Psychodynamic psychotherapy for depression

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Abstract

Depression is one of the most prevalent medical disorders. Attempts to sub-classify the disorder into "reactive" and "non-reactive" or "endogenous" proved to be unreliable. Depression can occur at any age and can be expressed with primary symptoms that do not involve obvious mood change. This is the reason why it is one of most commonly missed diagnoses. The psychodynamic understanding of depressive mood states is essentially influenced by the works of Freud and Abraham, and by the Kleinian object relations theory. Subsequently Beck and Seligman's cognitive behavioural approach was developed. Some clinical examples will, in this paper, illustrate the manifestations of depressive (unipolar) expressions of depressive disturbances of different intensity, including risk of suicide, from the viewpoints of age, developmental characteristics, personality structure, and cultural factors. Neurophysiological research is underscored as the next most important element in understanding depressive mood and its medical and psychotherapeutic treatments. The author suggests that empathic attunement and the sharp clinician's eye, assessment of prevailing defence mechanisms, and understanding transference, counter-transference and the therapeutic alliance will yield the best possible results in the treatment of depressive patients.

Keywords: depression, unipolar, psychodynamic psychotherapy

Introduction

The expression "depression" is now in very common usage. It is difficult to imagine that it was introduced in psychiatric nomenclature principally because of the attempts at the end of 19th century by the psychiatrist Emil Kraepelin to introduce a term that would have greater diagnostic specificity than the usual traditional term "melancholia". Depression is one of the most prevalent medical disorders and has been recognized as a distinct pathological entity from early Egyptian times. At the beginning of the 21st century the World Health Organisation (WHO) stated that depression is among the three most prevalent medical disorders, together with cardiovascular disorders and malignant disease (1, 2).

During the 20th century, clinicians have attempted to sub-classify the disorder on the basis of symptoms and causes. However, the attempt to distinguish depression that was "reactive" from depression that was "non-reactive" or "endogenous", i.e. not precipitated by psychosocial stress, did not prove to be reliable. Such judgments proved to be highly subjective and dependent on how detailed a history was obtained and how much weight was assigned by the patient or clinician to the changes that routinely occur in life (3). Distinctions regarding age have likewise proved suspect, because research results indicate that depression during the involutional period is qualitatively not different from that experienced during any other stage of life.

It is usually assumed that a depressed person will have prominent psychomotor retardation and anhedonia but there are patients suffering from depression that evidence psychomotor activation, feelings of guilt, shame, anxiety and occasionally even delusional thinking. Different somatic symptoms generally increase with the severity of depression (4-6).

The range of depressive symptoms depends to a large extent on the severity of the disorder; in the most severe cases, individuals may present with an extensive paranoid or nihilistic delusional system and experience hallucinations, usually self-deprecatory. In some cases the intensity of the depressive psychopathology provokes suicidal ideation, attempts or acts (7).

Depression can occur at any age and can be expressed with primary symptoms that do not involve obvious mood change. For example, depression in children may be difficult to diagnose. Because of the cognitive and linguistic developmental changes that occur in childhood, emotional states are experienced and projected in a developmentally appropriate way (8). In older people, the most significant symptom may be a change in cognitive function, that might suggest the slow development of senile dementia but that can be ameliorated with antidepressant treatment. In "masked depression", a condition where no apparent mood change is expressed, the course of the illness, prognosis and response to treatment are the same as those associated with classical major depression.

Depression is one of the most commonly missed diagnoses. It can be associated with some primary disorders of somatic origin but it more commonly occurs independently in the context of multisystem somatic complaints. Although depression can occur at any age, the average age of onset is about 40 years. In many cases symptoms develop following a significant loss or stress. The depressive episode may resolve spontaneously over a period of time or may become chronic and remain essentially unchanged over several years. Most patients with major depression respond well to somatic treatment but only about half have recovered completely at one-year follow-up. The risk of relapse after recovery from major depressive disorder is high for a short period. About 25% relapse within 12 weeks (3).

It is important to distinguish major depression from bipolar disorder and cyclothymic disorder. It is likely that unipolar depressive disorder represents part of bipolar affective disorder. In that frame of reference it appears to manifest in episodes, between which there are no apparent symptoms. Chronicity occurs in 15 to 20% of cases and usually manifests after 50 years of life.

In the last 30 years, family and genetic studies have indicated that the risk rate among first-degree relatives of individuals with major depression (unipolar) is approximately two to three times the risk in the general population. This is approximately half the rate reported among first-degree relatives of individuals suffering from bipolar illness. The concordance rate is about 11% for dizygotic twins and approaches 40% for monozygotic twins. This indicates a higher genetic vulnerability to successful regulation of mood states. This has been demonstrated by neuroscientific research over the last 30 years. Research in the area of regulatory disturbances in the monoamine neurotransmitter systems, particularly those involving norepinephrine and serotonin, as well as concepts of association of depression with alteration in acetylcholine-adrenergic balance characterized by a relative cholinergic dominance, continue to be the subject of further research and clinical testing (3, 9, 10).

All monoamine neurotransmitter systems are interrelated and subject to compensatory adaptation to perturbation over time. In addition, the discovery that many neuro-peptides and hormones may serve as neurotransmitters and neuromodulators in certain contexts has underscored the complexity of the neural regulation of mood. For the scope of this paper it should be noted that it is not only changes in the neurophysiological area that influence the mood of the patient but also the psychotherapeutic relationship which has its influence on the neurotransmitter system. In that sense the psychosocial factors emerge, together with primary relationships including the most important family and other environmental influences, as major factors that affect mood variations and the perception of one's mood status over time.

On the psychodynamic understanding of depression

In psychodynamic approaches to the phenomenon of depression it is usually assumed that regression to the oral phase of psychosexual development is the main characteristic. That is the reason why the person suffering from depression is searching for attention, tenderness and love. In that sense it could be understood as a desperate call for love. This condition, according to Freud, would be the consequence of an unsatisfactory process of mourning because of loss of the love object. There are ambivalent feelings towards the loved object that, during the process of identification, turn towards the depressed person. Depression emerges as the feeling of guilt over anger toward an ambivalently perceived (loved, hated) object. Some authors have elaborated Freud's view of depression as an ego response to helplessness rather than internalised anger. In any case, an essential prerequisite to the expression of major depressive disorder (unipolar included) is probably biological vulnerability. The cognitive distortions may become an overriding sense of worthlessness, self-doubt, guilt and/or shame, causing and/or maintaining the prolonged morbid mood state.

Internalisation of lost objects towards which there were ambivalent feelings brings about internal feelings of conflict, guilt, anger and contempt. Pathological mourning transforms into depression because ambivalent feelings that were directed towards internalised objects become directed towards oneself (11).

The above conceptualisations and theoretical positions are only a few basic attempts at understanding depressive phenomena which remain unclear, despite several research publications attempting to clarify the origin and developmental modalities of depressive mood states.

Psychodynamic understanding of depressive mood states is essentially influenced by the works of Freud and Abraham (4). In his work on mourning and melancholy Freud (1917) writes on the importance of comparison between these two affects: "The affect that corresponds to melancholy is mourning, i.e. bitter regret for the disappeared object", and: "melancholy is a grief provoked by loss of libido". He further explains that the object relation of predisposing persons to melancholic states means essentially narcissistic and ambivalent relations. Narcissistic, because these persons invest in love of their self as an object of love. Ambivalence means that the wish to destroy the object of love is never absent. The hate contained from the beginning in that kind of object relation could easily, after loss of the object, return towards the self. This is an explanation of the cruelty of the superego of melancholic patients towards their self, i.e. they can relate to themselves as to an object.

According to Freud, three conditions should be present for further delineation of melancholic attitude: initial ambivalence to the object of love, loss of that object, and regression of libido towards oneself. One of the most original contributions of Abraham pertains to the "primary" depression. He suggests that repetition of depressive episodes in one person corresponds to a repetition compulsion as a consequence of important trauma to the infantile narcissism because of an "original" deception. This means that before the Oedipal wish is overcome, a child is disappointed with his mother and his father; this entails feelings of total abandonment and a tendency to develop precocious depression.

Beginning in 1924, Melanie Klein developed her original theory about two essential positions that the newborn has to pass through during the first half year of extra-uterine life. She named them the schizo-paranoid and depressive positions. According to her understanding of the emotional vicissitudes of the newborn at the onset of extra-uterine life, it has to face two opposite experiences, of love and hate. There is no possibility to continue to live completely equipped as during intrauterine life, and to face the development of his relationship with the object of his desires, the mother or motherly figure. This mother could be felt as good or not good, in both cases stirring a spectrum of feelings that later will develop into essential experiences of life and the human condition. The newborn is able to recognize his mother as a "total" object, and to integrate her as a total object, towards which he attributes opposing feelings. In this way the newborn integrates his own self as a total self, and this is the same person - himself - that he loves and hates, which is his mother. This is the situation of being confronted with his own ambivalence and to feel fear that his destructive feelings do not annihilate the person that he loves and depends on totally. After completing the depressive phase the resolution of the depressive position finds its way into the next, Oedipal phase. The followers of this Kleinian theory enlarged her statements, extending the exchanging of both positions throughout life, thus contributing to the understanding of continuous dynamics in this sense and contributing to the understanding of the psychodynamics of object relations.

According to behavioural theory about some forms of depression, the depressed persons lack developed interpersonal relationships and think that they are unnecessary, thus provoking a negative reaction towards themselves. As a consequence they become even more lonely and more depressive.

There are cognitive interpretations of depression. According to Beck (12), depression is the consequence of negative feeling and conceptualisation of oneself. This results in feeling oneself as sinful, left alone and inadequate. The basic characteristic of the cognitive approach to depression is the negative cognitive triad, which consists of a negative perception of oneself, the future and the world. Another interpretation, according to Seligman, underscores learned helplessness (13).

Beck and Seligman, during the 1970s, developed their theory of depression connected with existential problems. The negative interpretation of events, especially "exogenous", events such as loss of an important object, is the focus of major concern. The negative constructs bring about a feeling of guilt. Beck offered the hypothesis that sadness follows maladaptation of the cognitive structure of a personality that

is rigid, bringing about a systematic negative interpretation of events.

As previously stated, clinical forms of depressive states are multiple and often present with difficult diagnostic problems. In this way they can be distinguished according to predominant symptoms relating to age, development, personality structure and cultural factors (4).

Depressive mood states and their clinical presentations

As already stated, every life period has some characteristics in forming and expressing depressive symptoms. This will be illustrated through some clinical examples. It must be emphasized that some basic symptoms of major depression can be always perceived. Such symptoms include: prominent psychomotor retardation, anhedonia, neglected appearance, depressive mood, slow thinking, downgraded will, reduced impulses (especially libido), reduced appetite, which results in reduction of body mass, changed vegetative functions and patients being negatively self-critical.

A very dramatic clinical picture of depression which an elderly patient presented will be described.

Clinical example 1: Depression in the elderly - a psychotic experience

The patient, aged 78, was referred for psychiatric hospitalization because he had been unsuccessfully treated as an outpatient diagnosed as having "senile psychosis". He had lived a very regular life, being always healthy and of good mood. It was only in the preceding two years that a melancholic mood started to prevail. He became distracted; he lost many of his interests. He was repeating ever more often that he was losing his appetite and weight because there was a long adder in his intestines that was eating whatever he swallowed. In the hospital he was prescribed antidepressants. Individual and group psychotherapy was added shortly after admission. It was a special task of the group leader to persuade the group participants not to insist on a rational approach to the symptoms of the elderly person because of the intensity of his experience and interpretation. The nurses reported that he had regular defecation every morning, despite his insistence that he had not defecated for months.

One day he became radiant, saying that finally we had succeeded in expelling the adder and he was feeling much better. He could not admit that he suffered from depressive symptoms either in individual or group psychotherapy. But the content that he spoke about during psychotherapeutic sessions was filled with depressive feelings and thoughts concerning the fear of death and the fear that some severe illness might appear which will consume him quickly. Due to his hypersensitivity and fearfulness, especially regarding the approaching end of his life, his old age was burdening him more and more. However, the psychodynamic reconstruction of the patient's emotional life uncovered that a considerable part of his 'optimistic character' was connected with fears of illness, old age and death in his primary family.

Psychodynamic comment

The patient was eager to take medication, motivated to "expel the adder" and to ameliorate his sleep. This was favourable in developing the treatment alliance (14-16). His verbal recounting of his primary family atmosphere and value system uncovered the reasons for his developing optimistic (hypomanic) attitudes throughout life. With diminished intellectual and emotional capacities due to aging he could not compensate the symptoms of losing his abilities and the shortening of his life expectancy. The depression of old age or "senility" caused a psychotic depressive state. With the combination of biological and psychological therapies it was possible to stabilize his mood and to enable him to return to his family and resume his usual style of life. What was not prognostically favourable, besides age, was the bizarre character and the duration of the cenesthetic hallucinatory symptom.

The clinical picture of the development of depression can be followed through the case of a young seaman, who was clinically observed to develop a unipolar depression.

Clinical example 2: Depression and somatic illness

The patient had been persuaded to consult a psychiatrist/psychotherapist. He was accompanied by his mother. He was 32 years old, single, and was living with his parents and his younger sister. His profession was that of an engineering technician. Immediately after finishing school he started to work as a seaman because he was motivated to earn money and to create a sound financial basis for his life. Nevertheless,

despite the fact that he was fulfilling his plans, he was rather dysphoric, and was lonely most of the time on-board. When he would return home he became more and more withdrawn and had no wish to meet with his friends. He always declined advice by many to consult a psychiatrist/psychotherapist. There was increasing anger in his behaviour. On a routine check-up it was discovered that he was diabetic (type I). This contributed to his complete withdrawal and bitter mood.

Although he was at first reluctant to cooperate, during psychotherapy sessions he was able to confront his disappointment with his body. He felt betrayed by his body's weakness, which prevented him from fulfilling his plans. He came from a very poor family. He was very frustrated during his childhood and adolescence by poverty and was greatly motivated to change the low financial level of his family. Now all his plans in that respect were overthrown and he was deeply depressed because he was facing economic misery again. We could talk very openly about his suicidal ideation and his feelings of the worthlessness of his life.

Although he was conscious of two major elements that contributed to the development of depressive symptoms, poverty and lifelong illness, his dysphoric mood and tendency to withdraw and to limit his social links suggested depression of the unipolar type. One of his uncles had been diagnosed as having bipolar disorder, and his grandfather probably suffered from maniacal mood. The despair of the patient was very deep and he was very open in admitting that he was deeply disappointed with his life prospects.

The results of therapy with medication and psychotherapeutic support were not very successful. After a year of individual psychotherapy combined with medication, analytic group psychotherapy was recommended. Through this, with time, the patient became more empathic and closer to the other group members, and also to the conductor. This was for him a corrective emotional experience that was reflected in his family and social life in a very positive way (17, 18). Due to this therapeutic formula, spontaneous depressive phases could be talked about and their development to the previous degree of intensity could be prevented.

Psychodynamic comment

In the field of psychic trauma, poverty, either material, emotional or both, is recognized as a major factor causing traumatisation. Since the beginning of his therapy the young man was recognised as seeking a reliable emotional attachment and at the same time being anxious of close relationships and empathic binding. Although he was eager to find his way into adult life with better prospects, the somatic illness was interfering, leaving him without the alliance he had been trusting so far – his physical health. The strength of his ego was very severely tested and withdrawal was his answer to the frustrating situation. The emergence of massive projections and projective identifications regarding the somatic illness and the social condition he had been suffering all his life, conditioned his answer with deeply depressive and even psychotic features. In that situation suicidal ideation could not be ruled out of his desperate thinking. To enable him gradually to accept and value the closeness of others and the trustful relationships offered by the therapist and later by the group, the emotional bonding started to develop and to close the gap between the cognitive and emotional spheres. The newly gained social insertion was a new experience in his life and a way out of his chronic depressive mood with frequent dysphoric outbursts.

Regarding personality structure

Clinical example 3: The mother and son who died from overdose

The problem of an unfinished mourning process results in the mourning becoming the prevailing way of life, and the person to become a chronic mourner. People who are either rigid or prone to a high level of anxiety reactions, inclined to superego attacks, often find it impossible to complete the mourning process, so that they uphold the bleeding wound of loss and it becomes a scar.

A mother who was bereaved after her son's death from an overdose five years previously, was persuaded to consult a psychotherapist. She described a long struggle to support her son to resist drug addiction, but this was in vain. Ever since his death she had been taking care of her son's room, keeping it exactly as it was left by him. Every day was started with her visiting his grave. Only after this ritual could she continue with her daily routine. She could permit herself no leisure time. She was very reluctant to accept that life could be understood in a different way.

During psychotherapy she could accept that due to the loss of her beloved son she was neglecting her husband and her daughter. The result of psychotherapy was that she could accept that in honour of her son she could try to help other young people struggling with their addictions, as well as their parents. This sublimatory shift resulted in the revival of her family atmosphere and restoration of her sense of life, and an increase in her self-esteem. In order to be sure that the change in her life from deeply depressive to optimistic and satisfactory was not subject to another change, she waited for two years to tell me about her new life. She was deeply impressed by the issue of the psychodynamic life narrative, especially from one critical session from which she described as having obtained the "sudden gain", that produced cognitive and emotional changes leading to a dramatic and lasting improvement (19, 20).

Psychodynamic comment

The psychodynamic understanding of her life narrative uncovered her unresolved attachment to her son, whom she was inclined to idealise. After his dramatic loss she expressed the way she was coping with this dramatic traumatic situation. Her defence mechanisms split off that event and she continued to take care of him as if he were alive, denying his loss in a psychotic way. In order not to expose this psychotic coping with the loss, she dissociated that part of her life from other areas, even from her family members. This rupture in her interpersonal relational network was filled with a quasi-mythological attitude that was protected from any change by her rigid behaviour. The therapeutic aim was to alleviate the defensive chain of her system for coping with this dramatic family loss and to support the transformation of her psychotic denial towards sublimatory activation of her willingness to help and to do something good that would dignify the memory of her son, but would also leave a place for loving expression to her family members and young people with addiction problems.

Regarding cultural factors

Clinical example 4: The widow - the loss of a husband and superego pressure

Mrs. Kate was a respected professor of history at high school. When she presented herself as an outpatient she was 58 years old. Her appearance was very carefully prearranged for her visit to the doctor. No detail was left neglected. In this way Mrs. Kate was non-verbally communicating to the psychiatrist that she is a very caring person and had to have all details under control.

She started to cry before explaining that she knows why she is suffering and that she had only come under pressure from her children. Her children, she said, did not understand her feelings and did not accept her explanations, considering her to be 'foolish'. She continued to cry.

It turned out that her beloved husband had died almost three years ago. Awakening after a siesta she found her husband dead in his armchair, where she had left him reading the newspaper.

The shock was terrible. They had been in love since the time they were students, when her husband had decided to move to study in another city. Living with him she was completely charmed by him and his friends, and when the time had come she decided to follow him and move to his home-town. She was a rather withdrawn person, rather obsessive in fulfilling her duties. Subsequently she was satisfied to live in the shadow of her husband with a sense of happiness and fulfilment. They had two children.

She continued reluctantly, saying that I would laugh at her explanation. The day before his death her husband had expressed the wish to eat a traditional meal made with sea fish. But the next morning she was preoccupied by some administrative obligations and, realising that she would not have enough time to prepare the fish meal, left the fish for the next day’s menu and instead prepared a meal with meat on the day her husband passed away. Because she had been so lucky as to share family life with such a dear person, she had, since her husband's death, experienced severe remorse that she had failed to fulfil the last wish of her beloved. With time she developed a sense of worthlessness and of low self-esteem. The experience of the loss facilitated her assuming the role of the 'help-rejecting complainer'. Finally her children persuaded her to visit the psychiatrist.

At the beginning she was rather ambivalent as to whether to accept the psychiatrist's advice of treatment, which was to include not only medication but also psychotherapy. After resolving her ambivalence towards the therapist she could, through transference, accept him not only as if he were something like her mate from the same town, but even as an empathic person whom she was lacking all her childhood

and was searching for all her life. After having worked through these 'as if' meanings, her self-esteem as a mother and grandmother increased, and she realised that she had been very much appreciated as a wife by her husband, which was witnessed to by her children, and could finally breathe more freely and accept her value as a person in her own right. Translated into family roles, she no longer thought of herself as a victim of an adverse life situation but as a valuable and appreciated person per se. Although she had a very sensitive personality, her place inside her family and social circles could be re-established and validated.

Psychodynamic comment

This is another example of a chronic mourner. Formally, she had managed to separate herself from her primary family members and from her environment, continuing her life in another city. Regarding her individuation she was a distinct personality in her professional life and an appreciated family member. Looking more closely at her separation and individuation processes as she was living and expressing herself, her dependency needs were transferred onto her husband and her individuation was highly connected with his personality. She was prone to undervalue her achievements and her merits. Obviously, her rather rigid style of life and the way he obeyed certain rules and customs reminded her of the characteristics of the region she came from. Now that she had to live without her husband it had become much more evident that she had not sufficiently completed her separation - individuation processes, and that her superego was provoking severe attacks on her ego, provoking irrational remorse and uncovering her proneness to low self-esteem, feelings of guilt and even of shame. At a certain point the patient expressed her wish to discontinue medication and to work on her emotional situation only through psychotherapy. Even at her age, her maturational processes could be unblocked, and this was assessed as the best way of preventing further depressive crises and near-psychotic states.

The following example will try to illustrate the (primarily) biologically prevailing origin of depressive mood with auto-aggressive impulses.

Clinical example 5: Depression, obsessive suicidal ideation and suicide - a unipolar depression?

Psychiatric/psychotherapeutic intervention was requested for a patient who was living in small village on an island with his wife and two children. He lived traditionally, fishing and cultivating vines and olives. He had completed professional high school.

In his thirties he started to feel the pressure of thoughts about suicide, which soon become an important urge. He tried to get rid of these alarming thoughts through confession, but he said that he was not feeling like a sinner, that he was suffering from these oppressive thoughts, understanding that there was no reasonable cause for him to commit suicide, and that his family did not deserve such a blow.

He was put on antidepressants and supportive psychotherapy. He had a tendency to analyse his past experiences from as early as he could remember. He was not complaining of special frustrations during his childhood and adolescence and was satisfied in his marriage. The 'suicidal ideas, very suggestive impulses' became more frequent with time. Talking with his wife could not diminish the impact of these 'impulses' and he was conscious of this. Often he cried during the psychotherapy sessions, because he felt impotent to counteract these auto-aggressive suggestions. One morning, his widow told me, they were lying in bed, both of them were crying and he was repeating that he should commit suicide, but he would try not to obey that 'impulse'. When he did not appear at a table at lunch time, the family searched for him and found him hanged.

The dissociative phenomena had been even more severe in his last years. Not even intensive medication and psychotherapeutic treatment could cope with the split off part of the patient's personality. He was so resistant to any therapeutic combination that finally his auto-aggressive 'urges' prevailed over attempts to preserve his life.

Psychodynamic comment

The psychotic intensity of the dissociative phenomenon, mentioned in this clinical example, indicates that dissociations can occur on a large scale causing from mild-to-marked splitting. Obviously, auto-aggressive impulses, especially in the case of agitated depression, might prove to be essentially self-destructive. Research by Faedda suggests that this clinical picture of unipolar depression, primarily characterized

by suicidal impulses, was a depressive mixed state (21). The authors write that treatment with antipsychotics and electroconvulsive therapy (ECT) could be very effective, while antidepressants could worsen the clinical picture. Koukopoulos suggests that this is a manifestation of bipolar disorder, but this clinical manifestation still requires further research support.

According to Freud's understanding, the inversion of the life instinct (Eros) could change its direction and move away towards its 'counterpart', an aggressive, destructive impulse - the death instinct (Thanatos). In this frame of reference he considered suicide as an active manifestation of Thanatos (7). In the above mentioned case it is difficult not to mention two levels of understanding of the patient's act: psychological and physiological. The psychological level would be the loss of emotions in the object relations towards the most important persons of his life. This dissociative phenomenon brought about his being conscious that he loved his family, friends and people in his environment, but he could not feel it. That was terrifying. On the other hand, there is a possibility that physiological changes provoked such a psychopathological state of mind that he could not understand, accept, or correct it through counteracting consciously and cognitively, nor through emotionally investing in positive attitudes. This splitting in his mind provoked continuous emotional pain and no stable and trusted link with positive object relations could be maintained. In the end the destructive forces prevailed. The dilemma about etiological elements, classification and more efficient treatment modalities remained.

Clinically this case is one of unipolar depression, but without the possibility to gain better insight into the developmental dynamics of the pervasive suicidal attitude that resulted in acting out, in reality, this auto-aggressive behaviour. This was highly suggestive of predominantly biological changes which led to the tragic end of the patient's life.

Features and principles in approaching (unipolar) depressive patients

Although depressive disorders progress in their manifestations and represent ever more important psychopathological symptoms of disruptions in mood regulation, it can be generally stated that psychotic depression is heavily under-investigated. Meta-analyses of research data so far have not given sufficient evidence of etiological elements that can cause the major disturbance of mood, causing disturbances of different characteristics and intensity which are manifested as psychotic depression. An important leap forward has been achieved in the last four decades regarding, among other important features, the role of trauma in the development of depression. Since depression can occur in any phase of human life, traumatic experiences of each human being should be carefully examined. Due to lack of motivation to talk, to explain oneself and one's sufferings, changes, lack of will, and motivation, it might take a long time for the patient to be able to disclose his/her sufferings, obsessive depressive thinking and relationships with him/her self and others.

There are several ways of describing the characteristics of depressive mood disturbances, especially regarding the age, developmental characteristics, personality structure and cultural factors. In this paper I have followed the approach of giving clinical examples as illustrations of the different types of manifestations of depressive disturbances that can be encountered in clinical practice. Besides the already mentioned common mood disorder characteristics there could be dramatic and even bizarre clinical expressions of the patient's suffering. The distinction between neurotic, borderline, narcissistic or psychotic levels of disturbance is important to establish, because it substantially influences the choice of treatment.

On one hand, many psychological approaches can be applied either in inpatient or in outpatient settings: psychosocial support, psychoeducational approach, psychodynamic psychotherapy, CBT and other forms of individual as well as group psychotherapies (22).

On the other hand, there is still not enough research as to whether biochemical disturbances cause expression of depressive symptoms or vice versa, that is, the cause-effect of biochemical and psychological parts of these elements which cause depression. A body is an emotional body, and the relationship between mother (motherly figure) and child, and other environmental factors brings about a continuous stirring up of emotions, imagery, and thinking, which modify the mind and the brain. This neuroplasticity represents the major scientific achievement which overarches the rational and emotional ways of expression of our mind-in-brain. These new understandings encourage new research in the field of the psychodynamics of mood disorders. Growing evidence, gained through research, points towards better results

of treatment if medication (when needed) is combined with some modalities of psychotherapy and psychodynamic understanding of depressive mood disorder (22). Empathic attunement and the sharp eye of a clinician, assessment of the prevailing activity of the defence mechanisms, the psychodynamic understanding of transference and countertransference, as well as of the therapeutic alliance, will yield the best possible result in the treatment of depressive patients.

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