Chapter 9
Complex Depression in High-Pressure Care Settings: Strategies and Therapeutic Competences

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Abstract As shown in this volume and others in this series, it is untenable nowadays to regard depression as a unidimensional phenomenon in terms of diagnosis and treatment. The notion of *complex depression* is closer to the clinical-etiological reality of the disorder and also provides a clearer impression of what professionals must deal with in highly demanding settings, including primary care (PC). This is especially true in low-medium-income countries (LMICs), where patients with complex depression are often likened to those who mental health practitioners call "difficult patients." From this perspective, the present chapter addresses complex depression and highlights its heterogeneous nature, marked by the functioning of patients' personality structure, depressive experience style, suicide risk, contextual factors, and medical comorbidities that have an impact on their response to treatment. After discussing how the treatment context and the characteristics of the professionals who treat these patients interact with the aforementioned factors, we present a model for the psychotherapeutic management of complex depression in high-demand settings, with an emphasis on the handling of personality dysfunctions.

Keywords Complex depression · Psychotherapy · Strategies · Competences · Institutional settings · Primary care

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9.1 Complex Depression

9.1.1 "Complexity" in Healthcare: Towards Personalized Treatment

The Cambridge English Dictionary (n.d.) defines complexity as "the state of having many parts and being difficult to understand or find an answer to," which applies to the multiple factors that influence depression in terms of its etiology, evolution, clinical manifestations, prognosis, and differential responses to treatment. In medicine in general and mental health in particular, the issue of complexity has been hard to define, conceptualize, operationalize, and study. Complexity and its effects on outcomes have posed a challenge to medicine (Safford, Allison, & Kiefe, 2007) inasmuch as clinical guidelines, for instance, guidelines for diabetes, hypertension, or depression, mention diagnoses but tend to exclude factors that "increase patient complexity." These factors include comorbidities, patient preferences, or value systems that may influence treatment adherence, barriers preventing access to treatment, socioeconomic contexts keeping patients from following medical suggestions (e.g., more expensive diets), and obstacles put in place by the medical institutions and practitioners in charge of these patients. Several authors have advanced models of complexity that extend beyond "comorbidity" and mere descriptions, such as the cumulative complexity model (Shippeea, Shaha, Mayc, Maird, & Montori, 2012) or the vector model put forward by Safford et al. (2007), who assert that determinants of health such as socioeconomics, culture, biology/genes, environment/ecology, and behavior have a differential "weight" (vectors) in the determination of the outcome of each case. Since these vectors are interrelated, much like a network, a factor influencing one of them will have an impact on the rest of the vectors and ultimately on the outcome. Thus, regarding the complex determinants of depression, psychotherapy – by influencing internal constructs and/or behavior – can have a positive effect despite the burden that other determinants may be exerting. We agree with the latter authors when they state: "Whether the provider and healthcare system prove helpful or effective depends upon both (1) the complete assessment of the patient's complexity, and (2) the provider and healthcare system being equipped to respond" (Safford et al., 2007, p. 383). This is an interesting point given that, as we will discuss in a later section, providers must possess the necessary competences to address patients' requirements. The authors also note that "an important goal of the medical encounter is for the doctor and patient to develop 'congruence,' or a shared view of realistically attainable health care goals" (p. 384). This notion, taken to the domain of psychotherapy, is consistent with evidence-based psychotherapy practice (APA, 2006; Mulder, Murray, & Rucklidge, 2017), which requires taking into account the patient's preferences and background in every indication process. An inevitable conclusion of this perspective is what the authors refer to as "trade-offs" in the indication process; in other words, they suggest that it is advisable to include not only the patient's factors, preferences, and culture but also the conditions that the institution and the practitioner can realistically offer. This is relevant in high-pressure care

settings (HPCS), especially in low- and middle-income countries (LMICs), where the treatments offered must often be adapted to the socioeconomic reality of both patients and healthcare institutions. In mental healthcare, trade-off indication is related to the concepts of "adaptive indication" (Thomä & Kächele, 1987), responsiveness in psychotherapy (Stiles, Honos-Webb, & Surko, 1998; Stiles & Horvath, 2017), and responsiveness in treatments for depression (Hardy, Stiles, Barkham, & Startup, 1998). These approaches converge in the concept of personalized medicine (Hassler, 2010), and, in the psychotherapy field, they are associated with a treatment that is tailored to the patient and his/her depressive style, for instance (Blatt & Luyten, 2009; Luyten & Blatt, 2007, 2011; Luyten, Fonagy, Lemma, & Target, 2012), or, more specifically, adapted to his/her dysfunctions. One such approach is exemplified by the contemporary perspectives of the NIH Research Domain Criteria, which refer to functional domains to be studied (and eventually treated). The psychotherapeutic perspective adopted in this chapter is specifically this adaptive, negotiated trade-off indication, which attempts to focus on the specific dysfunctions of each depressive patient in a given context.

9.1.2 Complex Depression and Its Determinants

Complex-depression patients who seek mental health treatment in HPCS, especially in LMICs, can be likened to those who clinicians and the literature refer to as "difficult patients" (Koekkoek, van Meijel, & Hutschemaekers, 2006; Moukaddam, Flores, Matorin, Hayden, & Tucci, 2017; Ruscio & Holohan, 2006). The determinants of complexity identified in the literature are ascribed to a) the patient and his/her context, b) the healthcare institution where the patient is treated, and c) the mental health professionals in charge of the treatment.

9.1.2.1 Patient Determinants

Personality: Disorders, Dysfunctions, Styles

The complexities derived from the clinical presentation of depression (e.g., recurrent depression, dual depression: dysthymia + major depressive disorder) are covered in other chapters and/or books of this series. However, depressive disorders are among the most frequent comorbidities in patients with borderline personality disorder (BPD, Leichsenring, Leibning, Kruse, New, & Leweke, 2011). This is not only due to their etiological risk factors, but is also a consequence of the overlap of symptoms in both disorders, for instance, affectivity alterations (dysregulation) or suicidal ideation (Behn, Herpertz, & Krause, 2018; Köhling et al., 2015; Leichsenring et al., 2011). The prevalence of these symptoms is such that some authors have advanced the concept of "bipolar depression," a specific phenomenology of depression in borderline personality disorder (BPD) (e.g., Gunderson & Phillips, 1991;

Paris, 2010; Silk, 2010). To date, the categorical view of personality disorders (PD) has facilitated clinicians' communication about patients while also simplifying research and treatment recommendations; however, this approach has several disadvantages such as not considering the high (pseudo) comorbidity observed, the excessive heterogeneity of its categories, the lack of a clear delimitation between what is normal and what constitutes a personality disorder, and clinicians' dissatisfaction with its usage (Clark, 2007; Trull & Durrett, 2005; Widiger & Samuel, 2005). Based on these limitations, there is consensus among authors regarding the need to generate dimensional models focused on identifying the dysfunctions that underlie categorical diagnoses, as this approach should provide a clearer picture of the phenomenon of comorbidity (Safford et al., 2007). This type of diagnosis makes it possible to identify functioning profiles and better reflect the heterogeneous presentation of the symptoms, in this case, those of patients with complex depression. Section III of the DSM-5 (American Psychiatric Association, 2013) and the chapter on PD and related traits in the recent version of the ICD-11 (World Health Organization, 2018) have furthered this dimensional perspective. Both models make it possible to identify generic traits, establish the severity of personality disorders, and study maladaptive functioning. Diagnosis makes it possible to establish deficiencies in both self-functioning and interpersonal relationships (Zimmermann, Kerber, Rek, Hopwood, & Krueger, 2019). A similar diagnostic approach was advanced in the 1990s in Germany: the Operationalized Psychodynamic Diagnosis (OPD Task Force, 2008), which enables practitioners to perform a thorough dimensional diagnosis of the affected functions. The functions evaluated are grouped into four domains: perception/cognition (self-perception and object-perception), regulation (self-regulation and regulation of relationships), communication (internal and external), and attachment (to internal objects and to external objects). Each of these functions has subfunctions that can be measured (see table 1). The separate diagnosis of these functions, which will be described in a later section, makes it possible to estimate an overall level of personality functioning (high integration, moderate integration, low integration, and disintegration). From the perspective of the OPD, patients previously described as "difficult" are those who, apart from having depressive symptoms, have a personality functioning that only allows them to access limited or reduced psychic capabilities or functions to maintain or recover their functional balance in response to internal or external stressors of everyday life, especially those of an interpersonal nature. These people have been unable to develop these functions because they have lived in extremely adverse environments, especially in early childhood, or have grown up in settings marked by conflicts that affect later phases of development, limiting the availability of these functions (OPD Task Force, 2008; Rudolf , 2013).

Clinically, these patients have limited or nonexistent psychic space for self-reflection, being affected by an unstable and shifting self-image or even identity diffusion. Furthermore, the topics of their internal conflicts take on a destructive character or become unrecognizable, becoming permanent conflicts with the outside world. These patients may also have permanent impulse regulation deficits or constrictions with intermittent regulation failures. Their main anxieties revolve

around losing meaningful relationships or being hurt by the loss of strongly idealized or strongly devalued people. Affective contact may be either limited and flat or easily overwhelmed and barely tolerant of negative effects. Apart from the complexity that these patient features impose on therapeutic strategies, they activate strong experiences in the therapists that are hardly understandable from the patients' perspective; rather, they generate astonishment or even violence in the therapists (OPD Task Force, 2008).

The concepts of dependence and self-criticism, which constitute another perspective on personality functioning, have also come to be regarded as a vulnerability factor for depression (e.g., Blatt, 2004; Mandel, Dunkley, & Moroz, 2015). These styles were covered in the previous chapter; however, it is worth remembering how they determine different levels of susceptibility to stressors (e.g., abandonment in dependent style, failure in self-critical style) as well as differential responses to treatment: self-critical patients, for instance, display more depressive symptoms at the start of treatment than dependent ones (e.g., Dagnino, Pérez, Gómez, Gloger, & Krause, 2017; de la Parra, Dagnino, Valdés, & Krause, 2017) and show poor response to cognitive behavioral therapy (CBT), interpersonal therapy (IPT), medication, and placebo pill (Blatt, Quinlan, Pilkonis, & Shea, 1995; Chui, Zilcha-Mano, Dinger, Barrett, & Barber, 2016; Marshall, Zuroff, McBride, & Bagby, 2008). Studies conducted by the Chilean Millennium Institute for Research in Depression and Personality (MIDAP) indicate that more self-critical subjects show greater reactivity to stress, less subjective awareness of stress, and reduced performance in general tasks, as well as higher dropout rates (Mellado et al., 2018) and a poorer response to various psychosocial interventions compared to highly dependent patients. Regarding these patients' personality functioning, it was observed that more self-critical ones displayed lower levels of personality functioning integration; specifically, they showed more vulnerabilities in attachment to internal objects (see later section) compared to more dependent patients, who displayed self-perception and relationship regulation vulnerabilities (Dagnino et al., 2018).

Socioeconomic and Gender Determinants

Well-known studies (Hidaka, 2012; Moyano & Barría, 2006) have shown a link between GDP per capita and depression and suicide risk: wealthier countries tend to display higher depression prevalence. As economic growth causes formerly traditional, community-centric societies to become individualistic and competitive, depression seems to increase (Kato & Kanba, 2017; Krause et al., 2015; Orchard & Jimenez, 2016; Patel et al., 2018), especially when perceived inequity is heightened (Jiménez, 2020). Chile, a LMIC that has gradually shifted towards individualism, is a case in point (Jiménez, 2020; Krause et al., 2015). Like the per capita income, perceived inequality and subjective and social distress have increased (PNUD, 1998, 2017). Depression has also risen, reaching 6.2% of the population and surpassing the global rate (4.4%; WHO, 2017). The prevalence of depression in Chilean women is five times higher than in men (10.1% vs. 2.1%), with low-income women

displaying the highest depression indexes (ELSOC, 2018; Patel et al., 2018). Thus, in LMICs, it is these women – who are more likely to have complex depression and be difficult patients – who will seek help in HPCS and primary care (Levy & O'Hara, 2010). To get there, they will need to overcome barriers to access determined by their context, such as difficulties finding someone within their support network to care for their children, problems obtaining work leaves, insufficient funds for transportation, and sometimes the inability to pay for their treatment. Furthermore, patients may also be affected by institutional barriers, as will be shown in the next section. Barriers to access are also a result of the patients' value system or bad therapeutic experiences that cause them to expect little from psychosocial treatments (Krause, 2005; Rojas et al., 2015; Zúñiga, 2019).

9.1.2.2 Other Factors That Add Complexity to Depressive Patients Seeking Help in High-Pressure Care Settings: Comorbidities, Suicidality, and Adverse Childhood Experiences

The relation between somatic comorbidities and depression is complex and bidirectional. According to the 2007 World Survey conducted by the World Health Organization (WHO, 2007), 9.3% to 23% of the respondents with one or more chronic diseases also had depression, a significant difference compared to the percentage of subjects who did not suffer from a chronic physical disease. The survey, which covered 245,404 people in 60 countries, also demonstrated that subjects with depression plus a chronic physical disease had the poorest health indexes in relation to those with other morbid states or depression alone. This association between chronic disease and depression is observable across different cultures and primary care levels (Kilzieh, Rastam, Maziak, & Ward, 2008; Martínez et al., 2017). In patients with multiple comorbidities, depression appears to be the most common pathology (Sinnige et al., 2013). Similarly, patients treated and diagnosed with depression in high-pressure care settings, such as primary care centers, display high comorbidity levels (Martín-Merino, Ruigómez, Johansson, Wallander, & García-Rodriguez, 2010). This is exemplified by Martínez et al. (2017), who examined a sample of 256 patients diagnosed with depression and found that 78.13% of them had one or more comorbidities: physical (29%), psychiatric (46%), or physical and psychiatric (25%). In primary care, one of the most common psychic comorbidities is anxiety disorder (Martín-Merino et al., 2010; Olfson et al., 2000), which hinders the prognosis of these patients. In brief, the high prevalence of comorbidities, especially in high demand settings such as primary care, makes it necessary to integrate physical and mental health effectively (Martínez et al., 2017).

Suicidal behavior, in its multiple manifestations, is a multifactor phenomenon that combines common factors and singularities. It tends to appear alongside psychiatric pathology and symptomatology, especially alcohol consumption disorders and depression (Bostwick & Pankratz, 2000; Schneider, 2009), significantly increasing suicide risk when accompanied by comorbidity (Cavanagh, Carson, Sharpe, & Lawrie, 2003). The multiple risk factors affecting people, from the social to the

individual, interact in complex and unique ways, progressively affecting them until suicide ideation and/or a suicide attempt occur. Suicide attempt survivors report a trajectory of harmful experiences throughout their lives (Morales, Echávarri, Barros, Zuloaga, & Taylor, 2016). These accumulated experiences are triggered by an event that leads the subject to a categorical confirmation, of a depressive nature, that there is no way out. The person, unable to cope with this situation, attempts suicide. The suicide attempt generally has an underlying intention that may be ambivalent (e.g., seeking help, making a statement, and, at the same time, running the risk of dying); alternatively, the person may be determined to die, expecting the attempt to result in his/her own death (Morales et al., 2016). It is not possible to predict suicide attempts: they are contingent on a temporal condition that can flare up at any given time, being highly sensitive to a person's current state of mind (Fowler, 2012). However, clinical experience and research show that it is possible to prevent states of distress prior to a suicide attempt (Barros et al., 2020). In this regard, psychotherapeutic interventions aimed at preventing suicide attempts are largely focused on detecting depressive states and emotional dysregulation, emphasizing the strengthening of protective factors and the recovery of weakened aspects that could be worked on and trained through psychotherapy. This approach, depending on each individual case, focuses on self-knowledge, emotional regulation, and the development of skills for life, especially regarding the person's relationship with him/herself and others (CONADIC, 2010).

With respect to early adversity, available evidence indicates that it is linked to various mental pathologies in adulthood (Fernandez et al., 2018; Gilbert et al., 2009; Li, D'arcy, & Meng, 2016), including personality disorders, depression, anxiety disorders, and post-traumatic stress disorder, among others (e.g., Adams, Mrug, & Knight, 2018; Comijs et al., 2013; Cougle, Timpano, Sachs-Ericsson, Keough, & Riccardi, 2010; Pajer et al., 2014; White, 2011). It has also been demonstrated that the course of depression, as well as its clinical presentation and treatment response, differs among depressive patients with and without a history of trauma (Chapman et al., 2004; Martins-Monteverde et al., 2019; Vitriol et al., 2014; Vitriol, Cancino, Ballesteros, Núñez, & Navarrete, 2017). The importance of the relationship between early adversity and depression has been examined in detail elsewhere in this book.

Complex Depression: Empirical Profiles

Some authors have studied complex depression from an empirical perspective. For instance, Ruscio and Holohan (2006) proposed a list of over 40 factors that characterized complex cases, grouped into several topics such as symptoms, security, physical aspects, intellectual aspects, and personality. Employing more complex analyses, in an ongoing investigation conducted by one of the authors of this chapter and colleagues studied 251 patients of outpatient clinics with a depression diagnosis. A machine learning procedure has preliminarily revealed three depression profiles, one of which displayed a high level of depressive symptomatology associated

with adverse experiences in childhood, a low level of personality functioning integration, a high level of self-criticism, somatization, and limited social networks and low satisfaction with them. This profile was labeled "complex depression" by the authors, being significantly different from the moderate and mild profiles. The moderate profile is characterized by a significant level of physical negligence in childhood, while the mild profile displays multiple satisfactory social networks. It should be noted that certain elements of personality, empirically verified through complex profiles, can be relevant variables when identifying complex depression. In this case, a higher level of self-criticism and a lower level of personality functioning integration, as shown above, interact in specific ways and lead to relevant therapeutic consequences.

Delgadillo, Huey, Bennett, and McMillan (2017), using a similar approach, examined the clinical records for 1512 patients and reported that complex cases are characterized by the presence of measurable factors in several domains: clinical, demographic, characterological, and attitudinal. This complexity also affects the prognosis, as more complex patients benefit from high-intensity therapies (vs low-intensity ones), especially in terms of depressive and anxious symptomatology. These studies make it possible to promptly identify complex cases and match them with interventions suited to these patients.

Institutional Determinants

High-pressure care settings, including primary care, often have waiting lists, lack professionals, and employ treatment models that do not meet the psychosocial requirements of mental health treatment: patients cannot get weekly sessions, sometimes they are not treated by the same therapist, or the sessions are too brief (de la Parra, Errázuriz, Gómez-Barris, & Zúñiga, 2019; Fischer, Cottin, Behn, Errázuriz, & Díaz, 2019; Koekkoek et al., 2006; Moukaddam et al., 2017; Rojas et al., 2015). Despite having clinical guidelines for depression treatment, these institutions often lack treatment models to deal with complex patients (Fischer et al., 2019; Koekkoek et al., 2006; Martínez et al., 2017; Zúñiga, Núñez, Araya, de la Parra, & Taubner, 2019). Thus, patients describe their psychotherapeutic experience in primary care as "just talking," without reporting a therapeutic effect derived from these sessions with a professional (Koekkoek et al., 2006; Rojas et al., 2015; Zúñiga, 2019; Zúñiga, Balboa & de la Parra, 2018). Therapists in these institutions complain about their working conditions: heavy workloads, productivity pressure, excessive paperwork, insufficient supervision, and a lack of recognition from professionals who do not work in mental health (Fischer et al., 2019; Haas, Leiser, Magill, & Sanyer, 2005; Koekkoek et al., 2006; Zúñiga, Balboa & de la Parra 2018).

Practitioner Determinants in Institutional Contexts

Especially within the context of primary care, depression management tends to be unsatisfactory and ineffective both in industrialized countries and LMICs (Araya, Flynn, Rojas, Fritsch, & Simon, 2006; Neumeyer-Gromen, Lampert, Stark, & Kallischnigg, 2004). One of the possible underlying factors of this situation is the lack of qualified professionals with the necessary competences and training to handle mental health disorders and address these patients' contextual factors (Patel, Chowdhary, Rahman, & Verdeli, 2011). In general, mental health specialists are less integrated in these settings, which forces clinicians (who are not experts) to treat more complex patients unaided (Rubenstein et al., 1999). Authors have shown that physicians (GPs) find it hard to diagnose depression, underestimating its severity and considering that their competences are limited (Acuña et al., 2016; Alvarado & Rojas, 2011; Burroughs et al., 2006; Shah & Harris, 1997). This situation, compounded by a negative attitude towards diagnosing depression, results in unsatisfactory clinical performance (Dowrick, Gask, Perry, Dixon, & Usherwood, 2000; Haddad et al., 2011). Therefore, GPs are more likely to act intuitively and often avoid diagnosing depression, as they feel that they cannot offer their patients anything better due to their limited training in therapeutic interventions, short time per session, and the impossibility of referring them to a psychologist or to secondary level care due to long waiting lists, among other aspects (Burroughs et al., 2006; Chew-Graham, Mullin, May, Hedley, & Cole, 2002).

It has also been observed that depressed patients prefer to be listened to and do not only wish to receive medical treatment for their depression; in this regard, they complain that providers do not listen, lack empathy, or are only interested in filling out their medical records and provide no guidance for their problems (Johnston et al., 2007; Zúñiga, 2019).

Psychological treatments for depression, having been created in high-income countries (HIC) (e.g., cognitive behavioral therapy based (CBT-based) and interpersonal therapy (IPT)), cannot be readily used in LMICs. Although they can be effective after implementing specialized training and supervision for therapists (Patel et al., 2011), it is necessary to adapt them to the contextual factors and characteristics of the community to be treated, considering its expectations and stigmatization regarding the disease (Patel et al., 2011).

In Latin America, most therapists report being psychodynamic (44.8%), followed by cognitive behavioral (31.9%) and integrative or eclectic (20.1%), while a smaller number are systemic (12.7%) and humanist (9.8%) (de la Parra, 2013). This characterization of the theoretical orientation of Latin American professionals will be relevant for the therapeutic model that we will present below.

Although psychologists receive undergraduate-level training in routine practice, authors have stressed that this is insufficient to work as a therapist (Jiménez 1998/2000); also, psychologists working in primary care have noted that undergraduate programs must provide more training in clinical psychology (31.5%), community psychology (16.8%), public policies (15.8%), and primary care management (8.4%) (Scharager & Molina, 2007). In this regard, it has been reported

that primary care psychologists' depression management competences are lowest for "treatment" ($Z < 0.10$), followed by "sociocultural approach," "treatment plan," and "clinical diagnosis" (slightly over 0.20) (Bedregal, 2017). Particularly in depressive disorders, psychotherapeutic competences correlate slightly, but positively and significantly, with better treatment outcomes ($r = 0.28$) (Webb, DeRubeis, & Barber, 2010). Therefore, it can be presumed that, if professionals lack the necessary competences to treat the disorder, they are limiting these users' chances of receiving effective treatment. With respect to the management of difficult patients with personality dysfunctions, it has been reported that, when therapists receive training in personality disorders with the aim of improving attitudes and service provision, they can develop competences such as empathy and the ability to provide a suitable diagnosis, thus increasing the likelihood of a successful treatment outcome (Beryl & Völlm, 2017; Shanks, Pfohl, Blum, & Black, 2011). Beyond competence deficits, therapist experience is another determinant: it has been observed that more years of practice correlate with better therapeutic management of complex patients, better communication, and good respectful interaction (Edgoose, 2012; Hinchey & Jackson, 2011). In contrast, younger clinicians tend to report frustrations, especially physicians who treat patients with psychosocial issues (Krebs, Garrett, & Konrad, 2006). Patients' interpersonal functioning, a major determinant in practitioners' performance, is influenced by dysfunctions associated with their personality structure (e.g., personality disorder) and others derived from their interaction with their providers and their own vulnerable background. These issues trigger feelings of rejection, pessimism, fatigue, and unease in professionals, reinforcing their idea that they are dealing with a difficult patient (Fischer et al., 2019; Koekkoek et al., 2006).

In brief, the evidence reviewed thus far shows how the interaction between patients' variables, their socioeconomic context, and therapists' variables, as well as their work context and competences, interact in the definition of a difficult or complex patient. Clinical complexity can thus be said to be a dimensional measure; that is, patients can be placed along a continuum ranging from less to more complexity (Delgadillo et al., 2017) depending on their accumulation of disadvantages in these multiple domains. Patients, apart from bringing their own complexity, may also react to negative attitudes in practitioners (Fischer et al., 2019), which can be triggered by idiosyncratic reasons or poor working conditions and/or a high-pressure job. Thus, in the interactional model proposed by Fischer et al. (2019) to explain "difficult" patients, the negative effect on the therapist's work and competences derives not only from the patient's characteristics and attitudes but also from the practitioner's feeling that he/she is working in a setting perceived as demanding and unsuitable. As these authors suggest (Fischer et al., 2019), a depressive patient with certain personality dysfunctions that color his/her clinical presentation may be regarded as an average patient in a work setting with sufficient resources; however, in a context marked by deficits, he/she may be considered complex or difficult.

9.2 The Treatment of Complex Depression: Towards a Competence-Based Model in High-Pressure Care Settings

9.2.1 Strategies

Although very severe personality disorders require complex, multidisciplinary settings, where patients can be treated in rapid succession by a variety of practitioners using, for instance, dialectical behavior therapy (DBT) (Chapman, 2006; Dimeff & Koerner, 2007; Linehan, 1993), the clinical reality of primary care, especially in LMICs, shows that many patients with a range of personality dysfunctions can benefit from individual treatments (Cuijpers, Quero, Dowrick, & Arroll, 2019; Gunderson & Links, 2014) that meet certain requirements, as we will discuss in a later section. Overall, authors have suggested that these patients be treated using a transdiagnostic perspective, that is, addressing both mood dysfunctions ("depressive mood"; see Cuijpers et al., 2019) and personality dysfunctions or those that characterize the self-critical or dependent styles, taking into account the patient's context and the therapist's work settings.

It has been established that, when personality dysfunctions color a patient's complex depression, therapists should focus on these aspects first (Clarkin, Petrini, & Diamond, 2019; Gunderson et al., 2014; Gunderson, Herpertz, Skodol, Torgersen, & Zanarini, 2018; Gunderson & Links, 2014); therefore, "structure-oriented psychotherapy" for addressing these patients will be discussed in detail. As previously mentioned, the model is based on the assumption that the primary care therapists working in high-pressure settings have a variety of therapeutic orientations, especially in LMICs (de la Parra, 2013); therefore, we have adopted the common factors model (CFM, Laska, Gurman, & Wampold, 2014; Wampold, 2015). This model makes it possible to explain why these different orientations can produce changes (e.g., Lambert, 2013), as any therapy that meets the requirements for a bona fide therapy can be effective.

A bona fide therapy can be defined as a procedure intended to be therapeutic and which includes a psychological theory of disease and healing, a convincing rational framework regarding treatment, therapeutic actions consistent with its underlying theories, and active collaboration between patient and therapist. In addition, the therapist is expected to perform the usual therapeutic actions, be flexible enough to adapt to each individual patient, and align with the treatment that he/she is providing (Wampold et al., 1997, 2010). In this regard, with respect to depression, Cuijpers et al. (2019) note:

> There is no evidence that the effects of different types of therapy significantly differ from each other. Trials directly comparing different types of therapy, as well as network meta-analyses, suggest that all major types of therapy have comparable effects. (p. 2)

Although these authors suggest taking these results cautiously and given that the controversy regarding specific and common factors in psychotherapy is far from

being settled (e.g., Cuijpers, Reijnders, & Huibers, 2019; Mulder et al., 2017), selecting the CFM is also a practical, cost-effective decision due to the diversity of the professionals working in PC and HPCS in LMICs.

The next list presents the elements of psychotherapy for complex depression in high-pressure care settings that guide therapeutic strategies from a CFM perspective:

1. Adaptive indication – responsiveness – trade-off indication
2. Brevity:
    A. Frequency and duration
    B. Responsive regulation of treatment duration (Barkham et al., 2006)
    C. One session, one pearl
3. Focus; focusing on structure
4. Therapeutic alliance, patient-therapist relationship

Adaptive Indication The term "adaptive indication" was coined by German psychotherapists in the 1980s (Thomä & Kächele, 1987) and was later rendered into English as "responsiveness" (Kramer & Stiles, 2015; Stiles & Horvath, 2017). Adaptive indication means that the treatment is modified to adapt to the patient in terms of the patient's needs, culture, and context, explanatory models of disease, difficulties in accessing treatment, and the maintenance of the therapeutic process. In addition, the treatment is modified to adapt to institutional conditions and needs. This conceptualization of adaptive indication is fully consistent with the concept of trade-off indication mentioned above: both suggest that the treatment of complex depression should consider not only the patient's clinical, personal, and contextual characteristics, as well as his/her ability to access treatment, but also the actual opportunities that the institution can offer the patient.

Brevity In high-pressure care settings and primary care, especially in LMICs, it is imperative to shorten waiting lists. Reducing waiting lists implies shortening treatments so that professionals can have an adequate patient turnover, which enables them to receive new patients; therefore, in this context, adaptive or trade-off indication means conducting brief treatments. Although authors have questioned the effectiveness of brief therapies for achieving full recovery from depression (Sotsky et al., 1991), several studies such as the meta-analysis performed by Nieuwsma et al. (2012) and the recent study by Cuijpers et al. (2019) indicate that brief therapies, including those for depression delivered in primary care in LIMCs, have positive outcomes. It should be noted that these examples and the literature on depression treatment in PC (Barley et al. 2011) do not refer to complex depression or difficult (depressive) patients as described in this chapter. Thus, when clinical depression takes center stage, sidelining the patient's personality traits, depressive symptoms must be prioritized, following the successful example of behavioral activation in PC in LMICs (Cuijpers, Quero, et al., 2019). Although the term "brief therapy" can refer to a set of 6 to 8 sessions, as in crisis interventions (Jacobson, 1979; Yeager & Roberts, 2015), and despite the fact that psychotherapies of this duration have been

given preference in depression treatment (Nieuwsma et al., 2012), the model described in the present chapter stipulates a maximum length of 12 weekly sessions. This decision was made following the revised guidelines issued by the Mental Health Department of the Chilean Ministry of Health (MINSAL 2017), which conclude that "after the 12-session course, each additional psychotherapy session would reduce the patient's score on standardized scales of depressive symptom evaluation by 0.038 points, controlling for time of contact with the therapist, duration in weeks, and psychotherapeutic approach" (p. 21). Twelve sessions also make it possible to cement the therapeutic relationship in patients with personality dysfunctions and/or a background of early adversity. For complex patients with more severe personality dysfunctions, these 12 sessions may be insufficient. In those cases, series of 12 sessions are recommended, after which patients are temporarily discharged until a new set of sessions with the same therapist: the therapy ends, but not the relationship, which can be resumed to establish a corrective emotional experience (Divac-Jovanovic & Svrakic, 2017; Gunderson & Links, 2014), as will be discussed in a later section.[1]

Regarding termination, it has been established that dropout rates range from over 45% to 20% (Swift & Greenberg, 2012; Wierzbicki & Pekarik, 1993). Studies with follow-up components have shown that some patients who interrupt their treatment and do not return felt better and are satisfied with the care received (de la Parra, Gómez-Barris, Zuñiga, Dagnino, & Valdés, 2018; Simon, Imel, Ludman, & Steinfeld, 2012), which means that their gains had reached a good enough level (Barkham et al., 2006; Stiles, Barkham, & Wheeler, 2015). This means that it is necessary to provide therapists with skills to detect these "good enough" gains and thus terminate therapies according to patient response, in other words, a "responsive regulation of treatment duration" (Barkham et al., 2006; Stiles et al., 2015). This would preserve the relationship for future therapeutic contacts, especially in primary care settings, where users must return to the same centers and meet the same practitioners.

Given the limited number of sessions and barriers to access, either due to patient factors or institutional reasons, the model proposed is informed by the notion of "one session, one pearl" (Defey, 2013), which means that each contact between the therapist and the user must be meaningful: the patient must always "take something home," so that a set of meaningful sessions will gradually form the therapy process, "the pearl necklace." This is consistent with patients' expectations of psychological care, a finding we have observed in ongoing research conducted by the first authors of this chapter.

Focus – Focusing on Structure According to the above, focusing makes it possible to abbreviate psychotherapy and contributes to the challenge of implementing brief psychotherapeutic treatments in HPCS. Several models of focal psychotherapy

[1] In the present chapter, we do not cover the psychotherapeutic treatment of the depressive symptoms of noncomplicated depression, since this topic is discussed in other chapters of this book and there is abundant literature on it.

exist in the psychodynamic domain (Messer & Warren, 1995), which are essentially based on addressing conflicts or maladaptive interpersonal patterns that underlie symptoms (Leichsenring & Schauenburg, 2014; OPD Task Force, 2008). Other psychotherapeutic traditions also focus on solving problems, which can involve behavioral patterns, emotional regulation, or dysfunctional cognitive patterns in patients with a personality pathology (Beck, Davis, & Freeman, 2015; Kellogg & Young, 2006; Linehan et al., 2006). In the present chapter, we will not discuss the traditional focal approach mentioned above nor will we cover other perspectives, since other chapters elaborate on these topics and the literature also provides further information about alternative approaches.

In consequence, when symptoms are largely generated and maintained by personality functioning deficits, treatment should address those deficits; in this case, the strategy will consist in focusing on these functional difficulties. In other words, this strategy involves centering psychotherapeutic work on patients' specific deficits, helping them to identify and recognize them in their everyday functioning and then develop self-regulation and adaptation processes in response to these structural limitations. These deficits can be identified following OPD-2 guidelines (OPD Task Force, 2008), which distinguish four domains defined earlier and detailed in the following table (see Table 9.1).

Table 9.1 Structural personality functions according to Axis IV of OPD-2

[1] Domain	Function	Sub-function
Perception/cognition	Self-perception	Self-reflection
		Affect differentiation
		Identity
	Object perception	Self-object differentiation
		Whole object perception
		Realistic object perception
Regulation	Self-regulation	Impulse control
		Affect tolerance
		Regulation of self-esteem
	Regulation of relationships	Protecting relationships
		Balancing interests
		Anticipation
Communication	Internal communication	Experiencing affect
		Use of fantasies
		Bodily self
	External communication	Making contact
		Communicating affect
		Empathy
Attachment	Attachment to internal objects	Internalization
		Utilizing introjects
		Variability of attachment
	Attachment to external objects	Capacity for attachment
		Accepting help
		Detaching from relationships

Structure-focused therapy (SFT) (Rudolf, 2013) is a therapeutic proposal that complements the OPD system (OPD Task Force, 2008), providing general recommendations about strategic decisions for planning therapy and specific therapeutic work techniques for difficult patients due to structural deficits or vulnerabilities. In SFT, the patient's difficulties are largely understood to be an expression of his/her deficits, with the therapist attempting to place in the field of observation (focus) those functions whose development was probably hindered by deficiencies in early emotional support. In this proposal for personality structure-oriented psychotherapy, apart from focusing on specific functions depending on each patient's profile, we suggest general work strategies adapted to the overall functioning characteristics of these patients. Some of the main strategies are presented in Table 9.2.

Table 9.2 General characteristics of therapeutic work in SFT

Therapist Attitude	
Emphasis on an enabling therapeutic attitude	1. The therapist is fully oriented towards the construction of the relationship
	2. Prepare yourself to connect with a "less than pleasant" patient
	3. Be a stable therapist, who strives to avoid feeling threatened, discouraged, or irritated
	4. Have a flexible stance in your reactions to the patient; that is, answer questions, display willingness to react to the patient's need for help and share your views on situations experienced by the patient
	5. Be respectful of the patient's coping attempts
	6. Empathize with the patient's experiences of adversity and precariousness
	7. Be available as a mentor-therapist, as a parental figure that encourages development
Therapeutic Relationship	
Prepare yourself for an intense countertransference	1. The patient's relational offer is characterized by intense needs and demands and little tolerance to frustration
	2. Relational needs are understood to be real and not unconscious instinctive desires
	3. The therapist does not interpret the patient's behavior as an offer necessarily directed to him/her
	4. Together, they seek to identify problematic patterns and learn to deal with them more effectively, gradually becoming more accountable
	5. The therapist pays attention to qualities, talents, and interests
	6. Therapist together with patient does not lose hope

(continued)

Table 9.2 (continued)

Focus selection and goal-setting (together with the patient)	1. Exploring and evaluating the structural functions that require more support
	2. Transforming them into focal points and goals of the therapy
	3. Including the patient's gradual increase in accountability as a therapeutic goal
Therapeutic Techniques and Interventions	
General techniques and interventions	1. Interpretations of meaning become secondary: focusing on "how" and not "why"
	2. Techniques to reinforce the basic stabilization of the self:
	Reflecting
	Asking
	Clarifying to focus the narrative
	Creating distance between the patient and his/her problems (disidentification)
	Stimulating mental production through words and other means
	Structure-generating interventions (helping the patient to plan, take care of him/herself, and set limits)
	Establishing hypotheses and connections
Establishing patterns	1. Learning to see behavior and experiences as patterns
	2. Learning to see behavioral patterns as emotional responses to current external or internal situations
	3. Developing a functional scheme
	4. Accepting that the scheme was biographically mediated and that it contains coping attempts
	5. Studying current functionality/dysfunctionality
	6. Accepting the pattern as part of oneself and taking responsibility
	7. Testing alternative possibilities
	8. Learning to use the therapeutic situation

(continued)

Table 9.2 (continued)

Adopting therapeutic relational "positions" with respect to the patient	1. Therapist positions him/herself behind the patient by:
	Identifying with the patient (sharing his/her perspective)
	Providing emotional support (embracing the pain and working through it)
	Compassion
	Auxiliary self
	Aid (mentor, coach)
	2. Therapist positions himself alongside the patient by:
	Sharing focus on the patient's situation (both look at a third party [the patient and his functioning], *insight* not about the meaning but about the patient's patterns and functioning)
	"Watching from the hill" to look at the patient's situation and functioning and generate affective distance
	Meta-observation
	3. Therapist positions him/herself in front of the patient by:
	Reflecting (therapist's perception is returned to the patient)
	Responding (allowing the therapist's emotional resonance to be seen)
	Highlighting differences with the other, for example, the therapist: alterity
	Confronting (aspects of reality and one's responsibility)
	4. Therapist positions him/herself ahead of the patient
	Foreseeing difficulties, tasks, and development issues and sharing them with the patient
	Avoiding harm by anticipating problems with an attitude of concern and care

(Adapted from Rudolf, 2013)

Box 9.1 Dependent Patients

According to the study cited, dependent patients perform more poorly in self-perception and self-regulation (with the latter including affect tolerance and regulation of self-esteem) as well as in attachment to external objects (as shown in Table 1, it includes the ability to detach from relationships). These structural functions should be proposed as the therapeutic focus and jointly agreed upon with the patient to be prioritized in therapy. In the case of dependent depressive patients, it is precisely dependence that will be used as a therapeutic resource, as their need to establish a bond becomes a chance to generate a therapeutic relationship quickly and thus work with a more permeable patient.

To work on these patients' self-perception deficits, the therapist takes an active interest in their subjective experience. Therapeutic interventions are aimed at supporting patients' self-reflection (see Table 1), helping them to

reflect on and differentiate their self-image, improving their ability to connect their affects to events in their lives (affective contextualization of events), and strengthening their ability to construct/produce their identity. The therapist can anticipate reasoning, feelings, and planning (positioning him/herself "ahead of the patient"), operating as an auxiliary self; on other occasions, he/she offers his/her own perception, sharing his/her thoughts and expressing his/her disagreements with the patient (positioning him/herself "in front of the patient"). Here, it is essential to use reflection and clarification techniques through detailed questions that encourage and organize the patient's communication. Work with dysfunctions in attachment to external objects in dependent depressive patients is based on the "parental attitude" proposed by Rudolf (2013). This makes it possible to regulate the distance with a patient who tends to cling on to others. Together with the patient, the therapist explores experiences of pain and anguish due to loss and separation and stimulates the ability to deal with mourning, helping the patient with the affective handling of these situations. Even in brief therapies, the working-through of the topic of separation is highly significant, since it enables the patient to experience separations that do not entail abandonment and boosts his/her ability to accept unfulfilled expectations while tolerating aggression and disillusionment regarding the lost object. Parental attitude, as will be discussed below, means that the therapist becomes a real object for the patient, which the patient is expected to internalize and take home after a series of 12 sessions ends, and they meet again at an unspecified point in the future. Thus, as previously noted, the therapy ends but the relationship remains: internal and external availability of the therapist within the framework of a corrective emotional experience (Alexander & French, 1946; Gunderson & Links, 2014). Dysfunctions in self-regulation require (Rudolf, 2013) therapist work focused on developing strategies for impulse management and integration, affect tolerance and responsibility, and regulation of self-esteem and feelings of humiliation. The aim of these efforts is to prevent an emotional inundation. This involves learning to perceive overwhelming affects quickly, setting up an early warning system to identify affective movements that are becoming stronger, and learning to see the relational context (the situation that triggered the affect) to find out how to overcome it. At the beginning of the therapy, the patient depends on the concrete experience of receiving external comfort from the therapist, who helps him/her to identify the affect and determine how to soothe him/herself. After recovering his/her composure, it is possible to work on the identification of the triggering event. This work entails the construction of an "observing self" encouraged by the "alongside the patient" position, where both participants adopt a "watching from the hill" perspective that allows them to see the patient's functioning from a distance.

In complex depression cases, as defined in this chapter, an approach based on specific structural deficits should focus on the most severely affected functions. As an example, in the box below, we will address the OPD personality functions that are supposed to be most affected in dependent and self-critical patients, according to preliminary results in de la Parra et al. (2017).[2]

Box 9.2 Self-Critical Patients

Constitute a larger challenge, not only due to what has been defined as the pathogenic power of self-critical perfectionism (Blatt, 1995) and associated barriers preventing the establishment of a therapeutic alliance, especially in brief treatments (Blatt, 2004; de la Parra et al., 2017; Mellado et al., 2018; see also the thorough review in the previous chapter), but also in connection with findings that reveal higher levels of self-criticism in patients with more complex profiles in personality structure. According to the preliminary findings cited (de la Parra et al., 2017), patients belonging to this profile find it more difficult to access the OPD functions of object perception and attachment to internal objects. Both dysfunctions are consistent with the clinical theory of the depressive and self-critical patient: inasmuch as he/she is concerned with permanent self-definition and uninterested in his/her ties to others (Blatt & Luyten, 2009), he/she will encounter more difficulties with object perception, while his/her dysfunctional attachment to internal objects will manifest itself through self-criticism and not through internal objects that support and console. Thus, from the perspective of structure-oriented psychotherapy, both self-criticism and its underlying dysfunctions become therapeutic focal points. Since self-criticism appears early on in the therapeutic process, it must be established from the start as a focal point through shared attention. The self-criticism process is observed from the "alongside the patient" relational position (see Table 2 and Kannan & Levitt, 2013); that is, the participants explore when and how it is activated and not why it is activated, since structure-oriented psychotherapy does not concern itself with the underlying meaning of a given functioning but with the actions needed to address it.

Difficulties in the alliance established with these patients can be viewed as a result of issues with object perception and attachment to internal objects. Therefore, it is necessary to construct, care for, and actively monitor the therapeutic alliance (Bateman & Fonagy, 2012; Safran & Muran, 2000). The therapist places him/herself in front of the patient as a real object, revealing his/her own perceptions and emotions in a therapeutic manner, encouraging differentiation, and thus leaving behind (traditional)neutral therapeutic positions.

[2] We reiterate the need to take these illustrations as a clinical exercise how to work structurally oriented, since a later study in another sample (Dagnino et al. 2018) did not replicate the same associations between dependence and self-criticism and specific structural dysfunctions. More research in greater clinical samples is needed.

Work on the object-perception function requires that the therapist foster the patient's ability to differentiate between self and object, that is, to verify what the self wants, thinks, or fears, in contrast to the objects' presumed intentions. In addition, it is essential to be able to perceive the other integrally and produce a realistic image, without idealizing or underestimating him/her, but accepting that the other is different and has experiences and convictions that may be opposed to those of the patient. To do this, the patient and the therapist can analyze the external situation that the patient has described, probing its affective meaning.

Deficits in attachment to internal objects functions must be addressed directly. Supporting oneself and using positive introjects to soothe oneself must be actively pointed out to be a necessity of life and should be rehearsed in some way. The therapist helps the patient to identify positive internal objects (internal aids) such as positive childhood figures or positive aspects of these figures, friends, teachers, and pets, among others, as well as experiences with a positive connotation (e.g., sports, hobbies, places). Once these objects have been identified, the participants can seek ways of using them for the patient to soothe him/herself. In addition to this explicit work, the therapist has an effect on implicit memory to support the operation of internal bonds: through the strategy of becoming a real object "to be internalized," by interacting with the patient, taking care of him/her, and offering him/her emotional support (similar to maternal holding and baby manipulation).

Therapeutic Alliance, Patient-Therapist Relationship We will not discuss here the extensive literature on the therapeutic alliance (Flückiger, Del Re, Wampold, & Horvath, 2018; Klein et al., 2003); however, what has been presented thus far has clearly illustrated the major importance of the therapeutic relationship. This relationship often moderates change; that is, psychosocial interventions, regardless of their theoretical perspective, will only be effective if they take place in a favorable relational climate. In other cases, as in complex depression with personality dysfunctions and/or a history of trauma, the relationship will mediate change, operating like a repairing relationship (Gunderson & Links, 2014). This means that the therapist must purposively conduct the relationship as described below, taking into account the relevant competences.

9.2.2 Competences for Addressing Complex Depression

Competences have been defined as the knowledge, skills, and attitudes – as well as the integration of these components – that enable therapists to fulfill various functions in healthcare centers, regardless of the therapeutic orientation of these professionals (Kaslow, Dunn, & Smith, 2008; McDaniel et al., 2014). As has been shown in this chapter, it is a challenge for therapists to treat patients with complex

depression in precarious and high-pressure care settings; however, from the patients' perspective, during in-depth interviews, psychologists can become facilitators who will enable them to access satisfactory treatment if they offer a helping relationship informed by the patients' expectations of change and bonding (ongoing research, Zúñiga & de la Parra,).

Considering that responsive competences are contextually dependent (Barber, Sharpless, Klostermann, & McCarthy, 2007; Stiles et al., 1998), the first authors of this chapter have conducted research aimed at generating a model of psychotherapeutic competences for treating complex depression in primary care centers that takes into account the users' views, the experience of the psychologists who work in these contexts, and the insights of academic experts (Zúñiga, 2019; Zúñiga, Balboa, & de la Parra, 2018). The preliminary results of this study, which refer to the source of depressive patients seeking help in high-pressure settings, are summarized in Fig. 9.1. The figure shows how institutional limitations and the lack training of therapists can prevent patients treated in PC from meeting their change expectations through psychological care. However, if the patients' expectations

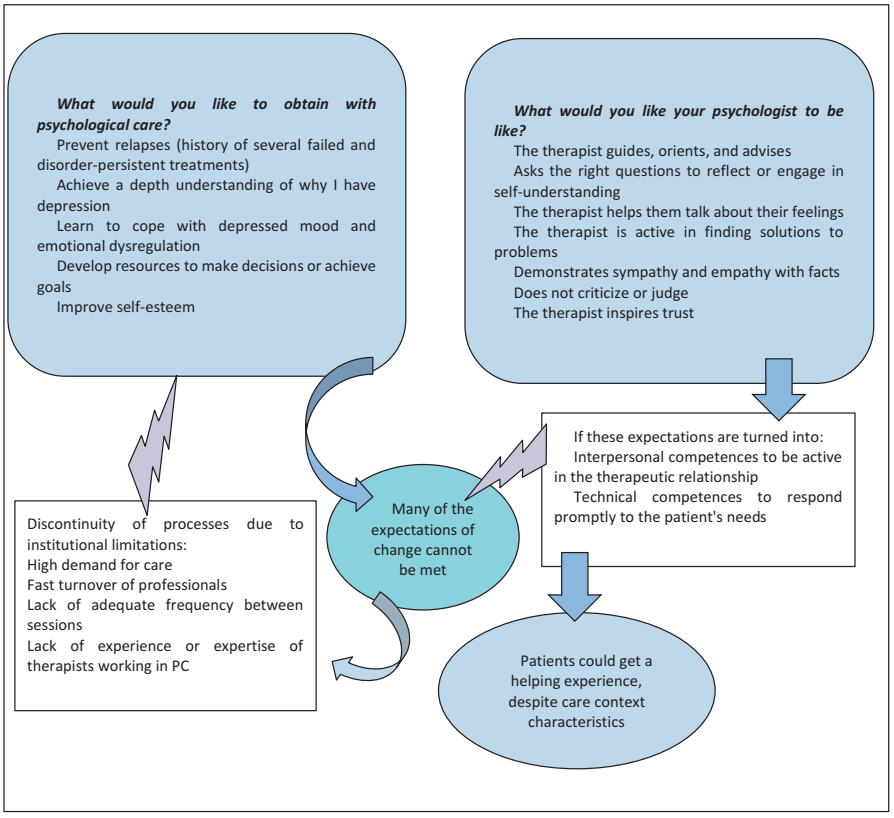

Fig. 9.1 Institutional limitations and the role of therapist competences for patients to meet their expectations in terms of care (Zúñiga et al., 2019)

regarding therapists are transformed into interpersonal competences allowing them to participate actively in the helping relationship and gain technical competences to respond *lively* to their needs, patients could get a helping experience despite of the limitations of the care context (Zúñiga et al., 2019).

According to these preliminary results, there appears to be a convergence between the patients' expectations regarding the therapeutic relationship and the experience of the psychologists working in PC. Both these elements stress the importance of therapists being warm, affectionate, empathetic, charismatic, and friendly when treating their patients. In the words of one patient, therapists should "smile when greeting me," "show interest in treating me," and essentially "keep me on their mind." For patients, it is essential that therapists do not judge them and inspire trust so that they can express what they are experiencing (Zúñiga, 2019; Zúñiga et al., 2018).

An ongoing analysis points out that therapists and experts have stressed the need for therapists to offer a therapeutic relationship based on humility, "acknowledging the mistakes made," "acting quickly in response to conflicts with the patient" (competences to repair alliance ruptures), and "working to prevent patients from slamming the door on their way out," since each and every moment with the patient is relevant in these contexts, where the continuity of the process is never guaranteed ("one session, one pearl," as noted earlier). Furthermore, for experts, if a patient goes home feeling like he/she met a professional who is committed to helping him/her even though the next session is in 1 month's time, it is enough to regard this effort as repairing and therapeutic in itself.

At the level of technical competences, patients' expectations show how important it is for therapists to offer and conduct a relevant and meaningful therapeutic dialog, helping them to understand "why me, why do I have depression?" and assisting them in their attempts to regulate their depressive mood and their negative emotions, thoughts, and impulses (Zúñiga, 2019). Again, therapists are expected to adopt an active role, identifying the *underlying* problem (which the patients cannot see) and guiding them to solve it (Zúñiga et al., 2018). Patients are highly appreciative of therapists' ability to suggest new points of view and listen actively, reminding what therapist worked with the patients in previous sessions and sharing a reflection or impression from the session (Zúñiga, 2019; Zúñiga et al., 2019).

Also, psychologists and experts agree that therapists should be familiar with public health and multiple treatment modes to be able to indicate the most suitable interventions for patients' problems, thus keeping therapists from depriving patients from accessing better treatments due to a lack of knowledge (or dogmatism) (Zúñiga, Balboa & de la Parra 2018). These sources also highlighted the relevance of teamwork, especially when treating complex patients (due to their disorder and/or adverse psychosocial determinants), knowing how to implement specific interventions to address suicide risk, distinguishing and applying interventions for managing depression and personality pathologies, offering psychoeducation, aiding patients when they are confronting their issues, and supporting their functioning (Zúñiga, Balboa & de la Parra, 2018; Zúñiga, 2019).

Lastly, psychologists and experts have stressed the importance of knowing how to adapt psychological techniques (interventions and therapeutic dialog) to patients' needs and their cultural context, bearing in mind gender- and belief-related barriers that may underlie the depressive disorder (Zúñiga, 2019; Zúñiga et al., 2018). This ability, referred to as "cultural competence," has been shown to increase the effectiveness of interventions in both developed countries and LMICs (Griner & Smith, 2006; Levy & O'Hara, 2010). Authors have suggested that, in LMICs, these cultural competences should be called "structural competences" to highlight the need for clinicians to be aware of the sociocultural context of their patients and actively mitigate the determinants of their mental health problems (Patel et al., 2018).

It should be noted that patients' expectations and psychologists' experiences are perfectly consistent with the model proposed above. Thus, when patients expect to "understand themselves," "get to the bottom of the problem," and "just understand," we are talking about focus, that is, the dynamics that underlies their reasons for seeking help. So, when they refer to their expectations regarding the therapist's personal characteristics, they mention relational characteristics like warmth and empathy, and when note that they expect to get insights in each session, they are referring to the pearl metaphor. Likewise, when psychologists mention relational qualities, the ability to adapt, and the need to possess a diverse toolset, they are talking about adaptive indication, that is, having a variety of resources to be able to adapt and respond to the needs of all their patients (de la Parra et al., 2019).

9.3 Conclusions

After reviewing a broad definition of complex depression, which goes far beyond the patient's diagnostic characteristics, we defined possible ways of approaching this disorder, with a special emphasis on structure-oriented therapy and the necessary competences to offer care to these patients. Yet, these descriptions leave out the context: the patients' contextual factors and the practitioners' work settings. These aspects are covered in the "Training Program in Psychotherapy Competences for Depression Treatment," which we developed for primary care and which will be tested in a number of centers in Chile (FONIS Project No. SA1910021). This program comprises six modules. Module I covers the theoretical-empirical basis of the model, including adaptive indication and the desirable competences for professionals, as explained above. Module II is wholly devoted to complex depression, addressing personality dysfunctions, self-critical and dependent functioning, and aspects of trauma. Module III focuses on the therapeutic relationship, laying out how the patient's context and the therapist's work setting influence the latter's emotional functioning. Self-care measures for the therapist are also discussed. Module IV is devoted to brief therapies, structure-focused therapy, and crisis interventions. Module V covers the management of suicide risk. Finally, Module VI discusses

culturally informed psychotherapy and therapists' community-related competences, such as patients' community involvement and network activation, among others.

Through the present chapter, we expect to have contributed to the understanding of complex depression and its management in HPCS, especially in LMICs.

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