International Journal of Cognitive Therapy, 6(3), 265–279, 2013

Impairments in Self Structures in Depression and Suicide in Psychodynamic and Cognitive Behavioral Approaches: Implications for Clinical Practice and Research

Patrick Luyten
University of Leuven, Belgium; University College London, UK

Sidney J. Blatt
Yale University

Peter Fonagy
University College London, UK

This paper discusses the growing convergence among cognitive behavioral and psychodynamic approaches to psychopathology, and to depression and suicide in particular, with a special focus on theoretical models emphasizing (a) the role of cognitive affective schemas or representations of self and others and (b) impairments in mentalizing or meta-cognition. We discuss similarities and differences between these approaches in the conceptualization and the treatment of depression. This review shows that despite continuing convergence, some important differences remain which may provide a particularly fruitful area for clinical practice and future research directed towards uncovering the mutative factors in the treatment of depression.

In this paper we review the growing convergence among cognitive behavioral and psychodynamic approaches to psychopathology, and depression and suicide in particular, with a special focus on two areas of convergence: (a) the role of mental representations or cognitive affective interpersonal schemas (Blatt & Zuroff, 1992); and (b) the role of impairments in meta-cognition or mentalizing, i.e., the

Address correspondence to Patrick Luyten, Ph.D., Faculty of Psychology and Educational Sciences, University of Leuven, Tiensestraat 102, P.O. Box 3722, 3000 Leuven, Belgium.

capacity to understand both the self and others in terms of mental states such as feelings, intentions, wishes, values, and goals (Allen, Fonagy, & Bateman, 2008).

These developments parallel a broader trend towards convergence between so-called *mental representations* and *mental process* (Fonagy, Moran, Edgcumbe, Kennedy, & Target, 1993) approaches to psychopathology. Mental representation approaches primarily focus on distortions in the content and/or developmental level of mental representations (or cognitive affective schemas or internal working models of self and others) in explaining vulnerability to psychopathology. In the mental process approach, in contrast, the focus is on distortions in processes related to the meta-cognitive ability to reflect on the self and others.

Well-known examples of the mental representation model within the psychodynamic and cognitive behavioral tradition are Blatt's and Beck's models emphasizing cognitive-affective schemas related to self-critical perfectionism/autonomy and dependency/sociotropy respectively, in depression (Beck, 1983; Blatt, 1974; Blatt, 2004). These approaches have received considerable empirical support over the years and have inspired several evidence- based treatments of depression within both cognitive behavioral and psychodynamic approaches (Driessen et al., 2010; Hollon, 2011; Luyten & Blatt, 2012).

The mental process approach is represented within the cognitive behavioral tradition by the so-called third generation cognitive behavioral approaches that focus on mindfulness and acceptance (Hayes, Levin, Plumb-Vilardaga, Villatte, & Pistorello, 2013; Kahl, Winter, & Schweiger, 2012; Segal, Williams, & Teasdale, 2013) and by mentalization-based approaches that have emerged within the psychodynamic tradition (Lemma, Target, & Fonagy, 2011b; Luyten, Fonagy, Lemma, & Target, 2012). Similarities between psychodynamic and cognitive-behavioral approaches in the conceptualization and treatment of depression are perhaps most clear in mentalization-based approaches to depression (Luyten, Fonagy, Lemma, et al., 2012) and in the treatment modality that evolved from this view, i.e., Dynamic Interpersonal Therapy (Lemma, Target, & Fonagy, 2011a; Lemma et al., 2011b).

In what follows, we discuss convergences in psychodynamic and cognitive accounts in emphasizing the centrality of cognitive affective schemas of self and others and mentalizing or metacognitive approaches to depression. Each time, we also focus on continuing areas of divergence in these approaches because these may provide important leads for future research concerning the nature and treatment of depression, even more so than areas of agreement.

MENTAL REPRESENTATIONS MODELS IN DEPRESSION

AREAS OF CONVERGENCE

Contemporary cognitive behavioral and psychodynamic formulations both emphasize the central role of mental representations or cognitive-affective schemas in explaining vulnerability to psychopathology and depression in particular (Beck,

Rush, Shaw, & Emery, 1979; Blatt, 1974; Blatt, 2004), thus providing a common language across these disciplines for researchers and clinicians alike.

There is increasing consensus that distortions in the content of mental representations confer vulnerability to depression in both psychodynamic (Blatt, 2004; Luyten & Blatt, 2012) and cognitive-behavioral (Beck, 1983; Young, Klosko, & Weishaar, 2003) theories. Moreover, whereas until recently, cognitive-behavior approaches were primarily aimed at addressing these distortions at the micro-level (e.g., targeting over-general autobiographical memories or other cognitive perceptual distortions), while psychodynamic approaches mainly focused on the macro-level (e.g., broad cognitive affective schemas such as Dependency and Self-Critical Perfectionism), both approaches now focus on both levels. For instance, Beck (1983) articulated the concepts of Sociotropy and Autonomy to refer to broad cognitive affective schemas or personality factors that are presumed to confer vulnerability to depression as well as other types of psychopathology. These dimensions have been shown to overlap both theoretically and empirically with psychodynamic formulations concerning dependency and self-critical perfectionism (Blatt, 2004; Luyten & Blatt, 2011, 2013). Conversely, as discussed in more detail below, psychodynamic approaches have increasingly begun to focus on the specifics of mentalizing impairments implicated in depression and their implications for intervention, thus closing the gap that has existed between its broad conceptual focus and specific clinical interventions (Fonagy, 2003; Luyten, Fonagy, Lemma, et al., 2012). Further, cognitive behavioral approaches have begun to show increasing interest in the developmental origins of these schemas (Renner, Lobbestael, Peeters, Arntz, & Huibers, 2012; Young et al., 2003), providing further common ground with psychodynamic approaches. Finally, the focus on cognitive affective schemas have led to a common interest in the neurobiology and neural circuits underlying representations of self and others (Luyten & Blatt, 2011).

There are good reasons for these convergences between psychodynamic and cognitive behavioral traditions. The psychodynamic approach has gradually replaced the obsolete drive model by a more comprehensive and empirically-informed object relational and attachment-based approach (Luyten & Blatt, 2012; Luyten, Mayes, Target, & Fonagy, 2012). Similarly, from a cognitive behavioral perspective, Beck (2009) has amply pointed out that although a focus on broad personality factors once was considered to be typical of psychodynamic formulations, cognitive-behavioral approaches had to shift from an almost exclusive focus on the symptomatic expressions of depression to considerations concerning personality dimensions as many depressed patients, despite symptomatic improvement, remained vulnerable to relapse because of continuing vulnerability associated with often highly treatment-resistant cognitive-affective schemas. Thus, disappointments with the results of traditional CBT led to the view that the reduction of underlying vulnerabilities such as cognitive-affective schemas should be the primary aim of treatment, and that symptom reduction as such is insufficient. As noted, this change was paralleled with recognition of the importance of developmental considerations within the cognitive-behavioral approach. Young and colleagues (Young et al., 2003), for instance, have advocated a more developmen-

tal interpersonal approach that is clearly rooted in psychoanalytic object relations theory emphasizing the role of Early Maladaptive Schemas, further closing the gap between cognitive behavioral and psychodynamic approaches to depression. Within the psychodynamic tradition, in turn, there has been a growing realization of the need for a closer relationship between theory and technique, and thus that broad considerations concerning the origins of depression, as such, are insufficient because they fail to provide clinicians with the necessary tools to understand the subjective inner world of the depressed and suicidal patient, and to intervene (Fonagy, 2003; Luyten, Fonagy, Lemma, et al., 2012).

In all these areas, the construct of mental representations provides a bridge between clinicians and investigators from various theoretical orientations. These various theoretical formulations concerning mental representations all propose (a) that representations of self and other are relatively stable characteristics that organize and guide the individual's affects, cognitions, and behaviors, and (b) that treatment can be conceptualized in terms of changes in the content and structural organization of these representations.

AREAS OF DIVERGENCE

Despite these similarities, important differences remain between cognitive behavioral and psychodynamic approaches. The focus in cognitive behavioral perspectives primarily is on the content of representations, while the focus in psychodynamic formulations more often is on the structural (cognitive or developmental) organization of these representations because they reflect more implicit or procedural aspects of these cognitive structures as well as important developmental characteristics (Blatt, Zuroff, Hawley, & Auerbach, 2010; Blatt, 2004).

Moreover, CBT approaches mainly emphasize fostering cognitive changes in the content of representations (e.g., to think differently about yourself and others; Beck, 1983; Renner et al., 2012), while psychodynamic approaches emphasize the affect associated with these representations and the role of an intense interpersonal relationship such as the therapeutic relationship (i.e., transference) in activating and re-experiencing the influence of these representations, thereby fostering the patient to revise earlier representations through becoming aware of their repetitive distortion of life experiences in the here-and-now of the therapeutic relationship (Blagys & Hilsenroth, 2000, 2002; Diener, Hilsenroth, & Weinberger, 2007; Luyten & Blatt, 2012). Again, however, the importance of re-experiencing affect in the context of an attachment relationship is increasingly recognized within the CBT movement (Godfrey, Chalder, Ridsdale, Seed, & Ogden, 2007; Hambrook et al., 2011; Lumley, 2011). This is particularly the case in schema therapy, in which there is a clear focus on affect and developmental levels, as well as the therapeutic relationship through the concept of limited re-parenting. Given its origins in psychoanalytic object relations theory, this should not be surprising. The implications of these shifts in technique are clear, indicating a greater focus on affect and interpersonal relationships in both traditions as well as an appreciation of more structural or developmental levels in understanding differences in the level of

personality (Koelen et al., 2012). For instance, in a naturalistic follow-up study of 576 psychiatric outpatients who received a manualized CBT for Axis I disorders, it was found that patients with low levels of personality organization were 3 times more likely to drop out compared to patients with higher levels of personality organization. These patients also had increased risk for deterioration as a result of treatment (Eurelings-Bontekoe et al., 2009).

Finally, within psychodynamic approaches, there remains a greater emphasis on the function of behavior and mental representations. For instance, cognitive affective schemas revolving around dependency are not solely seen as reflecting high dependency needs resulting from a history of deprivation, but also as an individual's best attempt, given his/her biological endowment and environmental context, however maladaptive, to establish some sense of stability in the sense of self and others. This view, again, has been clearly incorporated in schema therapy for instance through the notion of experiential avoidance and the view that schemas (and modes) may reflect compensatory strategies (Eurelings-Bontekoe, Luyten, Ijssennagger, van Vreeswijk, & Koelen, 2010; Young et al., 2003).

MENTALIZING AND SELF STRUCTURES IN DEPRESSION AND SUICIDE

META-COGNITIVE PROCESSES IN DEPRESSION

More recent psychodynamic and cognitive behavioral approaches have an increased interest in the role of impairments in meta-cognition or mentalizing (also referred to as reflective functioning) in depression and other disorders (Luyten, Fonagy, Lemma, et al., 2012; Segal et al., 2013; Watkins & Teasdale, 2004). Rather than focusing on the content of cognitive affective schemas in depression, both approaches center on the meta-cognitive processes involved in reflecting on the self and others. From a psychodynamic perspective, impairments in reflective functioning or mentalizing, i.e., the capacity to envision the self and others in terms of mental states such as feelings, wishes, desires, values, and goals, are thought to play a central role in depression and suicide (Lemma et al., 2011a; Luyten, Fonagy, Lemma et al., 2012). This is consistent with the so-called third wave cognitive approaches focusing on meta-cognitive awareness and mindfulness in depression and its treatment. These approaches complement views focusing on distorted cognitive affective schemas in depression and suicide and particularly provide a more comprehensive account of the depressed patient's subjective experiences, and the depressed patient's problems to overcome depressive feelings and thoughts.

In the context of the topic of this special issue, it is important to point out that these approaches provide a better account of the disintegration of the feeling of self that is so typical of many depressed patients and perhaps is the core of the depressive experience itself. These more phenomenological process-oriented accounts therefore also provide more direct and perhaps more effective clues for intervention when faced with patients that are severely depressed as lifting de-

pressed mood is often the first thing to do with these patients before any meaningful work that relates to the content of their depressive experiences can be done. This is perhaps one of the reasons why mindfulness-based cognitive therapy has demonstrated its effectiveness primarily in chronic depression (Kahl et al., 2012; Mathew, Whitford, Kenny, & Denson, 2010). By the same token, the mentalizing approach has originated in the treatment of patients with borderline personality disorder, many of whom struggle with intense and chronic feelings of depression (Luyten, Fonagy, Lemma et al., 2012). We discuss these trends in more detail and again note similarities and differences between psychodynamic and cognitive behavioral approaches.

AREAS OF CONVERGENCE

Both mindfulness and mentalization based approaches to depression have noted the influence of depressed mood on meta-cognitive abilities. The starting point of these approaches is that, regardless of the causes of depressed mood and depression, when depressed, the patient is often completely unable to reflect on the self and others, and when he or she does, reflective processes are severely biased by depressive thinking. Hence, in both mindfulness and mentalization based approaches, interventions that rely on insight and reflective capacities, typical of approaches based on mental representations models discussed earlier, are particularly avoided in the early stages of treatment as patients lack this capacity when severely depressed. Such interventions often lead to further pessimistic thoughts and feelings of helplessness and hopelessness as the therapist is seen as lacking in empathy or is even perceived as persecutory or accusatory, or both, depending on the content of the patient's cognitive affective schemas outlined above. Patients struggling with dependency issues, for instance, will feel that the therapist fails to recognize their suffering and actually attempts to blame the patient for her problems. More self-critical patients may feel that the therapist attempts to force, prematurely, interpretations on the patient, feels thwarted in her strivings for autonomy, and often drops out of treatment for this reason.

In contrast to the mindfulness approach, the mentalizing approach however does not transpose already existing meta-cognitive principles to depression. Rather, it has evolved from the study of subjectivity and the role of mental processes in (impaired) subjectivity, such as depression. Given that readers of this journal are likely to be less familiar with these views, in what follows, we briefly describe the role of non-mentalizing modes of experiencing subjectivity. From a mentalizing perspective, three types of so-called pre-mentalizing modes, i.e., modes of thinking that antedate full mentalizing, can be observed in depression: the psychic equivalence, the teleological and the pretend mode (Lemma et al., 2011a; Luyten, Fonagy, Lemma et al., 2012). These modes of thinking can also be observed in other forms of psychopathology and in all cases when individuals loose the capacity for full mentalizing, but in depression these modes tend to take on a specific form.

Psychic Equivalence Mode. The psychic equivalence mode is a developmentally earlier mode of experiencing subjectivity in which inner and outer reality are equated: "What I think/feel is real." Hence, when I think I'm worth nothing, I am worth nothing. This is typical for many depressed patients, and particularly when severely depressed, any attempt to correct these dysfunctional thoughts are meaningless themselves and only reinforce psychic equivalence thinking. Importantly, psychic equivalence also leads to equating psychological and physical pain, just as it leads to equating emotional and physical exhaustion. This may at least in part explain the high comorbidity between pain, fatigue, and depression (Hudson, Arnold, Keck, Auchenbach, & Pope, 2004; Van Houdenhove & Luyten, 2008). Not surprisingly, therefore, both mindfulness and mentalizing approaches have been applied to patients with chronic pain and fatigue conditions with good initial results (Luyten, Van Houdenhove, Lemma, Target, & Fonagy, 2013; Luyten, Van Houdenhove, Lemma, Target, & Fonagy, 2012; Rimes & Wingrove, 2013). There is a general concreteness of experiences, a de-symbolization: psychological pain means bodily pain, worries feel like a painful weight on one's shoulders, depressive thoughts literally de-press the self. Findings concerning common neural circuits involved in psychological and physical pain lead us to better understand that rejection may literally hurt (Eisenberger, Lieberman, & Williams, 2003). Even further, remarks or criticism by others are felt as an attack on the integrity of the self and often lead to feelings of disintegration. Hyperembodiment may result, a state in which all subjective experiences are experienced as too real, often leading to a psychic retreat because of the painfulness of thoughts and feelings, particularly of feelings of shame (Luyten, Fontaine, & Corveleyn, 2002). The so-called depressive realism that is typical of some depressed patients (Moore & Fresco, 2007; Yeh & Liu, 2007) seems also related to psychic equivalence: depressive "realism" may be realistic with regard to some issues, but it is often characterized by hypomentalizing: reality simply is what it is, which leads to feelings of emptiness and meaninglessness.

Teleological Mode. In a teleological mode or stance, there is a recognition of mental states as motivating self and others, but these are limited to goal-directed behaviors that result from observable causes (e.g., physical actions or biological causes). In this state of mind, many depressed patients only feel loved or recognized when the other physically demonstrates love or recognition (e.g., by not leaving the patient, or by buying something for the patient). Desperate attempts to get attachment figures, including professionals, to show that they care for the patient often follow, specifically in patients that primarily use attachment hyperactivating strategies to deal with loss and adversity (e.g., by demanding that the attachment figure never leaves the patient alone, or by demanding that the therapist is always available). In a teleological mode, patients, particularly those characterized by attachment deactivating strategies, may deny any role of psychological factors, and desperately cling onto biological theories as only biological causes can be recognized as real.

Pretend Mode. Depression clearly is not only associated with the hypomentalizing typical of psychic equivalence and the teleological mode. Often, depressed

patients seem to function in an extreme pretend or hypermentalizing mode. This may look like genuine mentalization, just as depressive realism often comes across as appropriate realism. There are a number of features, however, that distinguish narrative accounts of depressed patients in hypermentalizing mode from genuine mentalizing: (a) they are mostly overly analytical, repetitive, and lengthy; (b) they are biased by depressive themes such as guilt, shame, blame and responsibility, and worthlessness; (c) they are often self-serving (e.g., they lead to others showing empathy or compassion, or they are used to control or coerce others); (d) they may lack true affective grounding or, by contrast, affectively completely overwhelm the patient and others; and (e) when asked, patients experience an inability to switch perspectives (e.g, from a focus on the self to others), whereas genuine mentalizing is characterized by the ability to entertain the mind of others and the self simultaneously.

Hypermentalizing is thus often accompanied by what is called rumination from a cognitive behavioral perspective and should not be confused with genuine mentalizing. This is also borne out by studies supporting a distinction between reflection and brooding or rumination, with the former being related to increased mood, the latter with decreased mood and suicidal ideation (Mathew et al., 2010; Miranda & Nolen-Hoeksema, 2007).

SUICIDE

A consideration of suicidal thoughts and acts may help to further clarify the distinction between approaches to depression rooted in theories about cognitive affective schemas and meta-cognitive or mentalizing approaches. The former approaches see suicidal thoughts and acts as reflecting attempts to deal with feelings of helplessness and hopelessness as a result of abandonment by the loved object or feelings of failure, often involving anger directed towards others turned toward the self, desperate attempts to attract attention from the loved object, fantasies of killing hated parts of the self or reunion with lost or imagined loved ones—thoughts, feelings and experiences rooted in distorted cognitive affective schemas of self and others (i.e., being overly self-critical and/or dependent on others).

Although these explanations may be correct, from a mentalizing perspective, it is the too-realness of painful inner states as a result of psychic equivalence functioning that is seen as primary in suicidal acts or fantasies. In a teleological mode, there then seems to be only one solution to get rid of these feelings, which is by killing the self.

As noted, both approaches (i.e., those based on cognitive affective schemas and those rooted in metacognitive principles) need not to exclude each other. In a teleological mode, for instance, suicide is often experienced as a means of getting back to the loved one (Now she will finally realize how much she has hurt me). But there is a different emphasis, which clinically is important as the focus of interventions may shift from focusing on the content of suicidal thoughts and gestures (relating them to the content of cognitive affective schemas) versus the processes involved in the disruption of subjective experience.

AREAS OF DIVERGENCE: ARE PSYCHODYNAMIC AND COGNITIVE BEHAVIORAL META-COGNITIVE APPROACHES TO DEPRESSION MORE ALIKE THAN DIFFERENT?

Up to this point, the reader may feel that this paper confirms what he or she has been thinking all along: that there are more similarities than differences between cognitive behavioral and psychodynamic approaches to depression. They simply seem to use a different terminology. This is probably true to a large extent, which may also explain why these two approaches – rooted in different theoretical traditions—seem to be equally effective in the treatment of depression (Driessen et al., 2010; Luyten & Blatt, 2012). However, there are a number of differences that remain, and a careful consideration of these differences might lead to the development of more effective treatments. Hence, these remaining differences between meta-cognitive approaches might provide important leads to further research, enabling a deeper and more comprehensive understanding of depression and allowing a comprehensive treatment approach. Here, we discuss five such differences.

First, whereas cognitive-behavioral models mostly start by exploring the patient's thoughts, feelings, and behavior, and relate these to feelings of depression, the focus of mentalizing approaches in the treatment of depression is on the mind and how typical ways of thinking and feeling relate to interpersonal relationships which underpin enduring and recurring interpersonal problems related to depression. This interpersonal focus is most clearly evidenced in Dynamic Interpersonal Therapy, a recently developed integrative psychodynamic treatment for depression (Lemma et al., 2011a), in its focus on what is called the Interpersonal Affective Focus (IPAF), a relational pattern that is linked to the onset and/or perpetuation of depression and that is associated with specific mentalizing impairments. Of course, this focus on reflective functioning resembles the focus on meta-cognition in mindfulness approaches, but reflective functioning is a much broader (also including social cognition concerning others), and particularly more interpersonal concept as it is seen as fundamentally rooted in and linked to attachment relationships (Allen et al., 2008; Luyten, Fonagy, Lowyck, & Vermote, 2012).

Second, distorted mentalizing in depression is of course captured in cognitive behavioral formulations of depression. For example, psychic equivalence (e.g., a depressed individual interpreting a friend's failure to text her as an indication that this person no longer likes her), is conceptualized in terms of automatic thinking, which then leads to rumination: she starts thinking that she is indeed useless, that her friend is correct, and that she can't be really liked or loved by anyone. As a consequence, she starts to feel isolated and lonely, and increasingly engages in self-criticism. Moreover, she then selectively focuses on memories where she and others could see her as being inadequate, a biased focus that within a cognitive behavioral approach is understood in terms of impairments in autobiographical memory. This also leads her to think that the future has little positive in store (Beck's famous negative triad consisting of negative thoughts about the self, others, and the future).

From a mentalizing perspective, this same sequence can be understood as follows: psychic equivalence leads to a cascade of non-mentalizing reactions, which are primed by the (threat of) attachment disruption (her friend not liking her). Hence, interpersonal issues lead to a cascade of thoughts and feelings that exacerbate depression, illustrating the close link between depression and the interpersonal. In this psychic equivalence mode, her thoughts achieve a quality of physical reality. In an attempt to deal with this, she switches to pretend mode to deal with this unbearable distress—rumination thus is understood in terms of pretend mode functioning from a mentalizing perspective. What is important, however, is that the ruminative quality of her thinking entails a dissociation between her thinking and her life situation, typical of the pretend mode as noted above. Clinically, this is important, as this dissociation is associated with a lack of genuine meaning and feelings of emptiness because of its disconnect with reality. Also, challenging this series of thoughts by trying to find disconfirming evidence (a typical CBT intervention) might not be so much effective by finding disconfirming evidence as such (falsifying her assumptions), but by stopping her pretend mode functioning and the recovery of her capacity for mentalizing, the self-correcting tendency associated with genuine mentalizing.

Next, from a mentalizing perspective, the physical disengaging from friends and work colleagues can be understood as an attempt, in a teleological mode, to shut her off physically as she feels shut off psychologically. Yet, there is more. If we truly want to understand the depressed patient's subjective experience, it is important to acknowledge that the failure of mentalizing also leads to threatening disintegration and identify diffusion. In a psychic equivalence and pretend mode, she is no longer able to separate her thoughts and feelings about herself from those of others, leading her to think that everyone must feel about her as she thinks. The continuity of a sense of self that is normally generated by mentalizing becomes seriously impaired, creating a manifest discontinuity in her experience of the self past, present, and future, simply because she now feels to be a different person than she was in the past, and what she thinks she will feel like in the future.

Third, from a mentalizing perspective, there is a great emphasis on somatic features and embodiment more generally in depression (Luyten, Fonagy, Lemma et al., 2012; Luyten et al., 2013). Impairments in mentalizing bring about an inappropriate prioritization of bodily experience (Fonagy, Moran, & Higgitt, 1989), indicative of a process of de-symbolization. In depression, there is thus an extension of the teleological mode of thinking to the body. This may also explain the efficacy of treatments that prioritize exercise and physical activation more generally as they tend to lead to a re-investment of the body with (positive) meaning and thus the recovery of the capacity for mentalizing. Moreover, clinically, a focus on so-called somatic markers of emotions (i.e., bodily states such as sweating or hand-clenching; Abbass, Campbell, Magee, & Tarzwell, 2009), may often be a fertile starting point for interventions, particularly in patients with severe depression and/or functional somatic symptoms (Luyten et al., 2013).

Fourth, both CBT models and mentalizing approaches relate impairments in meta cognition in part to early (childhood) life experiences. Yet, within the mentalizing approach, the assumption is not that depression necessarily results from preexisting maladaptive expectations about the self and others, a key feature of diathesis-stress models within the cognitive approach. Although (early) attachment disruptions often play a role in explaining mentalizing impairments in depression, these distortions are often a consequence, rather than the cause of depressed states of minds, leading to a vicious cycle characterized by increasing mentalizing impairments. For instance, a recent study found that mentalizing impairments were correlated with illness duration, number of admissions and cognitive impairment (Fischer-Kern et al., 2013), suggesting that a chronic course of depression is associated with increasing mentalizing impairments.

Finally, as noted, both cognitive and mentalization-based approaches conceptualize expectations created by early experiences to be crucial in the development of vulnerability to depression. However, within the mentalization-based approach, these experiences are not so much thought of as creating a maladaptive set of expectations but as leading to disruptions in the robustness with which second-order representations are established, i.e., the capacity for mentalizing. Hence, it is not attachment disruptions per se that are thought to lead to the development of cognitive affective schemas conferring vulnerability to depression. After all, many individuals that have experienced similar attachment disruptions do not develop depression and are not at increased risk for depression. Rather, the extent to which these attachment disruptions impair mentalizing, particularly under conditions of high arousal and the activation of the attachment system, is thought to be important. Whereas high levels of mentalizing are associated with a virtuous cycle leading to resilience in the face of stress, this pattern generates a vulnerability to adverse life experiences. Hence, from a mentalizing perspective, negative experiences as such are not seen as the cause of vulnerability to depression, nor their impact on the development of expectations with regard to the self and others, but rather the impact of these experiences on mentalizing capacities. This is also expressed in the concept of earned secure attachment, which reflects a type of secure attachment in individuals that were previously characterized by (often severe) insecure attachment (Luyten, Vliegen, Van Houdenhove, & Blatt, 2008; Roisman, Padron, Sroufe, & Egeland, 2002).

DISCUSSION AND CONCLUSIONS

This paper presented similarities and differences in contemporary psychodynamic and cognitive behavioral approaches to depression. Despite considerable overlap, overall, compared to cognitive behavioral approaches, psychodynamic approaches are more person- than disordered-centered, interpersonal rather than intrapsychic, developmental rather than static, share a greater emphasis on the functions of representations rather than on their distorted nature, and on affect rather than cognition.

Of course, as noted, these are gross generalizations, particularly as studies suggest that clinicians from both orientations actually show great overlap in their assumptions and interventions (Goldfried, Raue, & Castonguay, 1998). Yet, differences in emphasis remain, and the study of these divergences may lead to substantial advances in our understanding of the nature of depression and psychopathology more generally. In our opinion, the field can only advance by directly examining the tenets of these different approaches and the efficacy of treatment approaches that originated from these approaches. In this respect, there is a clear need to bridge the divide between basic research and outcome research and bring current treatment approaches closer in line with research and clinical findings that have emerged over the past decades. Many outcome studies actually focus on the efficacy of treatments using treatment manuals that have been formulated decades ago. Again, the metacognitive tradition might fare slightly better in this respect, as there tends to be more integration between research and treatment within this tradition. But more efforts are needed, and there is particularly a need to study in more detail process-outcome relationships aimed at uncovering the mutative mechanisms in the treatment of depression, rather than the current focus on treatment packages as a whole. Moreover, given relatively limited effects of current brief treatments (Cuijpers, van Straten, Bohlmeijer, Hollon, & Andersson, 2010), the emphasis should shift towards treatment approaches focused on long-term treatment, including maintenance treatments and treatments that have been specifically developed for patients with personality issues, such as schema therapy and mentalization-based treatment. Likewise, evidence concerning scar effects of depression (Shahar, 2006; Shahar, Noyman, Schnidel-Allon, & Gilboa-Schechtman, 2013; Shahar & Priel, 2003) on personality call for a greater emphasis on prevention strategies, and both cognitive behavioral and psychodynamic approaches seem to have headed this call (Andersson et al., 2012; Johansson et al., 2012).

REFERENCES

Abbass, A., Campbell, S., Magee, K., & Tarzwell, R. (2009). Intensive short-term dynamic psychotherapy to reduce rates of emergency department return visits for patients with medically unexplained symptoms: Preliminary evidence from a pre-post intervention study. *Canadian Journal of Emergency Medicine*, *11*, 529–534.

Allen, J. G., Fonagy, P., & Bateman, A. W. (2008). *Mentalizing in clinical practice*. Washington: American Psychiatric Press.

Andersson, G., Paxling, B., Roch-Norlund, P., Östman, G., Norgren, A., Almlöv, J. et al. (2012). Internet-based psychodynamic versus cognitive behavioral guided self-help for generalized anxiety disorder: A randomized controlled trial. *Psychotherapy and Psychosomatics*, *81*, 344–355.

Beck, A. T. (1983). Cognitive therapy of depression: New perspectives. In P. J. Clayton & J. E. Barrett (Eds.), *Treatment of depression: Old controversies and new approaches* (pp. 265–290). New York: Raven Press.

Beck, A T. (2009). Cognitive aspects of personality disorders and their relation to syndromal disorders: A psychoevolutionary approach. In C. R. Cloninger (Ed.), *Personality and psychopathology* (pp. 411–429). Washington, DC: American Psychiatric Press.

Beck, A. T., Rush, J., Shaw, B., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford.

Blagys, M., & Hilsenroth, M. (2000). Distinctive features of short-term psychodynamic-interpersonal psychotherapy: A review of the comparative psychotherapy process-litera-

ture. *Clinical Psychology: Science and Practice*, *7*, 167–188.

Blagys, M., & Hilsenroth, M. (2002). Distinctive features of short-term cognitive-behavioral psychotherapy: An empirical review of the comparative psychotherapy process literature. *Clinical Psychology Review*, *22*, 671–706.

Blatt, S. J. (1974). Levels of object representation in anaclitic and introjective depression. *The Psychoanalytic Study of the Child*, *29*, 107–157.

Blatt, S. J. (2004). *Experiences of depression: Theoretical, clinical and research perspectives*. Washington, DC: American Psychological Association.

Blatt, S. J., & Zuroff, D. C. (1992). Interpersonal relatedness and self-definition: Two prototypes for depression. *Clinical Psychology review*, *12*, 527–562.

Blatt, S. J., Zuroff, D. C., Hawley, L. L., & Auerbach, J. S. (2010). Predictors of sustained therapeutic change. *Psychotherapy Research*, *20*, 37–54.

Cuijpers, P., van Straten, A., Bohlmeijer, E., Hollon, S. D., & Andersson, G. (2010). The effects of psychotherapy for adult depression are overestimated: A meta-analysis of study quality and effect size. *Psychological Medicine*, *40*, 211–223. doi: doi:10.1017/S0033291709006114

Diener, M. J., Hilsenroth, M., & Weinberger, J. (2007). Therapist affect focus and patient outcomes in psychodynamic psychotherapy: A meta-analysis. *American Journal of Psychiatry*, *164*, 936–941.

Driessen, E., Cuijpers, P., de Maat, S.C.M., Abbass, A. A., de Jonghe, F., & Dekker, J.J.M. (2010). The efficacy of short-term psychodynamic psychotherapy for depression: A meta-analysis. *Clinical Psychology Review*, *30*, 25–36.

Eisenberger, N. I., Lieberman, M. D., & Williams, K. D. (2003). Does rejection hurt? An FMRI study of social exclusion. *Science*, *302*, 290–292.

Eurelings-Bontekoe, E.H.M., Luyten, P., Ijssennagger, M., van Vreeswijk, M., & Koelen, J. (2010). Relationship between personality organization and Young's cognitive model of personality pathology. *Personality and Individual Differences*, *49*, 198–203. doi: 10.1016/j.paid.2010.03.034

Eurelings-Bontekoe, E. H., van Dam, A., Luyten, P., Verhulst, W. A., van Tilburg, C. A., de Heus, P., & Koelen, J. (2009). Structural personality organization as assessed with theory driven profile interpretation of the dutch short form of the MMPI predicts dropout and treatment response in brief cognitive behavioral group therapy for axis I disorders. *Journal of Personality Assessment*, *91*, 439–452. doi: 10.1080/00223890903087927

Fischer-Kern, M., Fonagy, P., Kapusta, N. D., Luyten, P., Boss, S., Naderer, A. et al. (2013). Mentalizing in female inpatients with major depressive disorder. *Journal of Nervous and Mental Disease*, *201*, 202–207. doi: 10.1097/NMD.0b013e3182845c0a

Fonagy, P., Moran, G., & Higgitt, A. (1989). Psychological factors in the self-management of insulin-dependent diabetes mellitus in children and adolescents. In J. Wardle & S. Pearce (Eds.), *The practice of behavioral medicine*. Oxford: Oxford University Press.

Fonagy, P., Moran, G. S., Edgcumbe, R., Kennedy, H., & Target, M. (1993). The roles of mental representations and mental processes in therapeutic action. *The Psychoanalytic Study of the Child*, *48*, 9–48.

Fonagy, P. (2003). Some complexities in the relationship of psychoanalytic theory to technique. *Psychoanalytic Quarterly*, *72*, 13–47.

Godfrey, E., Chalder, T., Ridsdale, L., Seed, P., & Ogden, J. (2007). Investigating the 'active ingredients' of cognitive behaviour therapy and counselling for patients with chronic fatigue in primary care: Developing a new measure to assess treatment fidelity and predict outcome. *British Journal of Clinical Psychology*, *46*, 253–272.

Goldfried, M. R., Raue, P. J., & Castonguay, L. G. (1998). The therapeutic focus in significant sessions of master therapists: A comparison of cognitive-behavioral and psychodynamic-interpersonal interventions. *Journal of Consulting and Clinical Psychology*, *66*, 803–810.

Hambrook, D., Oldershaw, A., Rimes, K., Schmidt, U., Tchanturia, K., Treasure, J., et al. (2011). Emotional expression, self-silencing, and distress tolerance in anorexia nervosa and chronic fatigue syndrome. *British Journal of Clinical Psychology*, *50*, 310–325.

Hayes, S. C., Levin, M. E., Plumb-Vilardaga, J., Villatte, J. L., & Pistorello, J. (2013). Acceptance and commitment therapy and contextual behavioral science: Examining the progress of a distinctive model of behavioral and cognitive therapy. *Behavior Therapy*, *44*, 180–198. doi: 10.1016/j.beth.2009.08.002

Hollon, S. D. (2011). Cognitive and behavior therapy in the treatment and prevention of depression. *Depression and Anxiety*, *28*, 263–266. doi: 10.1002/da.20797

Hudson, J. I., Arnold, L. M., Keck, P. E., Jr., Auchenbach, M. B., & Pope, H. G., Jr. (2004). Family study of fibromyalgia and affective spectrum disorder. *Biological Psychiatry*, *56*, 884–891. doi: S0006-3223(04)00895-9 [pii]10.1016/j.biopsych.2004.08.009

Johansson, R., Ekbladh, S., Hebert, A., Lindström, M., Möller, S., Petitt, E., et al.. (2012). Psychodynamic guided self-help for adult de-

pression through the internet: A randomised controlled trial. *PLoS ONE*, *7*, e38021.

Kahl, K. G., Winter, L., & Schweiger, U. (2012). The third wave of cognitive behavioural therapies: What is new and what is effective? *Current Opinion in Psychiatry*, *25*, 522–528. doi: 10.1097/YCO.0b013e328358e531

Koelen, J., Luyten, P., Eurelings-Bontekoe, E. H., Diguer, L., Vermote, R., Lowyck, B., & Bühring, M. (2012). The impact of level of personality organization on treatment response: A systematic review. *Psychiatry: Interpersonal and Biological Processes*, *75*, 355–374.

Lemma, A., Target, M., & Fonagy, P. (2011a). *Brief dynamic interpersonal therapy. A clinician's guide*. Oxford: Oxford University Press.

Lemma, A., Target, M., & Fonagy, P. (2011b). The development of a brief psychodynamic intervention (dynamic interpersonal therapy) and its application to depression: A pilot study. *Psychiatry: Interpersonal and Biological Processes*, *74*, 41–48.

Lumley, M. A. (2011). Beyond cognitive-behavioral therapy for fibromyalgia: Addressing stress by emotional exposure, processing, and resolution. *Arthritis Research and Therapy*, *13*, 136.

Luyten, P., & Blatt, S. J. (2011). Integrating theory-driven and empirically-derived models of personality development and psychopathology: A proposal for DSM-V. *Clinical Psychology Review*, *31*, 52–68.

Luyten, P., & Blatt, S. J. (2012). Psychodynamic treatment of depression. *Psychiatric Clinics of North America*, *35*, 111–129.

Luyten, P., & Blatt, S. J. (2013). Relatedness and self-definition in normal and disrupted personality development: Retrospect and prospect. *American Psychologist*, *68*, 172–183.

Luyten, P., Fonagy, P., Lemma, A., & Target, M. (2012). Depression. In A. Bateman & P. Fonagy (Eds.), *Handbook of mentalizing in mental health practice* (pp. 385–417). Washington, DC: American Psychiatric Association.

Luyten, P., Fonagy, P., Lowyck, B., & Vermote, R. (2012). The assessment of mentalization. In A. Bateman & P. Fonagy (Eds.), *Handbook of mentalizing in mental health practice* (pp. 43–65). Washington, DC: American Psychiatric Association.

Luyten, P., Fontaine, J.R.J., & Corveleyn, J. (2002). Does the test of self-conscious affect (TOSCA) measure maladaptive aspects of guilt and adaptive aspects of shame? An empirical investigation. *Personality and Individual Differences*, *33*, 1373–1387.

Luyten, P., Mayes, L. C., Target, M., & Fonagy, P. (2012). Developmental Research. In G. O. Gabbard, B. Litowitz, & P. Williams (Eds.), *Textbook of psychoanalysis* (2nd ed., pp. 423–442). Washington, DC: American Psychiatric Press.

Luyten, P., Van Houdenhove, B., Lemma, A., Target, M., & Fonagy, P. (2013). Vulnerability for functional somatic disorders: A contemporary psychodynamic approach. *Journal of Psychotherapy Integration*, *23*, 14–27.

Luyten, P., Van Houdenhove, B., Lemma, A., Target, M., & Fonagy, P. (2012). An attachment and mentalization-based approach to functional somatic disorders. *Psychoanalytic Psychotherapy*, *26*, 121–140.

Luyten, P., Vliegen, N., Van Houdenhove, B., & Blatt, S. J. (2008). Equifinality, multifinality, and the rediscovery of the importance of early experiences: Pathways from early adversity to psychiatric and (functional) somatic disorders. *The Psychoanalytic Study of the Child*, *63*, 27–60.

Mathew, K. L., Whitford, H. S., Kenny, M. A., & Denson, L. A. (2010). The long-term effects of mindfulness-based cognitive therapy as a relapse prevention treatment for Major Depressive Disorder. *Behavioural and Cognitive Psychotherapy*, *38*, 561-576. doi: doi:10.1017/S135246581000010X

Miranda, R., & Nolen-Hoeksema, S. (2007). Brooding and reflection: Rumination predicts suicidal ideation at 1-year follow-up in a community sample. *Behaviour Research and Therapy*, *45*, 3088–3095.

Moore, M. T., & Fresco, D. M. (2007). Depressive realism and attributional style: Implications for individuals at risk for depression. *Behavior Therapy*, *38*, 144–154.

Renner, F., Lobbestael, J., Peeters, F., Arntz, A., & Huibers, M. (2012). Early maladaptive schemas in depressed patients: Stability and relation with depressive symptoms over the course of treatment. *Journal of Affective Disorders*, *136*, 581–590. doi: 10.1016/j.jad.2011.10.027

Rimes, K. A., & Wingrove, J. (2013). Mindfulness-based cognitive therapy for people with chronic fatigue syndrome still experiencing excessive fatigue after cognitive behaviour therapy: A pilot randomized study. *Clinical Psychology & Psychotherapy*, *20*, 107–117. doi: 10.1002/cpp.793

Roisman, G. I., Padron, E., Sroufe, L. A., & Egeland, B. (2002). Earned secure attachment in retrospect and prospect. *Child Development*, *73*, 1204–1219.

Segal, Z. V., Williams, J.M.G., & Teasdale, J. D. (2013). *Mindfulness-based cognitive therapy for depression* (2nd ed.). New York: Guilford.

Shahar, G. (2006). Clinical action: Introduction to the special section on the action perspective in clinical psychology. *Journal of Clinical Psychology*, *62*, 1053–1064.

Shahar, G., Noyman, G., Schnidel-Allon, I., & Gilboa-Schechtman, E. (2013). Do PTSD symptoms and trauma-related cognitions about the self constitute a vicious cycle? Evidence for both cognitive vulnerability and scarring models. *Psychiatry Research*, *205*, 79–84. doi: 10.1016/j.psychres.2012.07.053

Shahar, G., & Priel, B. (2003). Active vulnerability, adolescent distress, and the mediating/suppressing role of life events. *Personality and Individual Differences*, *35*, 199–218.

Van Houdenhove, B., & Luyten, P. (2008). Customizing treatment of chronic fatigue syndrome and fibromyalgia: The role of perpetuating factors. *Psychosomatics*, *49*, 470–477. doi: 49/6/470 [pii] 10.1176/appi.psy.49.6.470

Watkins, E., & Teasdale, J. D. (2004). Adaptive and maladaptive self-focus in depression. *Journal of Affective Disorders*, *82*, 1–8.

Yeh, Z.-T., & Liu, S.-I. (2007). Depressive realism: Evidence from false interpersonal perception. *Psychiatry and Clinical Neurosciences, 61*(2), 135-141.

Young, J. E., Klosko, J. S, & Weishaar, M. E. (2003). *Schema therapy: A practioner's guide*. New York: Guilford.