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Efficacy and suitability of adding short-term psychodynamic psychotherapy (STPP) to pharmacotherapy in patients with depressive disorders: a systematic review

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Efficacy and suitability of adding short-term psychodynamic psychotherapy (STPP) to pharmacotherapy in patients with depressive disorders: a systematic review

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Abstract

Introduction: Recent guidelines on depressive disorders suggest a combination of antidepressants and psychotherapy in case of moderate to severe symptomatology. While cognitive behavioral therapy and interpersonal therapy are the most investigated interventions, psychodynamic psychotherapies have been less explored.

Objective: The aim of this paper is to systematically review literature data on the efficacy of shortterm psychodynamic psychotherapy (STPP) in combination with antidepressants in the treatment of depressive disorders, focusing both on short and on long-term results and on potential moderators that could influence its effectiveness.

Methods: The systematic review was conducted using the PRISMA guidelines. Databases searched were PubMed, Ovid, Scopus, and Cochrane Library, from inception to August 2023.

Results: Adding STPP to medications in the first six months of treatment didn't influence remission rates, but improved acceptability, work adjustment, interpersonal relationships, social role functioning, hospitalization rates and cost-effectiveness. After 12 months, a significant difference in remission rates arised, favouring combined therapy. In a long-term perspective, adding STPP to pharmacotherapy reduced the recurrence rate by almost 50%. STPP has proven to be more effective in longer depressive episodes, in more severe depressions and in patients with a childhood abuse history. Instead, STPP had no impact on major depressive disorder with comorbid Obsessive-Compulsive Disorder (OCD).
Conclusions: Combining STPP with antidepressants appeared to be helpful both in a short-term and in a long-term perspective. Still, there are few rigorous studies with large samples and further research is needed to identify which subgroups of patients may benefit more from STPP.
Keywords: psychotherapy, short-term psychodynamic psychotherapy, pharmacotherapy, antidepressants, depressive disorders.

Introduction

With the term Short-term psychodynamic psychotherapy (STPP) we refer to a variety of psychotherapeutic techniques which are rooted in psychoanalysis, relying on the principles of psychoanalytic theory [1]. These techniques developed over time more current and specific methodological approaches, embodying the need to evolve from traditional models [2]. Ferenczi and Rank firstly postulated the need to reduce the number of sessions and the overall duration of psychotherapies in 1924, challenging the relevance of the elaboration of infantile neurosis and the consequent development of personality as fundamental issues for therapeutic change [3]. Then, in 1946 Alexander and French questioned the belief that short-term therapies could not lead to lasting transformation, emphasizing that recovery takes place outside the therapy session rather than during them [4]. In the second half of the 20th century, Luborsky had an important role in the overcoming of traditional psychoanalysis, focusing on the relevance of taking awareness of recurring intrapsychic and interpersonal conflicts, rather than more typical psychoanalytic issues [5].

This problem-centered approach showed to be highly suitable in a setting with limited resources such as the public health care system. In this regard, beyond the

ideological and technical motivations that brought to the setting up of different techniques, the need of adjust psychotherapy for public assistance and hospitals was a pivotal issue during those years [6,7]. Applicability to the system became vital, cost containment was mandatory and lack of valuable studies documenting efficacy, appropriateness, safety and cost-effectiveness of therapies had to be overcome [8]. Indeed, STPP is already provided in several both European and American countries, such as Netherlands, Germany, Italy, Sweden, UK, USA, and Mexico [9]. In the last decades psychotherapy has been target of systematic research. Several studies evaluated the efficacy of STPP in treating psychiatric conditions including depressive disorders [10-16]. Notably, when the first studies showed high rates of resistance and relapse in depressed patients treated with medications only, the need for more suitable interventions emerged. This necessity was also enhanced by the reinterpretation of depression not as a single entity, but as a spectrum of disorders, whose clinical presentation is influenced by multiple variables such as emotional, cognitive, psychomotor, somatic and personality aspects [17]. The STPP approach aims to substantially modify the substrate of depressive disorder. This is achieved by reducing symptom severity through the expression of suppressed negative feelings, weakening feelings of guilt and inappropriateness, reinforcing self-esteem, and increasing awareness of the patient's relationships. [18].

In the nineties, some open-label uncontrolled studies underlined the capability of STPP to improve depressive symptoms in patients with depressive disorders [10,11,19,20,21,22]. In 2003, Hilsenroth and colleagues confirmed and extended these findings with a more rigorous study, where 21 subjects with major depressive disorder (MDD) underwent a 30-meeting cycle of STPP: a significant improvement in depressive symptoms and interpersonal, social and occupational functioning, measured on both semistructured clinical interviews and self-administered questionnaires, was detected in 80% of those who completed the study [23]. In the same years a meta-analysis on 416 patients highlighted an effective response at post-treatment in 45-70% of the patients with MDD treated with STPP, with a stable improvement during follow-up in 26-83% of them [24].

More recently, a few studies have been performed in order to examine whether STPP in monotherapy was as effective as pharmacotherapy for depressed patients. In 2008 STPP was compared with fluoxetine in 55 individuals with mild or moderate

depression by Salminen and colleagues: these two treatments appeared to be comparable in terms of effectiveness [25]. This finding was later confirmed by two other studies that took into account several antidepressants [26,27]. A naturalistic 5-year follow-up research found that depressed patients treated with brief psychodynamic psychotherapy only had significantly lower recurrence rates than those treated with medications (28,3% versus 53,2%) [28].

In a recent review our research group focused on the efficacy of STPP in monotherapy in major depression, highlighting that the effectiveness of STPP is more apparent at long-term follow-up rather than in the immediate post-treatment period [29].

Comparing STPP to other psychotherapeutic interventions, our research group underlined that STPP in monotherapy appeared to be more effective than brief supportive psychotherapy (BSP) in patients with moderate depression at 6 months of follow-up, while no significant differences between STPP and BSP on all efficacy measures emerged in patients with mild depression [30]. These results suggest that nonspecific interventions may be adequate to give improvement in patients with less severe symptoms, but that specific techniques may be essential for those with more severe depressions. Cognitive behavioral therapy (CBT) and interpersonal therapy (ITP) are the most investigated interventions, being the first recommendations for depressive disorders in the most recent guidelines [31,32,33,34] while psychodynamic psychotherapies have been less explored. Nevertheless, available data don't show significant differences between CBT and STPP in terms of efficacy on depressive symptoms, anxiety, pain and quality of life [35], confirming the results earlier obtained by Leichsenring [24]. Recently a meta-analysis on the efficacy of STPP in depressive disorders (both alone and in combination with antidepressants) was performed: STPP appeared to be more effective than support psychotherapy but slightly less effective than CBT [36].

Currently guidelines on depressive disorders treatment recommend psychotherapy in monotherapy as a first line in case of mild to moderate depressive symptoms, while a combination of antidepressants and psychotherapy is suggested in case of moderate to severe symptomatology [31,34]. However, a valid integration of psychotherapy and medications still represents a significant challenge in the treatment of mental illness.

The purpose of the present paper is to systematically review the current knowledge on the efficacy of STPP in combination with antidepressants in the treatment of depressive disorders. We specifically identified two key areas that can result into a more accurate assessment of outcomes, as well as into a more effective use of STPP in addition to pharmacotherapy in depressive disorders:

1) Effectiveness (short-term and long-term results)

STPP showed different effectiveness in depressive disorders depending on the moment when it was sought. We therefore differentiated between short-term and long-term results, focusing not only on remission rates but also on other pivotal outcomes such as treatment adherence, cost-effectiveness, occupational functioning, quality of life, hospitalization and recurrence rates.

2) Moderators of effectiveness

STPP may be more effective in a specific type of patient. Currently, only few studies have examined which patients could benefit specifically from STPP for depression [9,37]. So, the question to be raised is whether it could be possible to identify smaller subgroups of patients that might benefit more from STPP than other treatments, focusing on socio-demographic characteristics, clinical features and psychiatric comorbidities (so-called moderators).

Methods

The systematic review was conducted using the PRISMA guidelines [38,39].

The studies were retained if they met the following criteria: (a) participants diagnosed with unipolar depressive spectrum disorders; (b) participants treated with STPP and pharmacotherapy; (c) outcome clearly defined in terms of STPP efficacy.

The evaluation has been conducted by searching in different databases (PubMed, Ovid, Scopus, and Cochrane Library) from inception to August 2023. The search terms “short-term dynamic psychotherapy” and “STPP” were combined, using the boolean AND, with “depressive spectrum disorders”, “unipolar depression”, “major depressive disorder” and “MDD”. Moreover, a manual search for possible eligible articles from papers previously selected or from other reviews/metanalysis on this topic was conducted. We limited our research to English-language reports.

A three steps evaluation's process has been conducted by three Authors (GDS, CP and VR): title, abstract and full text. The studies included were independently chosen by each Author, according to inclusion criteria and clinical significance. The senior Reviewers (GM and GR) have been consulted in case of disagreement between Authors.

Results

A flowchart of studies selected and included in this systematic review is provided in Fig. 1.

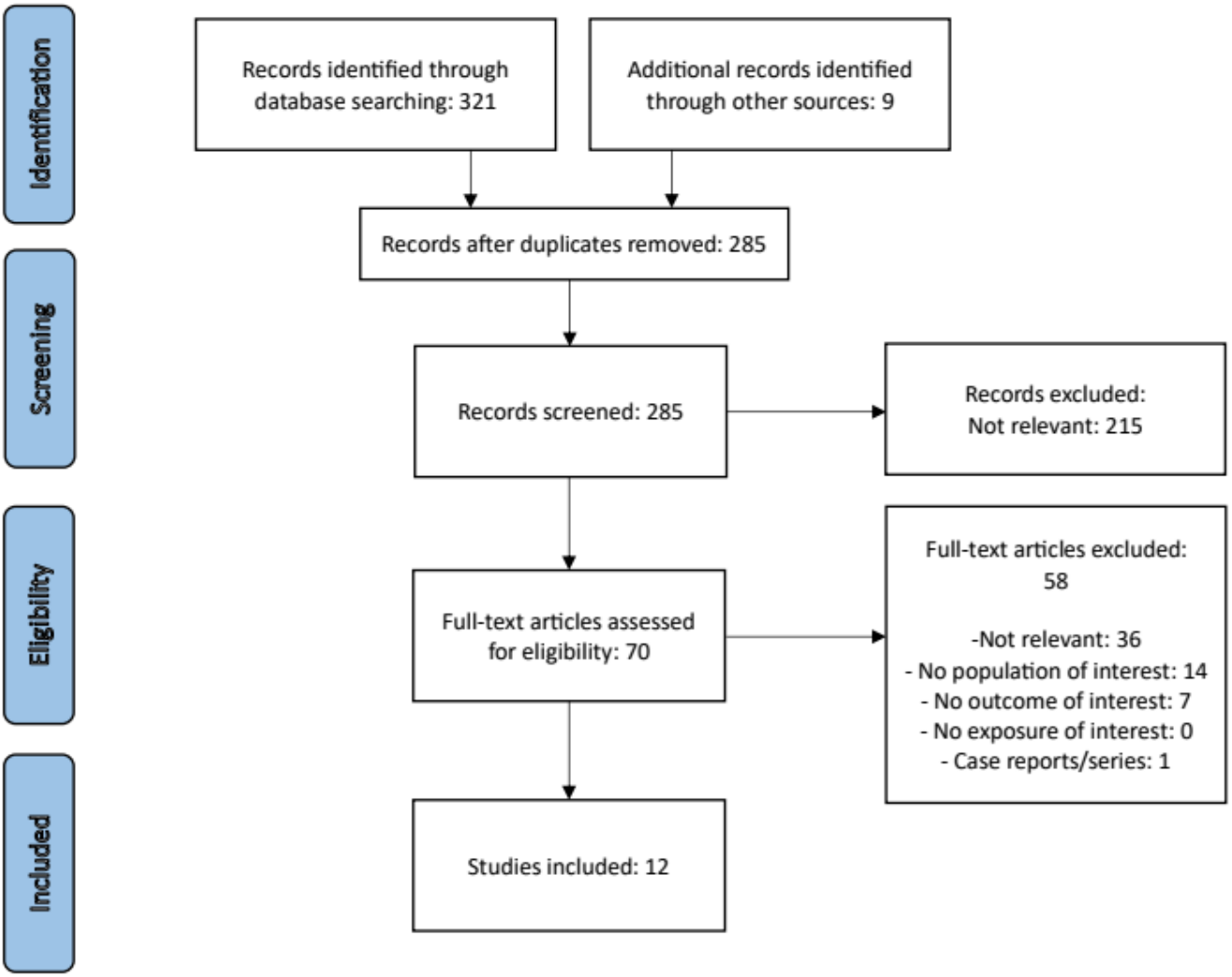

Fig. 1: Flow diagram of the review.

A total of 285 records were identified after excluding duplicates. Seventy articles met the eligibility criteria, with 58 of them being excluded due to irrelevance, being case reports, or lacking the relevant population/outcome of interest. Ultimately, 12 papers were included; the main data of the included studies are summarized in Tables 1 and 2.

Table **1**. Randomized controlled trials included

Title	Authors	Sample (N)	Diagnosis	Trial design	Aim
Brief dynamic therapy combined with pharmacotherapy in the treatment of major depressive disorder: long-term results	Maina et al. 2009 [40]	92	MDD, single episode	6-month acute phase (STPP+AD vs. AD) 6-month continuation phase (AD) 48-month naturalistic follow up	To evaluate recurrence rates in MDD patients responsive to acute phase combined treatment with STPP plus pharmacotherapy in comparison with patients initially treated with pharmacotherapy alone
Combined Brief Dynamic Therapy and Pharmacotherapy in the Treatment of Major Depressive Disorder: A Pilot Study	Maina et al. 2007 [41]	35	MDD	6-month acute phase (STPP+AD vs. brief supportive psychotherapy+AD) 6-month continuation phase (AD)	To compare the efficacy in MDD of STPP added to medication with that of brief supportive psychotherapy added to medication
Combining psychotherapy and antidepressants in the treatment of depression	de Jonghe et al. 2001 [43]	167	MDD	6 months (STPP+AD vs. AD)	To compare the efficacy of antidepressants with that of antidepressants plus STPP in MDD
Psychodynamic psychotherapy and clomipramine in the treatment of major depression	Burnand et al. 2002 [44]	74	MDD, also treatment- resistant	2,5 months (STPP+AD vs. brief supportive psychotherapy+AD)	To compare a combination of clomipramine and STPP with clomipramine alone in MDD

Evaluation of an Outpatient Intervention for Women With Severe Depression and a History of Childhood Trauma	Vitriol et al. 2009 [45]	87 women	MDD, severe episode, with childhood trauma	3 months (STPP+AD vs. brief supportive psychotherapy+AD)	To assess the effectiveness of a structured intervention developed for women with severe depression and childhood trauma by comparing it to standard treatment
Differential efficacy of cognitive behavioral therapy and psychodynamic therapy for major depression: a study of prescriptive factors.	Driessen et al. 2016 [46]	233	MDD	5,5 months (STPP/CBT both alone both with AD)	To identify patient characteristics that might moderate differential treatment effects between STPP+antidepressants vs. CBT+antidepressants
No effect of adding brief dynamic therapy to pharmacotherapy in the treatment of obsessive compulsive disorder with concurrent major depression.	Maina et al. 2010 [47]	57	OCD with concurrent MDD (also treatment-resistant)	4-month acute phase (STPP+AD vs. AD) 8-month continuation phase (AD)	To explore the efficacy of STPP combined with pharmacotherapy in comparison with pharmacotherapy alone in the treatment of OCD with concurrent MDD
Brief dynamic therapy combined with pharmacotherapy in the treatment of panic disorder with concurrent depressive symptoms.	Martini et al. 2011 [49]	39	Panic Disorder with concurrent depressive symptoms	4-month acute phase (STPP+AD vs. brief supportive psychotherapy+AD) 8-month continuation phase (AD)	To compare the efficacy of STPP and brief supportive therapy in the combined treatment of panic disorder with concurrent depressive symptoms

MDD: major depressive disorder STPP: short-term psychodynamic psychotherapy CBT: cognitive-behavioral therapy AD: antidepressants

Table 2. Systematic review and meta analysis included

Title	Authors	Studies included (N)	Diagnosis	Topic	Aim
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	Driessen et al. 2020 [42]	7 studies (482 patients)	MDD or another unipolar mood disorder	STPP plus AD	To examine the efficacy of adding STPP to antidepressants in the treatment of depression
Which patients benefit from adding short-term psychodynamic psychotherapy to antidepressants in the treatment of depression? A systematic review and meta-analysis of individual participant data	Driessen et al. 2022 [37]	7 studies (482 patients)	MDD or another unipolar mood disorder	STPP plus AD	To examine efficacy moderators of combined treatment (STPP + antidepressants) vs antidepressants for adults with depression
Psychological therapies for treatment-resistant depression in adults	Ijaz et al. 2018 [48]	6 studies	Treatment-resistant depression	Different type of psychotherapies plus AD	To assess the effectiveness of adding psychotherapies to AD for adults with treatment resistant depression
Efficacy of short-term psychodynamic psychotherapy (STPP) in depressive disorders: A	Caselli et al. 2023 [36]	31 studies	MDD or another unipolar mood disorder	STPP, both alone both with AD	To evaluate the efficacy of STPP in depression by comparing STPP with

systematic review and meta-analysis.	different types of interventions.

MDD: major depressive disorder STPP: short-term psychodynamic psychotherapy AD: antidepressants

All studies have considered the addition of STPP to antidepressants in patients with depressive disorders *ab initio*; no study in the literature has analyzed the potential efficacy of sequential combination strategies.

Effectiveness

Short-term results

In a short-term perspective, the literature indicates that there is no significant difference in remission rates after six months of treatment between depressed patients treated with antidepressants alone and those who received a combination of antidepressants and STPP. In a study conducted by Maina and colleagues with 92 patients with MDD, 64.1% achieved remission with combined treatment, while 61.4% achieved remission with medication monotherapy [40].

Our research group provided another interesting finding: after six months of combined treatment, during the continuation phase (when only medication is provided), a substantial number of patients who had been treated with STPP achieved remission or showed a further clinical improvement, while some patients treated just with antidepressants lost their positive results. In a randomized clinical trial (RCT) STPP was compared to Brief Supportive Psychotherapy (both combined with antidepressants) in 35 patients with MDD: after six month of continuation phase (so after 1 year from the beginning of the treatment), not only a significant reduction in symptomatology emerged on the Hamilton Depression Rating Scale (HAMD) and on the Clinical Global Impression (CGI) total scores (favouring combined therapy), but also statistically significant intergroup differences in terms of remission rates appeared [41].

This evidence was recently confirmed by a large meta-analysis ran by Driessen and her group: a 1,5 HAMD point difference, with no significant effect size, was highlighted at post-treatment between the patients treated with combined therapy and the ones treated with medication only. This point difference in HAMD increased up to 2,9 (with a significant effect size) after other 6 months/1 year of follow-up [42].

Aside from remission rates and depressive symptoms improvement, there are other pivotal outcomes to be considered at this stage.

In this regard, De Jonghe and colleagues, in their RCT on 167 patients with MDD, showed combined therapy as more acceptable than pharmacotherapy alone (13%

vs. 32% of patients - respectively – refused the treatment) and a significant difference in pharmacotherapy dropout rates between the two groups: 40% versus 22% in favor of combined therapy [43].

In the same period cost-effectiveness of adding STPP to medication in depressed patients was evaluated through an RCT on 74 patients with MDD treated with clomipramine alone or with clomipramine plus STPP. Different outcomes such as treatment effect, work effectiveness, hospitalization rates and costs, both at ten weeks of treatment and at discharge were analyzed. While no treatment effect was found at ten weeks (in accordance with the results by Maina and Driessen), adjustment to work, measured with the subscale of the modified HSRS (Health-Sickness Rating Scale) was found to be significantly better at 10 weeks of treatment in combined group. Moreover, assignment to combined treatment was associated with less working days lost (34.5±23 days compared with 56.2±34.6 days) and with a lower rate and fewer days of hospitalization. It was also associated with an overall savings—including direct and indirect costs—of $2,311 for patient ($3,394 among those who had stable employment when they entered the study) [44].

Referring to the quality of life, Vitriol and colleagues examined the effectiveness of a three-month structured outpatient intervention developed for 87 women with severe depression and childhood trauma. Better interpersonal relationships and social role functioning (measured with Lambert's Outcome Questionnaire - OQ-45.2) after six months emerged in the 44 patients treated with antidepressants plus STPP, compared with the 43 treated with antidepressants only [45].

Long-term results

To date, only one trial assessed the efficacy of adding STPP to pharmacotherapy in long-term. Maina and colleagues evaluated recurrence rates in 92 unipolar major depressed patients who were responsive to acute phase combined treatment (STPP plus pharmacotherapy), in comparison with patients initially treated with pharmacotherapy alone. The naturalistic study included a 4-year follow-up (without any treatment) and showed that patients who received combined treatment had a significantly lower rate of recurrences of depressive episodes at the end of the follow-up period (27,5% versus 46.9%) [40].

Moderators of effectiveness

Socio-demographic characteristics

Driessen and colleagues have recently run a meta-analysis specifically focused on features that may influence the response to adding STPP to antidepressants in 482 subjects with depressive disorders. They showed a better efficacy at post-treatment in participants with ⩽8 rather than 13–15 education years, but this interaction appeared not to be longer statistically significant when considering low risk of bias studies only [37].

We couldn't find other evidence about how socio-demographic characteristics may influence the response to STPP in depressive disorders.

Clinical features

Concerning the clinical features that could influence the effectiveness of adding STPP to antidepressants in depressive disorders, we found some evidence about characteristics such as severity, anxiety levels and duration of the current depressive episode. We also addressed whether adding STPP to antidepressants could be an option for treatment-resistant depression (TRD).

In a recent already-mentioned meta-analysis of individual participant data of 482 depressed patients, the effectiveness of adding STPP to medications appeared to be larger in patients with higher HAMD scores than in those with lower symptoms severity, both at post-treatment and follow-up. These results confirmed severity as a moderator of STPP effectiveness [37].

Focusing on other clinical moderators associated with differential efficacy of STPP and CBT in MDD, in a RCT on 233 adults with major depressive episode STPP proved to be more efficacious than CBT among patients with low anxiety levels. However, this resulted only in moderately depressed patients treated with psychotherapy only; the authors assumed this evidence could be explained by the fact that patients with less anxiety may be better able to enter into the insight-oriented dialog of STPP [46]. Nevertheless, a meta-analysis run by the same group highlighted different results in patients treated with both STPP and antidepressants: at follow-up, the effectiveness of combined therapy was greater in those with higher baseline anxiety symptom levels, even if this difference was no longer statistically significant when modeling all significant moderators simultaneously [37].

The abovementioned study by Driessen in 2016 brought attention to another moderator: the duration of the current depressive episode, which is linked to the varying effectiveness of STPP in high-severity patients receiving both psychotherapy and medications. CBT appeared to be more efficacious than STPP for patients with a duration < 1 year, while STPP was more efficacious than CBT in those with a duration ≥ 1 year. The research team hypothesized that the observed difference might be attributed to the stronger impact of personality structure on symptoms in patients with longer depressive episodes. This could lead to the development of more intricate working alliances and transference feelings, which can be effectively utilized in STPP rather than in CBT [46]. This evidence was later confirmed in a meta-analysis: a greater efficacy at post-treatment for patients with a depressive episode duration of >2 years rather than both <1 and 1-2 years appeared [37].

Only two studies assessing the efficacy of STPP in depression included patients with (TRD) in the sample [44,47]. So, the question to be raised is whether the efficacy of STPP is different in those who failed first-line treatments. Concerning that, adding psychotherapy to antidepressants appeared to be beneficial for depressive symptoms and for remission rates for patients with TRD [48]. This study included trials with CBT, intensive short-term dynamic psychotherapy, interpersonal therapy and group dialectical behavioral therapy. So, specific data for STPP are missing.

Comorbidities

Concerning how comorbidities could influence the effectiveness of adding STPP to antidepressants in depressive disorders, we found studies focused on Obsessive-Compulsive Disorder (OCD), Panic Disorder and childhood abuse.

Regarding OCD, a number of investigations have reported that patients with OCD and comorbid depression are less responsive to both pharmacotherapy and cognitive-behavioral techniques. Thus, these patients need to be targeted as a special population for treatment studies. A study conducted on OCD patients by our research group didn't highlight a significant impact of adding STPP to antidepressants in treating either depressive or obsessive symptoms: it is noteworthy how a comorbid condition can considerably influence the treatment outcome, given the efficacy of STPP in treating depression per se [47]. Thus, new treatment options still need to be explored for these patients.

Few studies addressed the question of the clinical utility and efficacy of the combination of STPP and pharmacotherapy in the treatment of panic disorder with concurrent depression. A RCT on 35 patients with panic disorder and depressive symptoms highlighted that adding STPP is effective and preferable to supportive psychotherapy in these patients [49]. However, the meta-analysis by Driessen highlighted a greater effectiveness of STPP plus medications at follow-up in patients without anxiety disorder comorbidity, even if this effect was no longer statistically significant when excluding the studies that only included participants with specific comorbidities [37].

Focusing on childhood abuse, in an already mentioned study, Vitriol and colleagues explored the efficacy of STPP in 87 women with severe depression and a childhood trauma history. STPP appeared to be more effective than standard treatment in improving depressive symptoms, interpersonal relationships and social role functioning [45]. Therefore, screening for past traumas could be useful to address the patient to a more specific intervention.

Discussion

The aim of this paper was to review literature data on the efficacy of STPP in combination with antidepressants in the treatment of depressive disorders. In particular, our work, compared to recent systematic reviews conducted on the subject in recent years [37,42], also takes into consideration the effect of adding STPP on other short-term outcomes (acceptability, work adjustment, interpersonal relationships, social role functioning, rates of hospitalization, and costs of intervention), in treatment-resistant depression, and on the prevention of long-term recurrences.

Although adding STPP to antidepressants is widely considered an effective therapeutic option for patients with depressive disorders and showed comparable efficacy with CBT and IPT, the empirical support for this statement is still quite small. Most of the available data comes from studies with small sample sizes, lacking statistical power; this may explain why STPP ranks second to CBT and IPT. Recently, a number of large-scale and high-quality studies have been conducted and others are being carried out.

Analyzing available data, despite the above-mentioned limitations, combining STPP with antidepressants appeared to be helpful both in a short-term and a long-term perspective. The size of this effect was small at post-treatment and moderate at follow-up. In particular, adding STPP in the first six months of treatment didn't appear to influence remission rates but it improved acceptability (reducing drop-out rates), work adjustment, interpersonal relationships, social role functioning, rates of hospitalization and it allowed consistent overall savings. At the end of the continuation phase (12 months) a significant difference in remission rates in patients treated with antidepressants plus STPP versus those treated with just medication arised. In a long-term perspective (4 years of naturalistic follow-up), adding STPP to pharmacotherapy reduced recurrence rate by almost 50%.

Moving towards a more tailored treatment, we identified some features that appeared to influence the response: STPP has proven to be more effective in longer depressive episodes, in more severe depressions and in patients with a childhood abuse history. Instead, STPP showed no impact on MDD with comorbid OCD. Focusing on concomitant anxiety levels/comorbidity, we found contrasting results, so further studies are needed. Basically, it remains largely unclear which patients can benefit specifically from STPP for depressive disorders, because relatively few studies have been done and the sample sizes are often small.

The results of the review, pertaining both to the efficacy of adding STPP to antidepressants and to potential moderators of effectiveness, should be considered in light of the primary limitation, which is represented by the scarcity of rigorous studies and thus the low number of includable papers.

In conclusion, adding STPP to medications can potentially become a major asset in the treatment of depressive disorders. Key strengths of STPP lie in its effectiveness in preventing depressive recurrences and its potential high applicability to public service due to its problem-centered approach and consequent shorter duration compared to other psychodynamic psychotherapeutic techniques. A potential obstacle to the dissemination of STPP in routine clinical practice is the limited availability of adequately trained therapists: this limitation is attributable to the scarcity of schools providing specialized training and supervision, as well as to the general shortage of economic resources and personnel in the public healthcare system. This review highlights that STPP is a technique not suitable for all patients

with depressive disorders, but rather preferable for those with specific characteristics. Still, there are few rigorous studies with large samples and further research is needed to identify which subgroup of patients can benefit more from STPP.

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Conflict of Interest Statement

The authors have no conflicts of interest to declare.

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