5 Cards to Play for Major Depression

Brief Psychotherapy Options

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Linda's Low

Linda, 35, presents complaining of:

- three months of sleep loss,
- low mood,
- loss of energy,
- low sex drive,
- loss of interest and
- loss of appetite without weight loss.

There is no suicidal ideation. She is married and works as an office assistant. Linda's symptoms began one month after being criticized at her job. She reports having "no feelings" about being put down. She describes a negative view of herself and social avoidance since this event. These patterns became generalized over the months since.

For more on Linda, go to page 85.

Our current understanding of depression is that a mixture of biochemical factors and psychosocial factors predispose, precipitate and perpetuate major depression. For example, people with stroke, cardiovascular disease, thyroid dysfunction and a range of other physical conditions have elevated rates of depression, which we assume to have a physical basis in addition to any psychologic effects of these conditions.

Although a specific brain basis for depression has not been established, response to medication in some cases has been given as possible evidence that a neurochemical basis exists.

Psychologic models, including cognitive, behavioural, psychodynamic and interpersonal understanding all have validity based on treatment response and research into specific psychologic profiles of depressed patients. A recent study found that over 80% of depressed patients turn anger inward towards themselves.[1] Cognitive and behavioural concomitants of depression have been well described.

1. Cognitive therapy

Cognitive therapy works by identifying and challenging distortions in thinking patterns. These thoughts may contain a bleak view of oneself, one's activities and the future. The therapist and patient collaborate on sorting out what ways the patient tends to think, identify more realistic ways to think and substitute these for the previous depressive cognitive set. In short, the therapist helps the patient change depressive thought patterns.

2. Behaviour therapy

Behaviour therapy works by determining the behavioural antecedents that lead to depressed mood states; by changing behaviours, a depressogenic behavioural cycle is broken. For example, if the person is completely inactive at home, one can see cycles of inactivity leading to depressed mood, which in turn leads to inactivity. These cycles can be interrupted by planning, carrying out and evaluating activities. This breaks the depressive behaviour cycle. The therapist helps the patient change the things a patient does that are perpetuating depression.

Are brief psychotherapies effective in depression?

Available evidence is that brief psychotherapies, including cognitive behavioural therapy, interpersonal therapy and short-term dynamic psychotherapy, are as effective as medications in treating depressed patients. In certain circumstances, such as patients with personality disorders and histories of trauma, psychotherapies may, in fact, be superior to medications alone, as evidenced by recent research.[2,3]

3. Brief psychodynamic therapy

In general, this model works by helping the patient experience emotions that are unconsciously avoided and leading to depression. A mixture of love and rage felt for the same person is a typical example of complex feelings that can lead to depression. Emotions may be linked to past trauma (*i.e.,* the death of a parent in early childhood) and are mobilized by parallel, present situations (*i.e.,* losing a job).

In this therapy, the pattern of internalizing anger is undone and healing of old wounds may take place. In short, unconscious emotional processes that lead to depression are managed.

4. Interpersonal therapy

This treatment helps the patient examine relationship patterns and bring about changes in these patterns. The treatment dyad then focuses on one or other interpersonal issue, such as loss or role transitions.

For example, in the loss focus, the process is on grieving and adjusting to a loss of a relationship. Through examining and changing interpersonal patterns, this therapy can also help lift depression.

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Psychotherapies appear better tolerated, and may yield superior long-term outcomes. Given the option, more patients prefer psychotherapy to medications.[4] Patients provided psychotherapy stay in studies longer and fewer drop out. There is a lower incidence of side-effects in psychotherapy. The therapeutic alliance may improve medication compliance when psychotherapy is added to medication treatment. And the long-term outcomes, including reduced relapse rates, may make psychotherapies the treatment of choice in major depression.[5]

How do psychotherapies work?

In general, psychotherapies appear to work through general and specific factors. Some general therapeutic factors include:

- collaboration,
- validation,
- gaining self-understanding,
- emotional mobilization,
- seeing how the past has influenced the present situation and
- modeling by the therapist.

The greatest overall therapy factor is the development of a therapeutic alliance—a partnership with the patient against the designated set of problems.

The different major psychotherapy models bring about changes in specific depressive forces or drivers, in addition to providing these common factors. While one may present these separately, the reality is there is much overlap in the real world between these models. The experienced therapist will end up employing aspects of all these in a given course of therapy in a cohesive and patient-specific fashion.

How do you choose an approach?

First, assess the patient to rule out extreme depression requiring hospitalization or emergent intervention. Then, assess the patient's:

- cognitive sets,
- behavioural patterns,
- interpersonal patterns and
- emotional patterns.

The patient may have already tried conservative measures, self-help, exercise and lifestyle changes. If not, these can be recommended first in the case of mild depression.

The choice of psychotherapy type may unfortunately be limited by availability of services in the public sector. The selective focus on emotional patterns related to the past, thinking patterns, behavioural patterns or relationship issues may make one or other approach more desirable to a patient at a given point in time.

Patients with personality disorders and chronic self-destructive patterns in addition to depression may benefit from brief dynamic therapy approaches that have recently been validated in this population.

Patients with comorbid substance abuse require a multimodal team approach to deal with physical and social issues. Major family- or couple-related precipitating factors may best be addressed by involving the related individuals in therapy. Ultimately, the best test of suitability is a trial of the treatment over a few sessions to see if there is good fit between patient, therapist and model.

What about combinations with medications?

The current consensus is that adding psychotherapy to drug treatment of depression significantly increases the odds of beneficial outcome and decreases the dropout rate.[6]

Given the evidence that 50% to 60% of patients will not remit with medications alone, high rates of relapse on cessation and the rate of poor compliance with medication alone, one could argue that medication should not be offered alone at any time. However, one does not routinely need both treatments in mild or uncomplicated depression, since the range of psychotherapies and medications may be sufficient as single treatments.

In severe depression, chronic depression and in the elderly, psychotherapy should be added to medication treatments. In those with histories of trauma and in those with personality disorders, and when psychotherapy is the patient's preference, psychotherapy should be part of the treatment, if not the first-line and only treatment.

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5. Other models

Group therapy and a range of alternative therapies also treat depression through some of the above noted therapy factors, as well as others. For example, yoga, massage, exercise and reading self-help books all have some data to suggest they can treat at least mild depression.

Treating Linda

Linda is offered brief psychotherapy and medications alone or in combination. After an interview, brief dynamic therapy is chosen, focusing on emotional factors which are leading to anxiety, avoidance and depressed mood states.

Linda's chronic fear of emotions, such as anger, are found to date back to verbal abuse in her childhood. Over 12 sessions, she notices improved thinking patterns, more confidence, more energy and more assertiveness. She becomes more comfortable handling emotions in her work relationships and at home.

References

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