcome of (Cluster C) personality disorder patients. However, this refers to Cluster C personality disorders and may be different for more severe (Clusters A and B) personality disorders.

As mentioned above, in some studies of short-term psychodynamic psychotherapy, transference interpretations were negatively associated with outcome in more severely disturbed patients (Piper et al., 1991; Ogrodniczuk et al., 1999). However, in a study of long-term psychodynamic psychotherapy transference interpretations were positively associated with outcome in patients with a weak therapeutic alliance and a low quality of object relations (Høglend et al., 2006, 2008, 2011). In patients with more mature object relations and a good alliance, a negative effect of transference interpretations was found. In this analysis furthermore women benefited significantly more from transference interpretations than men (Ulberg et al., 2012). It is of importance that these data come from studies in diagnostically heterogeneous patient samples and therefore are not specific to patients with depression. Thus, further systematic research is required to see if and how treatments for patients with depression need to be modified if comorbid personality disorders are present. These modifications may also depend on the type and severity of the personality disorder. Treating a major depressive disorder within the context of a borderline personality disorder requires more and other modifications compared with treating depression if a comorbid avoidant personality disorder is present. In the first case, more supportive interventions e.g. for maintaining or building ego-functions may be required (e.g. Wallerstein, 1989), in the latter case more confronting interventions may be needed (Abbass et al., 2008). This is consistent with the concept of a supportive–expressive continuum of interventions we used for UPP-Depression.

As PDT traditionally focuses on core underlying processes of disorders and tends to have a modular (and transdiagnostic) format, acceptability of UPP-Depression among psychodynamic psychotherapists in clinical practice may be high.

The UPP-Depression addresses priorities put forward by the NIMH, such as innovative methods, translational research, impact on public health, and facilitating dissemination of cost effective treatments (Insel, 2009).

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