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Short-term Psychodynamic Psychotherapy is a First Line Option for Depression and Treatment Resistant Depression According to Available Evidence

Allan Abbass¹, Patrick Luyten^{2, 3}, Falk Leichsenring^{4,5}

¹ Dalhousie University, Halifax, NS, Canada

² Faculty of Psychology and Educational Sciences, University of Leuven, Leuven, Belgium,

³ Research Department of Clinical, Educational and Health Psychology, University College London, London, United Kingdom

⁴ Department of Psychosomatics and Psychotherapy, University of Giessen, Giessen, Germany;

⁵ Department of Psychosomatics and Psychotherapy, University of Rostock, Rostock, Germany;

Corresponding author

Prof. Dr. Allan Abbass

Dalhousie University, Halifax, NS, Canada

Allan.Abbass@Dal.Ca

The recent CANMAT depression treatment guidelines recommend short-term psychodynamic therapy (STPP) as a second line treatment.¹ However, this recommendation does not fit with current available evidence.

CANMAT did not cite any meta-analysis of STPP for depression.²⁻⁴ Yet, a meta-analysis available to CANMAT published in 2015 with 33 RCTs showed STPP to be superior to controls, as efficacious as other psychotherapies.³ STPP outperformed other psychotherapies on measures of anxiety³, a known risk factor for non-remission. Comorbid personality disorder (PD) is also a common risk factor for non-remission and suicide, however CANMAT did not note another meta-analysis of STPP RCTs of patients with comorbid depression and PDs, showing STPP to be efficacious.² Instead they declared CBT, without any reference to empirical support, as the only recommended treatment when there is comorbid PD or anxiety disorders.

CANMAT's search up to May 2023 unfortunately missed a June 2023 umbrella review using updated and rigorous GRADE criteria.⁴ This review found STPP to outperform controls in critical outcomes for depression with clinically meaningful effect sizes, based on high quality evidence. No meaningful differences in efficacy were found between STPP and other evidence-based treatments. Confidence intervals were comparable to that of CBT.⁴ The benefits outweighed the costs and harms, as required by GRADE.⁴ According to the GRADE criteria as used by CANMAT, STPP received a strong recommendation in the treatment of major depression.⁴

With regards to treatment resistant depression (TRD), the CANMAT group singled out one study of CBT and declared CBT as the only treatment to be recommended (second line). They did not note an RCT of Intensive Short-term Dynamic Psychotherapy (ISTDP) for TRD showing greater

symptom benefits, cost effectiveness and medication reductions than community treatment-as-usual (Town et al, 2020 cited in ⁴). In this RCT, approximately 90% of participants had chronic medical illness and personality disorders, known risk factors for suicide and non-remission. This study has been recently independently replicated. ⁵ Both studies had 60 or more participants as required by CANMAT and both were published in high quality journals.

The CANMAT criteria for first line treatments require level I or level II evidence plus clinical support, taking side effects and feasibility into account (Table B). As shown above, STPP fulfills these criteria for the treatment of depression in general ⁴ and for TRD in particular.⁵

Although CBT is considered a first line psychological treatment option for treatment of MDD, recent empirical research involving CBT where CBT is actually compared to other active psychological treatments (as opposed to waiting list controls) shows little evidence that CBT is actually a uniquely superior treatment for treatment of MDD. CBT does not have a monopoly on efficacy for acute psychological treatment of MDD and given the high rates of non-response for both CBT and pharmacotherapy, other distinct and promising treatment options should not be overlooked.

Based on the recent evidence above, STPP and in specific ISTDP should be considered as a first line treatment option for depression in general and in particular for depression with comorbid personality disorders, anxiety disorders and in TRD. The argument that STPP should be rated as second line because it may be less available than CBT is a circular one: if guidelines inappropriately downgrade STPP it will become less accessible, and patients will be deprived of this efficacious treatment option.

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