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Research Paper

Comparative Effectiveness of Mindfulness-Based Cognitive Therapy and Psychodynamic Therapy in Treating Depression and Anxiety: An Overview

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ABSTRACT

As India grapples with the challenges of a dynamic societal transformation, the need for efficacious mental health interventions has never been more pronounced. This paper offers an in-depth exploration of two prominent therapeutic techniques, namely Mindfulness-Based Cognitive Therapy (MBCT) and psychodynamic therapy, and their respective merits in addressing depression and anxiety disorders. MBCT has been evidenced to offer tangible benefits, particularly in reducing the recurrence of depressive episodes and amplifying mindfulness attributes. In parallel, psychodynamic therapy goes beyond surface symptoms, probing deeper into unresolved emotional entanglements and consistently showcasing benefits that outlast the therapy duration. Furthermore, in the culturally rich and diverse context of India, it becomes essential to understand the interplay of cultural, societal, and individual nuances when deploying these therapies. The study reveals that no single therapy is universally superior; rather, the choice should be tailored, considering the patient's unique needs, background, and the specific manifestations of their mental health challenges. This comprehensive assessment serves not only as a guiding light for creating awareness amongst the general population but also emphasises the global need for culturally-sensitive and individualised therapeutic interventions.

Keywords: *Mental Health, Mindfulness-Based Cognitive Therapy, Psychodynamic Therapy, India, Cultural Sensitivity, Depression, Anxiety, Therapeutic Effectiveness*

Depression and anxiety stand as predominant mental health challenges, affecting countless individuals on a global scale (Kessler et al., 2005). Their origins are multifaceted, encompassing genetic, biological, psychological, and environmental determinants (Rice et al., 2002; Stein & Stein, 2008). The concurrent manifestation of these disorders within an individual, termed as comorbidity, has been extensively documented (Kessler et al., 2005). Their comorbidity is underpinned by overlapping genetic and neurobiological mechanisms, coupled with analogous cognitive and behavioral susceptibilities (Stein et al., 2001; Beck, 2008). Consequently, the efficacy of numerous theoretical frameworks and therapeutic interventions predominantly addresses these afflictions in tandem, whilst recognising their intrinsic interconnectedness.

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Given their status as prevalent co-occurring mental health disorders, depression and anxiety exert profound distress and functional debilitation on the afflicted (Kessler et al., 2005). Addressing these disorders in contemporary society is imperative for manifold reasons. Primarily, elevating consciousness concerning these maladies mitigates societal stigma, thereby advocating for timely intervention and broader accessibility to mental healthcare provisions (Corrigan, 2004). Furthermore, this discourse illuminates the intricate interrelation between genetic, biological, psychological, and environmental underpinnings, which aids in devising superior therapeutic and preventive measures (Rice et al., 2002; Stein & Stein, 2008). Lastly, given the profound repercussions of depression and anxiety on an individual's overall quality of life, societal productivity, and concomitant healthcare expenditures (Greenberg et al., 2015), these disorders' timely addressing becomes paramount for the augmentation of public health and holistic well-being.

Over the years, an array of therapeutic modalities has emerged to combat these disorders, with cognitive-behavioural therapy (CBT) and psychodynamic therapy being foremost among them (Leichsenring et al., 2015; Cuijpers et al., 2016). Even though both modalities are extensively employed and are buttressed by empirical validation for treating depression and anxiety (Leichsenring et al., 2015; Cuijpers et al., 2016), this article intends to dissect and juxtapose the efficacies of mindfulness-based cognitive therapy (MBCT) — an offshoot of CBT combined with mindfulness principles — and traditional psychodynamic therapy in addressing these prevalent disorders.

Mindfulness-Based Cognitive Therapy: A Fusion of Ancient Wisdom and Contemporary Psychology

Introduction to Mindfulness in the Realm of Psychology:

Tracing back to ancient Buddhist traditions, mindfulness, particularly associated with Vipassana meditation, is a practice centered on cultivating non-judgmental awareness of present-moment thoughts and emotions (Gethin, 2011). At the heart of Buddhist philosophy lies the concept of mindfulness (known as *'sati'* in Pali). It is revered for its role in nurturing insight and steering practitioners toward liberation (Bodhi, 2011). However, it was only in the late 20th century that mindfulness started resonating with Western psychology. This shift can be largely credited to Jon Kabat-Zinn's pioneering efforts in introducing the Mindfulness-Based Stress Reduction (MBSR) in the 1970s, a program designed to assist individuals grappling with chronic pain and stress (Kabat-Zinn, 1990). Through MBSR, the essence of mindfulness — embodying non-judgmental, present-moment awareness — was unveiled as a potent tool not only for alleviating emotional distress but also for nurturing self-compassion.

Emergence of Mindfulness-based Cognitive Therapy (MBCT):

MBCT stands as a testament to the harmonious blend of ancient mindfulness techniques with the robust structure of traditional Cognitive Behavioural Therapy (CBT), aiming to augment its therapeutic potential (Segal et al., 2002). While CBT in itself is potent, the visionaries in the field discerned an opportunity: what if the timeless art of mindfulness could amplify its effects? Driven by this quest, and in response to the identified constraints of traditional CBT, the discipline of MBCT took shape.

Crafted meticulously by Segal, Williams, and Teasdale in 2002, MBCT amalgamates the core components of CBT with the meditative practices intrinsic to MBSR. The mission was clear: to tailor an intervention specifically catering to those battling recurrent depression,

empowering them with skills to discern and break free from the vortex of negative thought patterns that trigger relapses. And as they delve deeper into the world of MBCT, individuals are gently nudged towards fostering a transformative relationship with their thoughts and emotions, a relationship marked by acceptance and devoid of reactivity (Kuyken et al., 2016).

Therapeutic Modalities of MBCT:

At the heart of MBCT lies a trinity of modalities: mindfulness practices, cognitive restructuring, and psychoeducation. These elements collectively pave the way for individuals to not only confront but also transcend negative emotions, mitigating symptoms tied to depression and anxiety (Hofmann et al., 2010).

Within the mindfulness realm of MBCT, one encounters a diverse tapestry of meditation exercises ranging from body scans and breath awareness to the nurturing embrace of loving-kindness meditation (Kabat-Zinn, 1990). These practices invite individuals into the realm of the present, dissuading the mind from its habitual tendencies to ruminate and spiral into negative territories (Teasdale et al., 2000). More than just practices, they are avenues leading towards self-acceptance and compassion, cornerstones for emotional harmony (Neff, 2003).
MBCT further harnesses cognitive restructuring, a pillar of CBT, to challenge and remodel counterproductive thought patterns and beliefs (Beck, 2008). When married to mindfulness, the resulting synergy empowers individuals to not just identify but also distance themselves from negative cogitations without succumbing to emotional turbulence (Segal et al., 2002).
Psychoeducation within MBCT serves as a beacon, illuminating the intricate landscapes of depression and anxiety for its seekers (Segal et al., 2002). Armed with this knowledge, individuals become adept at spotting early signs of a potential relapse and fashioning proactive coping strategies (Ma & Teasdale, 2004).

Efficacy of MBCT: Evidence from the Field

Empirical Demonstrations of Effectiveness:

The efficacy of Mindfulness-Based Cognitive Therapy (MBCT) in attenuating symptoms of depression and anxiety has been corroborated by a plethora of studies. A rigorous meta-analysis orchestrated by Hofmann et al. (2010) unveiled significant symptom alleviation in both ailments, putting MBCT's effect sizes on par with traditional CBT and other gold-standard interventions. Beyond mere symptom attenuation, MBCT has carved a niche for itself in acting as a bulwark against relapses in individuals with a history of recurrent depression. An intricate individual patient data meta-analysis of randomised trials spearheaded by Kuyken et al. (2016) affirmed MBCT's pronounced efficacy in curbing relapse rates, especially among those who've navigated the turbulent waters of multiple depressive episodes. Not to be confined to symptom reduction, MBCT has also emerged as a beacon of enhanced self-compassion, psychological well-being, and life satisfaction, as echoed in a study by Crane et al. (2014).

Socio-cultural Nuances: Tailoring MBCT for Cultural Fit

Cultural tapestry plays a pivotal role in shaping the receptiveness and efficacy of therapeutic interventions. In the realm of MBCT, cultural constructs, ranging from shared beliefs and values to societal norms, influence an individual's rapport with therapeutic processes (Chiesa & Malinowski, 2011).

Mindfulness, while enjoying widespread acclaim in Western milieus, might encounter varied interpretations and acceptance in non-Western cultures, potentially recalibrating the potency of MBCT. Recognising this, the call for culturally resonant interventions has gained momentum. Such interventions, steeped in the cultural ethos, values, and nuances of their target demographics, have showcased superior outcomes compared to their non-tailored counterparts (Chowdhary et al., 2014).

Beyond cultural dimensions, socio-economic gradients, linguistic nuances, and accessibility to adept mental health care also wield influence over MBCT's effectiveness. Equitable access and culturally astute therapists are paramount in harnessing MBCT's full potential across diverse socio-cultural landscapes (Kearney et al., 2013).

Strengths & Caveats of MBCT: A Dual Lens

Harnessing MBCT for alleviating anxiety and depression presents a medley of strengths. At the forefront is its empirically demonstrated prowess in symptom reduction and its protective shield against relapses (Hofmann et al., 2010; Kuyken et al., 2016). Moreover, MBCT's emphasis on cultivating emotional equilibrium fosters self-compassion and bolsters overall well-being, enriching life's tapestry (Crane et al., 2014).

However, like any therapeutic modality, MBCT is not without its caveats. Individuals in the throes of acute crises or grappling with severe symptomatology might find the introspective nature of mindfulness practices overwhelming (Chiesa et al., 2011). Additionally, the communal ambiance of many MBCT sessions might not resonate with everyone. Some individuals, hesitant to unmask their vulnerabilities in collective settings, might find the group dynamics less therapeutic, underscoring the need for varied delivery modes (Crane & Kuyken, 2013).

Psychodynamic Therapy: Delving into the Depths of the Unconscious Mind

The Genesis of the Psychodynamic Approach:

Born from the insightful mind of Sigmund Freud, the psychodynamic approach stood as a beacon in psychoanalysis during the transitional phase between the 19th and 20th centuries. Freud's revolutionary assertion was this: the echoes of childhood, unconscious impulses, and unresolved conflicts substantially influence our behaviour and mental health. Diving into the intricacies of Freud's theory, one encounters the vast landscape of the unconscious mind. Freud designated distinct territories: the id, the ego, and the superego. He also identified psychological barriers or defence mechanisms, shields that we deploy to ward off anxiety-inducing cognitions (Freud, 1923/1961). Central to his theory were concepts like the Oedipus complex, repression, and the intriguing dynamics of transference and countertransference. However, the psychodynamic realm wasn't solely Freud's domain. Luminaries like Carl Jung, Alfred Adler, and Melanie Klein ventured onto this terrain, crafting their own interpretations and diverging from Freud's map in certain aspects. Regardless of their differences, a common thread ran through their theories: the undeniable influence of unconscious mechanisms, pivotal early life events, and the potent therapeutic relationship in steering psychological wellness.

Psychodynamic Therapy Today:

Today's psychodynamic therapy embraces this rich tapestry of theoretical perspectives, seamlessly weaving them together. The quintessence of this therapeutic approach is to offer clients the lantern of insight, illuminating those dim corridors where unconscious processes

and unresolved conflicts lurk (Gabbard, 2014). Journeying with therapists, clients traverse through techniques like free association, dream deciphering, and the nuanced understanding of the transference-countertransference dynamic.

Decoding Depression and Anxiety with a Psychodynamic Lens:

Freud once postulated a provocative idea: the shadows of early life, the suppressed emotions, and latent conflicts could be the puppeteers behind the masks of anxiety and depression. Over the sands of time, therapies evolved, fine-tuning their tools to confront and dispel these internal spectres, and in turn, bestow emotional solace (Gabbard, 2014). Embarking on this therapeutic odyssey, several signposts guide the way. Therapists gently usher clients to converse candidly, casting light on obscured patterns and dormant conflicts (Shedler, 2010). With a deft touch, therapists interpret the client's narrative, forging a path to deeper self-understanding (Gabbard, 2014). By revisiting the bygone alleys of early life, psychodynamic therapy underscores their influence on the present psyche (Leichsenring et al., 2015). The bond of the therapeutic relationship forms the bedrock of the therapy. Within its sanctum, clients re-live and resolve bygone battles, healing old wounds (Gabbard, 2014). Imbued with newfound clarity, clients meld fragmented emotions and conflicts, ascending to a plateau of psychological tranquility and wellness (Shedler, 2010).

The world of psychodynamic therapy, much like the mind it seeks to understand, remains vast, layered, and ever-evolving.

Efficacy of Psychodynamic Therapy: Insights from Research:

The robustness of psychodynamic therapy is not merely based on theory but is solidly anchored in empirical evidence. Multiple studies spotlight its effectiveness, especially in treating conditions such as depression and anxiety. In fact, the fruits of psychodynamic therapy often persist, ripening well after therapy concludes (Leichsenring et al., 2015). One notable meta-analysis steered by Leichsenring and his team (2004) showcases that short-term psychodynamic psychotherapy (STPP) rivals other stalwarts like cognitive-behavioural therapy in treating depressive and anxiety disorders. Echoing these findings, Driessen et al. (2015) also highlight the lasting advantages of psychodynamic therapy in treating depression, with these benefits often intensifying during subsequent follow-up assessments.

Worth noting is the particular efficacy of psychodynamic therapy when navigating the treacherous waters of complex or chronic manifestations of depression and anxiety, such as those intertwined with personality disorders (Town et al., 2012). This therapy doesn't merely skim the surface but dives deep, addressing latent emotional tempests and relational dynamics, facilitating profound and enduring transformation in one's psychological tapestry (Shedler, 2010).

Socio-cultural Nuances in Psychodynamic Therapy:

While the tools of psychodynamic therapy are sharp and incisive, cultural mores and societal influences can sometimes act as shields, influencing how therapy is perceived and engaged with (Gabbard, 2014). At the heart of this approach is the therapeutic alliance—a delicate dance between therapist and client. Yet, this dance can stumble when cultural differences come into play, altering perceptions about mental health, emotional expression, or even the therapist's role.

Emotions—the raw material for psychodynamic exploration—can be expressed, suppressed, or celebrated differently across cultures, potentially influencing therapeutic outcomes (Ryde, 2016). Furthermore, linguistic hurdles and culturally unique expressions of distress can

muddy the waters, making the therapist's interpretative role challenging. Fortunately, the evolution of psychodynamic interventions, tailor-made to respect and incorporate cultural values and beliefs, offers a promising direction, with preliminary findings suggesting their superior efficacy compared to generic counterparts (Bernal & Adames, 2017).

Weighing the Pros and Cons

The allure of psychodynamic therapy is multifaceted. It shines particularly bright with its intensive focus on the root causes of distress, the promise of lasting change, and its adeptness in untangling intricate psychological webs (Shedler, 2010). However, no therapy is without its shadows. The extended duration of psychodynamic therapy, compared to other modalities, might stretch patience and purse strings alike (Leichsenring et al., 2004). Moreover, while its empirical backing is growing, it still trails behind more structured modalities, like CBT. One must also remember that the efficacy of this therapy is somewhat in the hands of the practitioner—their skill, training, and fidelity to the therapeutic principles can significantly shape the therapeutic journey and its outcomes (Gabbard, 2014).

In sum, while psychodynamic therapy offers a deep, introspective journey into the self, its effectiveness and appropriateness are nuanced, with socio-cultural considerations and individual contexts playing pivotal roles.

CONCLUSION

In the labyrinth of mental health treatments, Mindfulness-Based Cognitive Therapy (MBCT) and psychodynamic therapy emerge as two potent avenues for alleviating depression and anxiety. Empirical evidence robustly supports both: MBCT shines in reducing relapse rates in recurrent depression and enhancing mindfulness and self-compassion (Kuyken et al., 2016; Hoge et al., 2013), while psychodynamic therapy offers enduring benefits, particularly in complex cases entangled with personality disorders (Leichsenring et al., 2004; Driessen et al., 2015).

The debate over their relative merits is far from settled. Some research lauds MBCT for its edge in symptom reduction and relapse prevention (Kuyken et al., 2016), whereas other studies advocate for the equal efficacy of both therapies (Cuijpers et al., 2013). Yet, these approaches are not one-size-fits-all; their suitability oscillates based on individual idiosyncrasies and the nuanced presentation of depression or anxiety.

Given the complex nature of human psychology, the decision between MBCT and psychodynamic therapy isn't a binary one but should rather be a collaborative, nuanced choice, informed by the individual's unique needs, symptom complexity, and personal preferences. Thus, it becomes crucial to deepen our understanding through more nuanced research, focusing on factors that could influence the relative merits of these therapeutic options for different populations and settings.

The implications of this discourse extend beyond the academic realm, striking a resonant chord in contemporary Indian society. In a nation where the dialogue around mental health is finally gaining volume, yet still often stigmatised, these findings offer alternative pathways to wellness. Traditional familial and societal structures in India sometimes make it difficult for individuals to seek mental health treatment openly. Moreover, with a soaring youth population vulnerable to stress, anxiety, and depression owing to societal pressures and rapid modernisation, the urgency for effective therapeutic options is palpable.

MBCT, with its roots in mindfulness—a concept not foreign to Indian philosophy—could find easier social acceptance. On the other hand, psychodynamic therapy, with its emphasis on familial and early life factors, resonates with the cultural importance of family and upbringing in India. Thus, each has a unique cultural leverage that could be tapped into for more effective, locally-resonant mental health solutions.

In essence, understanding the unique benefits and limitations of MBCT and psychodynamic therapy is not merely an academic exercise but a societal imperative, especially in diverse and evolving landscapes like India. As the nation grapples with its mental health crisis, this research could serve as a linchpin, informing not just individual choices but also healthcare policies and public discourse.

REFERENCES

Abbass, A., & Stride, C. (2012). A randomised controlled trial of intensive short-term dynamic psychotherapy for treatment resistant depression: the Halifax Depression Study. Journal of Affective Disorders, 139(3), 200-207.

Adler, A. (1927). Understanding human nature. New York, NY: Greenberg.

Beck, A. T. (2008). The evolution of the cognitive model of depression and its neurobiological correlates. American Journal of Psychiatry, 165(8), 969-977.

Bernal, G., & Adames, C. (2017). Cultural adaptations: Conceptual, ethical, contextual, and methodological issues for working with ethnocultural and majority-world populations. Prevention Science, 18(6), 681-688.

Chiesa, A., & Malinowski, P. (2011). Mindfulness-based approaches: Are they all the same? Journal of Clinical Psychology, 67(4), 404-424.

Chiesa, A., Castagner, V., Andrisano, C., Serretti, A., Mandelli, L., Porcelli, S., & Giommi, F. (2011). Mindfulness-based cognitive therapy vs. psycho-education for patients with major depression who did not achieve remission following antidepressant treatment. Psychiatry Research, 187(3), 414-419.

Chowdhary, N., Jotheeswaran, A. T., Nadkarni, A., Hollon, S. D., King, M., Jordans, M. J., ... & Patel, V. (2014). The methods and outcomes of cultural adaptations of psychological treatments for depressive disorders: a systematic review. Psychological Medicine, 44(6), 1131-1146.

Corrigan, P. W. (2004). How stigma interferes with mental health care. American Psychologist, 59(7), 614-625.

Crane, C., Crane, R. S., Eames, C., Fennell, M. J., Silverton, S., Williams, J. M., & Barnhofer, T. (2014). The effects of amount of home meditation practice in mindfulness-based cognitive therapy on hazard of relapse to depression in the Staying Well After Depression Trial. Behaviour Research and Therapy, 63, 17-24.

Cuijpers, P., Cristea, I. A., Karyotaki, E., Reijnders, M., & Huibers, M. J. H. (2016). How effective are cognitive behavior therapies for major depression and anxiety disorders? A meta-analytic update of the evidence. World Psychiatry, 15(3), 245-258.

Cuijpers, P., Sijbrandij, M., Koole, S. L., Andersson, G., Beekman, A. T., & Reynolds, C. F. (2013). The efficacy of psychotherapy and pharmacotherapy in treating depressive and anxiety disorders: a meta-analysis of direct comparisons. World Psychiatry, 12(2), 137-148.

Driessen, E., Hegelmaier, L. M., Abbass, A. A., Barber, J. P., Dekker, J. J. M., Van, H. L., ... & Cuijpers, P. (2015). The efficacy of short-term psychodynamic psychotherapy for depression: a meta-analysis update. Clinical Psychology Review, 42, 1-15.

Fresco, D. M., Segal, Z. V., Buis, T., & Kennedy, S. (2007). Relationship of post treatment decentering and cognitive reactivity to relapse in major depression. Journal of Consulting and Clinical Psychology, 75(3), 447-455.

Freud, S. (1905/1953). Three essays on the theory of sexuality. In J. Strachey (Ed. & Trans.), The standard edition of the complete psychological works of Sigmund Freud (Vol. 7, pp. 123-246). London, UK: Hogarth Press.

Freud, S. (1923/1961). The ego and the id. In J. Strachey (Ed. & Trans.), The standard edition of the complete psychological works of Sigmund Freud (Vol. 19, pp. 3-66). London, UK: Hogarth Press.

Gabbard, G. O. (2014). Psychodynamic psychiatry in clinical practice (5th ed.). Arlington, VA: American Psychiatric Publishing.

Greenberg, P. E., Fournier, A. A., Sisitsky, T., Pike, C. T., & Kessler, R. C. (2015). The economic burden of adults with major depressive disorder in the United States (2005 and 2010). The Journal of Clinical Psychiatry, 76(2), 155-162.

Hofmann, S. G., Sawyer, A. T., Witt, A. A., & Oh, D. (2010). The effect of mindfulness-based therapy on anxiety and depression: A meta-analytic review. Journal of Consulting and Clinical Psychology, 78(2), 169-183.

Hoge, E. A., Bui, E., Marques, L., Metcalf, C. A., Morris, L. K., Robinaugh, D. J., ... & Simon, N. M. (2013). Randomized controlled trial of mindfulness meditation for generalized anxiety disorder: effects on anxiety and stress reactivity. The Journal of Clinical Psychiatry, 74(8), 786-792.

Jung, C. G. (1961). Memories, dreams, reflections. New York, NY: Random House.

Kabat-Zinn, J. (1990). Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness. New York, NY: Delacorte Press.

Kearney, D. J., Malte, C. A., McManus, C., Martinez, M. E., Felleman, B., & Simpson, T. L. (2013). Loving-kindness meditation for posttraumatic stress disorder: a pilot study. Journal of Traumatic Stress, 26(4), 426-434.

Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 617-627.

Klein, M. (1946). Notes on some schizoid mechanisms. International Journal of Psychoanalysis, 27, 99-110.

Kuyken, W., Warren, F. C., Taylor, R. S., Whalley, B., Crane, C., Bondolfi, G., ... & Segal, Z. (2016). Efficacy of mindfulness-based cognitive therapy in prevention of depressive relapse: an individual patient data meta-analysis from randomized trials. JAMA Psychiatry, 73(6), 565-574.

Leichsenring, F., Leweke, F., Klein, S., & Steinert, C. (2015). The empirical status of psychodynamic psychotherapy - an update: Bambi's alive and kicking. Psychotherapy and Psychosomatics, 84(3), 129-148.

Leichsenring, F., Luyten, P., Hilsenroth, M. J., Abbass, A., Barber, J. P., Keefe, J. R., ... & Rabung, S. (2015). Psychodynamic therapy meets evidence-based medicine: a systematic review using updated criteria. The Lancet Psychiatry, 2(7), 648-660.

Leichsenring, F., Rabung, S., & Leibing, E. (2004). The efficacy of short-term psychodynamic psychotherapy in specific psychiatric disorders: a meta-analysis. Archives of General Psychiatry, 61(12), 1208-1216.

Ma, S. H., & Teasdale, J. D. (2004). Mindfulness-based cognitive therapy for depression: replication and exploration of differential relapse prevention effects. Journal of Consulting and Clinical Psychology, 72(1), 31-40.

Neff, K. D. (2003). The development and validation of a scale to measure self-compassion. Self and Identity, 2(3), 223-250.

Nolen-Hoeksema, S., Wisco, B. E., & Lyubomirsky, S. (2008). Rethinking rumination. Perspectives on Psychological Science, 3(5), 400-424.

Rice, F., Harold, G. T., & Thapar, A. (2002). Assessing the effects of age, sex and shared environment on the genetic aetiology of depression in childhood and adolescence. Journal of Child Psychology and Psychiatry, 43(8), 1039-1051.

Ryde, J. (2016). Cultural issues in therapy: A practitioner's guide to working with clients from diverse cultural backgrounds. Washington, DC: Lifespan Learning Institute.

Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse. New York, NY: Guilford Press.

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. American Psychologist, 65(2), 98-109.

Stein, D. J., Joffe, B., & Seedat, S. (2001). The neurobiology of comorbid anxiety disorders and depression. CNS Spectrums, 6(11), 924-930.

Stein, M. B., & Stein, D. J. (2008). Social anxiety disorder. The Lancet, 371(9618), 1115-1125.

Teasdale, J. D., Segal, Z. V., Williams, J. M. G., Ridgeway, V. A., Soulsby, J. M., & Lau, M. A. (2000). Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. Journal of Consulting and Clinical Psychology, 68(4), 615-623.

Town, J. M., Abbass, A., & Stride, C. (2012). A randomised controlled trial of intensive short-term dynamic psychotherapy for treatment resistant depression: the Halifax Depression Study. Journal of Affective Disorders, 139(3), 200-207.

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Conflict of Interest

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