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LONG-TERM PSYCHOANALYTIC PSYCHOTHERAPY AS AN EFFECTIVE APPROACH IN THE TREATMENT OF SEVERE DEPRESSION – A BRIEF REVIEW OF CONTEMPORARY LITERATURE AND CLINICAL CASE REPORT

depression
psychoanalytic psychotherapy
psychotic functioning

Summary

This paper is focused on the clinical effectiveness of long-term psychoanalytic psychotherapy in the treatment of severe forms of depression. Empirical data, recent reviews, and exemplary research data prove that this form of therapy represents an effective method of treating depression, especially its more severe forms. The author also presents a brief discussion of some crucial theoretical notes regarding psychoanalytic understanding of severe and chronic forms of depressive disorders: the classic psychoanalytic view of depression as difficulty in coping with loss, which leads to turning aggression to the inside; the differentiation between normal, neurotic, and psychotic depression; and the idea of psychotic functioning as an aspect of mind which is withdrawn from reality. The main part of this article is a clinical case of psychotherapy conducted in line with technical clues derived from theoretical premises: transference was used to co-create representations of experiences which had remained unsusceptible to psychological processing.

1. Introduction

This paper is focused on the clinical effectiveness of long-term psychoanalytic psychotherapy in the treatment of severe forms of depression. The paper is divided into three parts: 1) review of recent research data regarding the general effectiveness of long-term psychoanalytic psychotherapy in the treatment of depression; 2) discussion of some brief theoretical notes regarding the psychoanalytic understanding of severe and chronic forms of depressive disorders; and 3) a clinical case. The clinical material describes a psychotherapy of severe depression with psychotic features in a 27-year old woman.

Long-term psychoanalytic psychotherapy as a method of treating depression – review of recent research data

Recent literature on the effectiveness of psychotherapy unanimously suggests that psychoanalytic and/or psychodynamic psychotherapy is an effective method of treating mental disorders, including depression [1-4]. Contemporary researchers focus rather on "exploring […]

specific treatment components to address the key problems of individual patients" [1, p. 137] than on assessing the effectiveness of psychotherapy in general. Speaking from this perspective, I propose a brief review of recent research concentrated on a narrow, specific topic: the effectiveness of long-term psychoanalytic/psychodynamic psychotherapy in the treatment of more severe forms of depressive disorder.

In his review of research projects concerning the psychodynamic treatment of depression, Taylor [5] points out that short-term psychodynamic treatments are as effective as pharmacological treatment and behavioral-cognitive therapy. Long-term psychodynamic treatments are as effective as short-term psychodynamic treatments but additionally tend to improve the patients' functioning in the areas of social, occupational and interpersonal life.

Luyten and Blatt [6] formulate a similar conclusion to their review of relevant literature. They emphasize that long-term psychoanalytic psychotherapy and classic psychoanalysis tend to give the most promising results when applied to treating depressive patients with co-morbid disorders, where depression occurs simultaneously with personality disorders. These authors point out that long-term psychotherapies tend to be more effective in a longer perspective, more so with chronic depressions. They also stress that for many depressed patients psychoanalytic therapies are the preferred form of treatment.

Huner, Henrich, Clarkin and Clug [7] explored the differences in the effectiveness of more and less intensive forms of psychodynamic psychotherapies. They defined long-term psychoanalytic psychotherapy as a treatment lasting 39 months with 6 sessions per month on average and long-term psychodynamic psychotherapy as a treatment lasting 34 months with 2.5 sessions per month on average. Effectiveness was measured with questionnaires; the main measure was Beck's depression inventory, supplemented by other methods of assessing social support, general mental health and interpersonal problems (SPC, SCL-90, IIP, SSQ). Statistical analysis proved that three years after termination of treatment, long-term psychoanalytic psychotherapy was significantly more effective in improving depressive symptoms, general mental health, personality functioning and social support. No significant differences were found between the two therapeutic methods regarding their effectiveness in improving interpersonal problems. The researchers conclude that the more intense the psychotherapy, the longer the results last.

Researchers from Helsinki [8, 9] conducted a project in which they compared 4 forms of treatment: solution-focused therapy (SFT, 10 sessions in 8 months on average), short-term psychodynamic psychotherapy (STPP, 20 sessions in 6 months on average), long-term psychodynamic psychotherapy (LTPP, 230 sessions in 31 months on average) and psychoanalysis (PA, 3-5 sessions / week for 5 years). Depressive symptoms were measured with Beck's scale in the 3rd, 7th, 9th, 18th, 24th,

36th and 72nd month after the beginning of the treatment (which means some treatments were already terminated). All groups achieved large effect sizes: 0.8 to 1.5 (Cohen's *d*). In the first year after the beginning of the treatment, SFT and STPP groups were significantly more effective in reducing symptoms than LTPP, in the second year no significant differences were noted, and in the third year, symptom improvement in the LTPP group was significantly better than in the two other groups. Psychoanalysis proved to be the most effective in the 5th year. The researchers from Helsinki conclude that short-term therapies give faster benefits, but in a long run it is the long-term treatments that prove much more effective.

Tavistock Adult Depression Study [10], a British research project, was focused on the effectiveness of long-term psychoanalytic psychotherapy in treating treatment-resistant depression (i.e. depressive disorder previously unsuccessfully treated with at least two other methods). The project was conducted on 129 patients divided into an experimental group, treated with long-term psychoanalytic psychotherapy (LTPP), and a control group, treated with non-specific "treatment as usual" (TAU). By the termination of treatments, both groups had a small percentage of total remission and no significant differences were noted between the groups concerning partial remission (32.1% in the experimental group and 23.9% in the control group). Improvement was measured with Beck's and Hamilton's scales. Significant differences were noted in follow-up studies. Patients treated with LTPP obtained a better improvement in the area of depressive symptoms: 24 months after termination 38.8% of the patients from the LTPP group were in remission, while only 19.2% in the TAU group (p=0,03), 30 months after termination - 34.7% vs 12.2% (p=0.008), respectively, and 42 months after termination - 30% versus 4.4% (p=0.001), respectively.

Some brief notes on theory and technique of treating depression from the psychoanalytic perspective

Depression in classic psychoanalysis

Psychoanalytic theorists have formulated some important ideas concerning the general understanding of depression and the causes for developing its chronic forms. In his classic work on depression, Freud [11] introduced the term "melancholia", which is rich in meanings spanning beyond depression, but having a lot of similarities with clinical depression diagnosed today. Contemporary researchers like Taylor and Fink, point to a biological component of melancholy (cortisol metabolism) and distinguish various forms of melancholy (e.g. psychotic depression and postpartum depression). In his work published 1917, Freud noted that depression is based in **directing one's aggression towards him- or herself**, which in turn leads to **low self-esteem**, **self-accusations** or even **suicide**. A depressive individual has given love to another person in his or her childhood and was disappointed (which is called "loss of one's loved object"). In effect, such an individual identifies with this lost

object and incorporates it into his or her ego. Anger, originally felt towards the disappointing lost object becomes directed towards the depressive individual themselves. Subsequent experiences of loss and rejection can activate feelings related to this first object loss, which can lead to depression. Freud claims that in such circumstances "love for the object – a love which cannot be given up […] takes refuge in narcissistic identification. Then the hate comes into operation on this substitutive object [which already has become a part of the ego – comment by L.K.], abusing it, debasing it, making it suffer and deriving sadistic satisfaction from its suffering" [11, p. 153]

Types of depression according to Jacobson and ICD-10

In the late 1970s, Edith Jacobson [12] formulated a clinically relevant differentiation between particular forms of depression: normal, neurotic, and psychotic depression. Normal depression, in Jacobson's view, resembles in many respects a state of mind termed a depressive position by Klein [13]. Depressive position is a generally healthy state of mind, which involves an ability to tolerate guilt, to process psychic pain and emotional problems, and to include thinking in coming to terms with those problems [14]. In the context of contemporary diagnostic norms, such experiences are not diagnosed as a clinical disorder.

Neurotic depression, in Jacobson's view, is a condition (in broad terms) based on excessive reaction to stress, which is related to limited psychological resources and lack of external support. Jacobson suggests that the onset of such depression disorders often proves to be closely connected with external factors – important relational losses. In such circumstances, supportive reactions from one's relatives often can provide sufficient response, and in cases where psychotherapy is applied, pharmacological therapy might be unnecessary [15]. In the contemporary diagnostic approach, such a state corresponds with mild and moderate episodes of depression [16].

The condition which was termed "psychotic depression" by Jacobson, in contemporary diagnostic manuals is called a major depressive disorder, recurrent, severe, with psychotic symptoms [16]. In such states feelings of worthlessness, low self-esteem and guilt take a central stage. Delusions and hallucinations occur in psychotic episodes, with a primary content of sins, poverty, guilt, imminent failure and catastrophe. This type of depression is almost always accompanied by somatic symptoms like problems with sleep (waking up very early) and psychomotor slowness, weight loss, decrease of libido and stoppage of menstruation. Contemporary psychiatry connects these symptoms with neuro-hormonal dysfunctions like invalid melatonin secretion and a low level of sex hormones [17]. Psychotic depression is also accompanied with hypochondriac symptoms – pains in head and stomach, often connected with fear of cancer, atypical face pains and suicidal thoughts [18]. Patients suffering from this form of depression make suicidal attempts in which factual killing themselves is the main or sole intention, in contrast to less severe forms of depression, where the suicidal intention is also driven

with other motivations like calling for help [15]. Their treatment often demands a combination of psychotherapy, pharmacological therapy, and hospitalization. These elements of a condition termed "psychotic depression" by Jacobson can be found in many cases of severe or recurring depressive disorders [16].

Psychotic functioning in depression

In the practical attempt to treat patients suffering from psychotic forms of depression, a clinician needs to formulate and employ a clear conception of psychotic functioning in general. In the psychoanalytic perspective, the most prominent feature of psychotic functioning is a loss of connection with reality, both external (material facts) and emotional (i.e. the loss of contact with one's emotions and their source, both in factual relations and internal dynamics) [19]. Thus, it's not the most spectacular features of psychotic functioning, like hallucinations and delusions, that are predominant, but rather a combination of rationalizations and withdrawal from reality. Rationalizations are not as vivid as positive symptoms, but they allow the psychotic part of personality to substantiate and protect its delusional beliefs from the verifying influence of reality [15, 19].

The psychoanalytic understanding of psychotic forms of depression introduces a concept of the *psychotic superego*. The term "superego" is rooted in classic psychoanalysis (structural theory) and is used to describe a psychic instance which stems from internalized parental attitudes and which is responsible for moral values, conscience and the sense of guilt [20]. In the context of psychotic depressive disorders, one might emphasize the power of devastating self-accusations, which are not connected to reality (e.g. to the patient's factual guilt or responsibility for his or her state) and are thus of delusional quality. In more contemporary terms, the idea of the "psychotic superego" might be formulated as a state of delusionally tormenting oneself with responsibility for suffered losses, without paying respect to reality.

Therapy technique with patients suffering from depression with psychotic qualities

A therapeutic relationship based on transference and countertransference, i.e. on the patient's and the therapist's feelings generated in the course of the therapy, is a specific contribution of the psychoanalytic perspective to the area of working with psychotic aspects of functioning. The psychotic area of the mind is relatively resistant to attempts of verbal therapeutic interventions – delusions can not be put to a stop solely by cognitive questioning [21]. In this regard, the role of direct emotional experiences needs to be stressed. The focus on emotional experiences in the therapeutic relationship allows for psychological work in the area of experience, instead of cognitive beliefs.

Contemporary psychoanalysis, especially intersubjective [22] and relational [23] approaches, supplements the above idea with emphasizing the need to adjust the way of working in transference to the patient's level of disturbance. In case of contact with the psychotic area of the mind, formulating

advanced transference interpretations, e.g. reconstructive interpretations, in which the therapist tries to find connections between the therapeutic relationship and the patient's past [24], need to be put in the background. The situation in transference-countertransference should rather be used to carefully and receptively support the patient in developing their ability to think about their formerly un-thought experiences. In cases of psychotic depression, work in transference and countertransference might serve to co-create representations of those feelings of loss and guilt that were painfully experienced without the ability to think about them – i.e. were experienced in a psychotic manner [25]. Contemporary psychoanalytic writers use different contexts to stress the possibility of using this relationship to co-create mental representations of experiences which lack those representations: examples of such a context are the theory of mentalization [26], or Bion's theory of mind [23].

2. A clinical case

The following clinical illustration comes from the treatment of a woman diagnosed with recurrent major depressive disorder with psychotic symptoms. The patient was treated for 4 years with psychoanalytic psychotherapy conducted twice weekly.

Ms A started her psychotherapy when she was 27 years old. She decided to reach for help due to some months of experiencing very low mood which resulted in increasingly strong suicidal thoughts. She consulted a psychiatrist simultaneously to starting psychotherapy and was diagnosed with recurrent, severe depression with psychotic symptoms. For the first time, Ms A was diagnosed with a depressive episode when she was 19 years old. At this time, she had received hospitalization and group psychotherapy.

During the initial interview, Ms A said she experienced a continuous depressive feeling, she felt no hope and lacked any meaning. She said she felt "trapped without any possible exit". Sometimes she felt she was "behind a glass screen", which prevented her contact with other people. Due to those experiences, she was afraid she would be going insane. She hated herself for this condition. She was considering suicide, and she was able to stop herself from taking her life only because she felt she would hurt other people by doing so.

With strong emotions, Ms A presented some background regarding her family history and her own past. Since she remembered, she felt out of touch with her mother, who, as she perceived it, had not been able to understand Ms A as a child. The patient's mother suffered from an undiagnosed mental illness, which presented in an intense tendency to withdraw from contact with the world. Her mother had never worked, though when she had felt better, she had taken care of the household. Ms A spoke of her mother in a cold manner, sometimes she sounded contemptuous. In her childhood, she had perceived her father as a hero, a role model, and a protector, despite the fact that he had often argued

with her mother and drawn Ms A into those quarrels. She felt deeply disappointed in her adolescence, when she realized that her father provided only intellectual, pseudo-ideal solutions, while he was not interested in her emotions. Ms A graduated from high school and moved to another city to start her studies. She had a part-time job, but when she got into some financial troubles, her father told her he could not help her in any way – and insisted that she had to quit her studies. Ms A suffered a depressive breakdown, underwent a brief hospitalization and started a group therapy on a day-care ward. She started a relationship with an older man, whom she perceived as a supportive partner. She moved to his place and started another job but ever since she felt an intense emptiness inside. This recent crisis started when she lost her current job. She felt totally worthless, and looking back at her life she found that it was devoid of any meaning - she had achieved nothing, she was going nowhere. Her feelings intensified. She was terrified of her own emotions, so she decided to seek therapy. It could be noted that Ms A's life contained many experiences of loss, disappointment, and disillusionment, which corresponds with idea of the "loss of a loved object" as a source of internal depressive disaster [11]**.**

Apart from low mood, depressive feelings, and emptiness, Ms A suffered from somatic symptoms, typical for more severe depressions, though not so obviously connected with depression from the perspective of an outside observer. She experienced hypochondriac fears: she was afraid not only of mental illnesses, but also of various somatic diseases like cancers. Sometimes she experienced acute, agoraphobic panic attacks, especially when she had to move far away from her home. She also often found herself in states which she called "lagging": for example, she discovered she had spent a few hours in front of her computer, thoughtlessly scrolling through job offers. "Lagging" can be conceived as a dissociative experience, stemming from the psychotic part of Ms A's mind**.**

A common feature of Ms A's symptoms was a tendency to experience very strict, punitive thoughts about herself, which achieved a quality and strength of delusion.

Devastating self-accusations: a psychotic thread

In my perspective, the factor responsible for the severity and chronic quality of Ms A's symptoms was her tendency to employ devastating self-accusations. It was an area of her functioning which can be called a psychotic area of her mind, as it involved delusional beliefs, experienced without any doubt and impervious to contact with reality. I will try to focus on phases of working through this aspect of the patient's depression. Simultaneously, we were engaged in more common therapeutic work, aimed at supporting Ms A's healthier ways of coping with depressive affect and anxiety.

In the first phase of her therapy, Ms A formulated her devastating self-accusations as an absolute truth about herself. She was totally certain she was different than other people, she was a weirdo, a person unable to live everyday life, create relationships or start a satisfying job. She was also

absolutely certain her life would end in a catastrophe and she will become insane sooner or later. The inability to mentalize consequences of loss, i.e. strict self-accusations, led to the creation of a "crushing superego", which was unmentalized and insusceptible to thought but continued to torment Ms A. In my view, this "crushing superego" consisted of both an unconscious, unmentalized experience of abusing and debasing herself – and a conscious experience of this state, which included the sense of catastrophe and being a "weirdo". When Ms A experienced feelings without representations, she could not think about them and thus she had to accept them as a "divine truth" and remained helpless.

In this stage, we were concentrated on the first attempts to create a psychic representation of this area of the patient's experience, in order to gain a possibility to explore delusional beliefs from some distance (this was, of course, possible only in those moments when the patient was not totally immersed in them). The supposition or the image of "being a bad person" has a very different impact than the absolute certainty, experienced delusionally as "an obvious fact". Finally, Ms A was able to formulate an image of "a gang of taunters" - internal voices, or, as she said, "little figures", who suggested her the most negative and catastrophic interpretations of any given event. It needs to be stressed that Ms A had no professional connection with psychoanalysis and psychology, so in spite of a possible association with the well-known idea of the "narcissistic gang" formulated by Rosenfeld [27], this representation was Ms A's original creation. It was her first imaginative representation of the psychotic area of her mind.

In the next phase, Ms A attempted to explore the origins of her "gang of taunters". In those sessions, she spoke at length about her memories from childhood, especially regarding her parents: her omnipotent, ruthless father, who advocated intense work as a response to any problem, and her sick, helpless mother, who did not have any will of her own. Ms A felt that her former unwavering faith in the voices of the "gang of taunters" was connected to the fact that they voiced her father's attitude: which was extremely strict, but in Ms A's view still better than sinking into her mother's illness and helplessness. Our systematic exploration of this area helped Ms A in building a conviction that some alternatives are possible: she can recognize her weakness and need for support without making those feelings the definite proof for her illness and insanity. A crucial aspect of our work on this thread in transference occurred when I decided to lower my fee for Ms A, due to her occupational problems. When Ms A got into financial troubles, she was certain that her problems are tantamount to the necessity of immediate termination of treatment or at least lessening the frequency of the sessions, which in her view would finally prove her destined catastrophe. She expected me to treat her as an internalized father figure, i.e. ruthlessly and coldly, or as an internalized mother figure – i.e. helplessly and passively. When I reacted in a different manner, Ms A could realize that her expectation stemmed from ascribing me some characteristics of her internalized parents, while in fact both feelings of

ruthlessness and coldness – and helplessness and passivity were Ms A's own emotional experience. My attitude, in which I included both Ms A's present weakness and the supposition that she can develop and overcome problems in time (I offered her a reduced fee for 3 months, not forever), was a shocking surprise for Ms A – and she felt deeply moved by this. A close inspection of these feelings helped Ms A in internalizing such an attitude, so she could start treating her problems in a similar manner herself: she started to perceive problems as weaknesses prone to working through, instead of seeing them as a definite proof for her worthlessness.

I will provide an example of a session from the third year of psychotherapy, when our work was focused on enhancing and stabilizing Ms A's ability to think about psychic representations of strict self-accusations – and at the same time we were engaged in threads typical in analytic therapy: exploring issues of dependence and separateness in the relation with the therapist. At that time, Ms A was going through hard times in her life: she was moving, there were important changes in her intimate relationship, and she had some brief occupational problems.

She started the session by saying: “It is hopeless... As it was in the beginning, I'm having some flashes of those horrible, darkest feelings... It all stretches, like a rubber... I thought I'm over this... The hardest part was the night. I couldn't sleep, my thoughts tormented me long into the night. I wasn't thinking about anything particular, I just bullied myself, I told myself I'm in a helpless situation, I have no way out. You know, by day I even tried to explain myself that it needs to look like this, that maybe I'm going through unstable times, but in the evening I lost my strength and these thoughts got me. They tormented me today as well, I was doubting if I'm able to come to your office today, but I managed to convince myself. Today I hear my gang very clearly, they are continuously debasing me... I started by saying that it is as it was in the beginning, but this is not true, I still have the other perspective... Sometimes I can think that these are just shitty times, I can recognize that from distance many things look a lot better. I also thought for a while that we're going to meet today and you can help me in some way... But this is so damned hard... I hoped this wouldn't be so hard anymore”.

In my response I have tried to support active recognition of real-life difficulties and emphasize possible reactions which Ms A has discovered: the reaction of the “gang of taunters”, which stemmed from the psychotic part of her personality and ignored reality (the temporary character of problems); and the alternative possibility of making use of the therapeutic relationship and her own resources to survive troubles without experiencing them as infinite and without blaming herself. It was important for me not to overstate neither the part about resources nor the part about difficulties and to present a picture of Ms A's state that was as full as possible. So I said:

“I have no doubts that you are going through objectively hard times: loss of job, move, changes in your relationship; you feel a lack of support, are alone among cardboard boxes. But I also feel that

you are talking about different reactions to those objective difficulties: at the main stage there is a reaction of the “gang of taunters”, a commentary that everything falls into pieces, once again your life is falling apart. But you also find another perspective, a feeling that you can have some support in therapy and in yourself and that you are not alone in your troubles, not so helpless. I think that your feelings can be very mixed: a lot of disappointment in me and therapy, but also some trust and hope for being helped”.

The patient said that the “gang of taunters” was stronger at that time due to her real-life problems. She talked about this for some time and then she added: “And this disappointment included you as well, just as you said: when I felt so terrible at night, I could think about you, but this didn't help, because I thought that right here, right now, I'm on my own. And on my way to the session today I had such complicated feelings. On the one hand, the gang told me that the crazy lady is going to treat her head again; but on the other hand, I just wanted to see you because I hoped I would feel better.” I answered her: “I think you are talking about being able to feel that there is someone who really thinks with concern about your life: being able to feel this not only in your internal life, in thoughts and feelings, but also in real, live contact. So I think maybe you came here to experience this feeling, not to be cured with my therapeutic magic”. The patient apparently relaxed and said: “Yes, it's true. I needed to have contact with you”.

From this moment in the session, Ms A started to elaborate on a potentially new relation and her hope to get into a relationship with a man she found interesting. At the end of the session I wanted to address her separation feelings and to support her ability to consciously experience loss and to think about this, thus I said (in the context of the meetings with her potential new partner): “I suppose it is similar here - you perceive me as a close person when we are physically together in this room, but I can imagine that as you leave this room, the “gang of taunters” might pull you into feeling lonely and hopeless”. The patient said: “Ha, this is a good remark: I really feel better after talking to you, but I guess when I leave and get back to my move and boxes, I will feel all alone again, as you will not put these boxes into the car with me... You know, I've tentatively arranged a meeting with a close friend tomorrow evening, I thought after the move we can get together, I really need this. But on those waves of darkness, I felt that maybe this is hopeless, I feel my head starts hurting, tomorrow it will hurt much more, I will only complain, maybe I will cancel the meeting with my friend. But now I feel that it is important not to cancel this meeting, and not to be alone in my new apartment. I will meet her even if my head hurts, maybe I will complain about my head, tough luck, but I really feel intensely that I need to be with someone, especially after the move: I still have the weekend in perspective and unpacking all those things, maybe I need to do something for myself”.

I experienced this as an expression of the patient's increasing ability to make use of supportive relationships with others due to being able to imagine the potential influence of "crushing self-accusations" ("a wave of darkness", a hurting head and "complaining") and to better understand the role of live contact with people (not only a therapist) in fighting off those feelings.

In the final phases of the therapeutic work, we focused mainly on Ms A's taking responsibility for her former submission to the "gang of taunters" and on accepting this area of her mind. She felt supported and encouraged by the fact that the development of the healthier part of her mind has weakened the domination of the psychotic part. Taking responsibility for this aspect of her mind included developing new perspectives of perceiving Ms A's parents and their place in her personal history. She was able to recognize positive aspects of her parents (the intellectual curiosity of her father and the simple, good-willed care of her mother, within her possibilities) and to experience compassion towards their situation in the past. With considerate sadness she stated that things happened the following way: the "gang of taunters" had had the upper hand in her mind for many years, but there was no-one to blame for this, and now she was just happy not to feel so helpless any more. Ms A's acceptance of the area of her mind linked with inadequate, strict self-accusations was founded, as noted above, on a growing ability to resort to her healthier aspects. This was also strongly backed by our work in transference. In retrospect, Ms A remembered that in her view, among the most important moments in therapy were those sessions when she felt ongoing waves on devastating self-accusations that rendered both of us helpless. Ms A felt that I was not able to help her at those moments, but she was surprised to recognize that I was still trying to understand her and I was willing to see her again and again. This helped her in transforming her view of a "flawless therapist", always knowing what to say – into a "good-enough therapist", who sometimes has no idea what to say, but is generally helpful. Ms A could accept that sometimes I might be powerless when faced with her delusional beliefs, but after some time I was able to offer her a useful comment – and she started to treat her problems similarly, as temporary states rather than a total disaster.

Pharmacological therapy

During the initial interviews, Ms A asked me if it was all right that she had made an appointment with a psychiatrist, since she experienced suicidal thoughts. I emphasized Ms A's fear of her own impulsiveness and loss of control and I encouraged her to see the psychiatrist. Ms A told me she felt deeply relieved by my reaction. Then she went on to tell me that 2 months before she had called me, she had seen another psychologist, who had told her that since Ms A was planning to commit suicide, she (the psychologist) could not help her and a psychiatrist would be the only option. Ms A did not go to a psychiatrist, but also did not visit the psychologist again, as she felt that the psychologist was terrified of her condition.

It needs to be stressed that the psychologist reacted in an adequate manner when she suggested a psychiatric consultation when faced with suicidal thoughts. Her intervention might have been ineffective because it was not complete. Perhaps Ms A needed a response which would have included recognizing both the psychotic aspect of her mind, which required a psychiatric intervention and pharmacological help, and the non-psychotic aspect, which was prone to emotional development and able to make use of psychological or psychotherapeutic help.

Encouraged by me, Ms A started pharmacological treatment simultaneously to starting her psychotherapy. At first, the fact of using drugs became a source for self-criticism and catastrophic visions. She wondered if she was already playing the role written by previous generations of her family, becoming crazy, beginning a life-long drug treatment. It can be said that in the first phase of psychotherapy, Ms A's pharmacological therapy became an additional source of her devastating self-accusations. Intense psychotherapeutic work on this experiences has helped the patient in building trust towards psychiatric treatment. When Ms A managed to question her strict, self-accusative beliefs, she could recognize facts which she had formerly completely ignored: psychiatric drugs were directly helpful, as they stabilized her mood and gave her some energy – and she was treated with moderate doses. When Ms A allowed herself to more trust towards the benefits of using drugs, she was able to recognize her ability to function without drug treatment. During the next months of psychotherapy, Ms A broadened the area of acceptable experiences and tolerable emotions, which made her think she could try even smaller doses, and to finish her pharmacological treatment after a few more months, all this in close cooperation with her psychiatrist. Her drug treatment lasted for a year and in retrospect, it might be said that it was an important part of her improvement for at least two reasons. In the first phase of therapy, drugs made Ms A feel more secure, as they reduced the risk of impulsive reactions to strict self-accusations (e.g. suicide), while in later phases, drug therapy became another domain in which Ms A learned to perceive her development in a new manner: from the state of weakness and helplessness (the need to use drugs), through making use of support and help (the choice to use drugs), to the feeling of ability and independence (the choice not to use drugs). After finishing her drug therapy, Ms A felt intense pride and treated this moment as an important step towards health. She felt similar emotions when she ended her psychotherapy, which followed along the same line of emotional development.

It needs to be said that my supportive attitude towards pharmacological therapy, in which I stressed both immediate, positive effects and its meaning for the emotional development, were reflected by the psychiatrist's attitude, as she (the psychiatrist) always encouraged her patients to continue their psychotherapy, even after termination of drug therapy.

Benefits of long-term psychotherapy in the treatment of psychotic aspects of depressions

Ms A's psychotherapy lasted for 4 years, with sessions twice weekly. It can generally be said that first year of psychotherapy, supported by pharmacological therapy, allowed to successfully overcome the present, severe episode of depression, while the following three years served to work through the reasons of the recurring depression: grasping the psychotic mechanism of devastating self-accusations, supporting the non-psychotic aspect of her personality and developing more mature ways of coping with feelings of weakness, incompetence, and failure.

In the context of psychoanalytic theories of psychic change, it can be said that this second, longer part of therapy served to strengthen Ms A's ego [28], build more stable and secure object relations [13] and develop containing abilities [29]. But I suppose that the most vivid picture of emotional development and psychic change was provided by the patient herself, who has created a specific, metaphorical image, which has surfaced along various phases of our work. In the first year of therapy, focused on the current depressive episode, the patient said she was "broken" and that "no-one could fix her". She had some hopes, though, I would be able to fix her: she told me that drugs helped her cope with everyday life, but she needed fixing, so she came to me. After her depressive symptoms clearly lessened, she felt she was "fixed", but she was afraid – I suppose she was right – of "getting broken again and again". So she decided to continue her psychotherapy, because she hoped to become more proficient at recognizing those "defects" and "repairing them" herself.

During one of the sessions in the most intense phase of psychotherapeutic work, at the break of the third year of therapy, Ms A said: "I imagine it like this: previously, I often felt that you have this big shed with tools here. I came here with broken things, and you fixed them with your tools. And I thought some day we would say goodbye, you would give me a small hammer, but this wouldn't help a bit, because things would get broken again, and I don't have my own tool shed. And now I feel that I come to you and we fix things together: we use your tools, but the most important thing is that we fix them together, I'm learning to fix things, and I will gather my tools even though it requires some time".

When we decided to terminate the psychotherapy, Ms A said that she had her own toolbox. She expected that every now and then things would get broken inside her and she would have to make some fixes. But she felt secure and satisfied as she was sure she had gathered enough tools and, most of all, learned how to use them. We both were able to comprehensively elaborate feelings included in this vivid image: Ms A could accept the inevitability of failures, temporary states of weakness and incompetence ("defects"); she felt she had the ability to contain and process those feelings in a constructive manner ("tools"); and thus she felt no longer prone to the delusional state of a certain disaster ("being broken beyond all fixes").

A brief summary of external gains from psychotherapy seems to suggest that this was a good-enough treatment. At the end of the second year of therapy, Ms A started her studies again, as she had always dreamed of. She was able to continue her studies in spite of inevitable difficulties and occasional failures. At the same time, she stabilized her occupational situation, which was based on her growing, stable belief that she can work even when she feels depressed. In the third year of treatment, Ms A focused intensively on attempts at fixing her relationship, which seemed to function well as long as she was dependent on her partner. The relationship shook in its foundations when it occurred that Ms A did not feel submissive any more and wanted to include her developmental needs (a marriage and a child, at thought which her partner jibed at). Finally, she decided to end this relationship. For some time she lived single-handedly in a rented apartment, making a living on her own and continuing her studies. Going through these hard times and perceiving them as problems to overcome, not as a proof of her worthlessness, was an extremely important experience for Ms A. After some time, she started to build a new relationship, in which she felt a worthwhile person on her own: she felt she wanted to be with her partner, though she was able to live alone (in her former relationship she was convinced she would be utterly lost if she was alone).

At the moment of termination, Ms A had not experienced depressive symptoms of clinical importance for two years. In the last sessions, she contentedly said that now she had just normal problems – sometimes she just had a bad day and an awful mood.

3. Summary

This article describes a clinical case of effective psychotherapy of a patient suffering from recurring depression with psychotic qualities. I have described a way in which the psychotic aspect of the patient's mind cast has been expressed in Ms A's functioning. At the moment of the beginning of the psychotherapy, Ms A experienced a delusional belief of being destined to disaster, being worse than other people and guilty of all her failures. These delusional beliefs were impervious to contact with reality (facts from occupational and social life of Ms A) and characteristic to psychotic functioning in their totality and boundlessness. The chronic quality of Ms A's depression was linked, among other things, to the fact that psychotic, devastating self-accusations pushed her to factual withdrawal from reality, which in turn supported and strengthened the domination of the psychotic aspect of her mind to the point where suicidal thoughts intensified. The basic psychotherapeutic aim in this area of mind was to co-create a psychic representation (image) of her experiences, which had previously been devoid of a consistent representation and thus insusceptible to psychological work. These representations have gathered emotional meaning in the context of psychotherapeutic work and events in psychotherapy, which involved authentic, painful feelings of uncertainty and helplessness on

part of the patient and the therapist. The four years-long therapy was terminated after the patient had been free from clinical symptoms of depression for two years, her external life had undergone significant, positive (from Ms A's point of view) changes, and her internal world had been enriched by a growing ability of making her own psychological work on difficult feelings, including residues of inadequate self-accusations.

From the perspective of internal relations, it can be said that the success of the clinical work was also based on transforming internal object relationships, which has led to a better ability to mentalize the experience of frustration and loss, without the need to turn aggression to the inside. I think that those changes were bi-directional: the creation of psychic representations of self-accusations and guilt feelings have allowed to think and talk about these experiences in the context of a supportive, emotional relationship with the therapist and to experience and internalize a relationship with the good object – while the emotionally supportive therapeutic relationship has helped the patient in a more trustful exploration of her massive self-accusations and self-regret.

This clinical case has served as a practical example of applying psychoanalytic psychotherapy to treat a recurring depression with psychotic symptoms. According to contemporary knowledge and above cited recent research data, long-term psychoanalytic psychotherapy is an effective way of treating severe depression and leads to persisting, positive effects both in symptomatology and in general psychic and social functioning. One dimension of the psychoanalytic approach is the link between the technique of therapy and theoretical premises. I have presented a few brief, important psychoanalytic ideas which my work with Ms A was based on. These ideas included a classic psychoanalytic view of depression as difficulty in coping with loss, which leads to turning aggression to the inside; the differentiation between normal, neurotic and psychotic depression; and the idea of psychotic functioning as an aspect of mind which is withdrawn from reality. Clues for the technique of therapy were derived from these theoretical premises: the point of focus was a transference relationship used to support the co-creation of representations of feelings that had lacked representations and thus were not susceptible to psychological processing. I have used the example of Ms A's treatment to present a practical, clinical example of effective psychotherapy of severe depression based on recent research results, theoretical background and technical clues.

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